

Putting Managed Care Regulation in Perspective

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A regulatory framework has been developed to address managed care activities as they exist today. Current and future regulation will continue to serve an important purpose, but regulation is not the ideal way to address every concern about managed care. Employer and consumer demands can and do influence the insurance products offered. The current crisis of affordability and the uninsured warrants judicious use of regulation and some reliance on market forces to allow managed care plans to be one part of the total solution.

Regulatory Evolution

Regulation plays an important role in our society and our economy. Numerous industries and professions are subject to regulation, with the common generic purpose of protecting “the public good.” In the case of managed care, North Carolina’s regulation protects the insurance-buying public first and foremost by imposing financial requirements to ensure that funds are available to pay claims. However, there are other types of regulation. Our laws impose minimum standards for insurers’ operations and practices to ensure that promised coverage and services are delivered fairly and in accordance with policy provisions. We also have regulation to require coverage for certain services under certain circumstances in order to promote insureds’ health and protect them when they might be most vulnerable and in need of care. Finally, there is very limited regulation of insurers’ business relations with health care providers.

Regulation is, by its nature, reactive. Many regulatory requirements are created only after the entity being regulated begins engaging in a new activity—or finds a new way to carry out an ongoing activity—and real or potential consumer harm becomes apparent. Consequently, managed care regulation has changed as the managed care industry has changed.

Before managed care, health insurers were in the business of reimbursing insureds for medical expenses. The primary focus of regulation of these insurers was financial—making sure that they maintained adequate capital and reserves so funds would be available to pay claims. There was also basic market conduct regulation, such as setting standards for marketing and advertising to ensure that insurance policies accurately disclosed conditions of coverage, and standards for claims adjudication to ensure that claims were paid according to the insureds’ policy. This focus was appropriate to the industry as it then existed.

With the establishment of HMOs, new regulatory requirements appropriate to first-generation managed care were enacted. First, there was recognition of the fact that, unlike traditional insurers, who simply reimbursed insureds for expenses incurred, HMOs are a system for health care financing and delivery. The need for financial regulation was greater than for traditional insurers because HMO members purchased prepaid medical services, which meant that insufficient funds could mean a disruption in care rather than a reimbursement problem. Regulation also required that HMOs secure the contracts necessary to offer a network of providers to deliver the care promised.

During the late 1980s and early 1990s, indemnity insurers developed their preferred provider organization (PPO) benefit plans, and HMOs became more sophisticated in their methods of “managing care.” Managed care regulation was expanded to address these developments. New laws and regulations set standards for provider credentialing, network adequacy, utilization review (UR), appeal and grievance processes for insureds, quality assurance programs, and disclosure of certain information to insureds. By the late 1990s “managed care regulation” no longer meant regulating just HMOs, but PPO plans too, and North Carolina had a comprehensive regulatory framework to match the major activities of managed care plans. External review laws, which became effective in 2002, completed North Carolina’s so-called “Patient Bill of Rights.” This regulatory framework was crafted to ensure that managed care plans have systems to develop and maintain a network of providers sufficient to

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deliver covered services, that medical management procedures are developed and administered in accordance with minimum standards so that coverage will not be denied in an arbitrary or capricious manner, and that insureds have a reasonable standardized process through which they can appeal insurer decisions. In short, this regulation of industry practices and operations was intended to result in all managed care plans having and using systems designed to ensure that all insureds receive meaningful coverage consistent with their policy.

Another category of regulation is aimed at avoiding very specific consumer harm that could result from certain managed care activities. A significant number of these "single issue" laws have been enacted since the mid-1990s. To name a few examples, laws now address coverage of emergency medical care, hospital length of stay for childbirth and mastectomies, coverage for breast reconstruction following mastectomy, coverage for nonformulary prescription drugs and exemptions from drug management programs such as step-therapy, access to standing referrals to specialists for up to one year, and access to specific types of health care providers within a network when a needed service falls under the scope of practice of more than one type of network provider. These types of regulatory provisions are often intended to protect subpopulations of insureds who have specific needs due to specific circumstances. Usually, any associated cost is covered by premiums paid by all insureds. But some of these laws are also examples of cases when not all insureds share the same interest. The less the odds that a given insured will someday benefit from one of these protections, the greater the subsidy effect. Of course, insurance is based on the principle of spreading the risk of potential loss over a large population. And some consumers who may never avail themselves of these protections may still value them for the peace of mind they provide "just in case" they are needed. However, to the extent that the cost of these protections renders insurance unaffordable for some, protecting the public good is less straightforward, since it creates winners (those who remain insured and enjoy these new protections, whether or not they ever directly benefit from them) and losers (those who can no longer afford insurance).

Finally, in a departure from the traditional focus on insureds, managed care regulation relating to insurer and HMO dealings with health care providers has also been enacted in recent years. North Carolina enacted a Prompt Pay Law in 2000 and Uniform Provider Credentialing Law in 2001. Because managed care plans' provider networks are integral to the delivery of covered services to insureds, it is not always possible to draw a bright line between insureds' interests and providers'. Additional provider concerns regarding insurer and HMO contracting and claim practices will likely be aired during the 2003 legislative session, and our state legislators will have to decide whether there is sufficient connection to insureds to justify further regulation of the

contractual relationship between providers and insurers. If there is not sufficient connection to insureds, legislators may determine that the increasingly adversarial relationship between providers and insurers warrants regulation simply to protect providers.

Regulation Is Not a Panacea

I believe that North Carolina's regulatory system provides a strong base of consumer protection, but is by no means perfect. Managed care operations do not run perfectly, and insureds and providers do not believe that every UR or claim determination is correct nor every plan feature fair. Insurers say that they bear significant costs due to various types of regulation, and these are being passed on to insureds, rendering insurance unaffordable to some. But managed care plans are subject to an extraordinary array of detailed regulation that, on the whole, does provide for a great deal of accountability and procedural protections compared to most consumer transactions, and also enhances the real value of coverage.

Regulation and the authority of regulatory agencies are defined by law and administrative rules promulgated pursuant to law. From a practical standpoint, this fact limits what regulation can accomplish. Even the most carefully written laws can have a loophole, fail to address a specific situation, or otherwise fall short when implemented. Due to its nature, the legislative process nearly always must involve compromise. These compromises sometimes result in a law that is difficult to implement despite the best efforts of all parties involved. If adjustments are later found to be needed, or the law is found not to be a workable or effective solution, it cannot be changed except by additional legislation. Furthermore, legislation may only be sought and considered as permitted by the legislative calendar.

For all of the reasons above and many more, market forces are a legitimate and appropriate alternative means to satisfying consumer needs and demands. While the profit motive can potentially create incentives for some insurers to do the "wrong thing" by reducing medical costs too much or by the wrong means, it is also a powerful incentive to offer health plans that provide the coverage people want and can afford. When accompanied by strong regulatory requirements for company operations and conduct, market forces can yield the right products to meet demands and give insurers the flexibility to change and update products as demands change.

Admittedly, because most people receive health insurance through their employer, insurers often focus on meeting the demands of employers, which are not always the same as the demands of the insureds. However, employee expectations can still have an impact on plan design. Employee demands for more flexible managed care during the latter

half of the 1990s, when the economy was strong and the labor market tight, resulted in lasting changes to managed care plans. We saw this occur in the development of HMO point-of-service and open-access plans, the resurgence of PPO plans, and reduced reliance by insurers on traditional UR. Despite the fact that the economy and job market are much weaker today and health insurance premiums are rising at a rapid pace, employers and insurers are presently not reverting to the old managed care model of restricted networks and heavy UR. Employers and insurers apparently view cost-shifting, whether in the form of greater share of premium paid by employees or higher deductibles and copays, as more acceptable to employees than a return to more rigid managed care. I believe this says a lot about the power consumer expectations have in influencing health plan design.

Employers and insurers are also beginning to explore defined contribution plans and consumer-driven plans as a means of controlling and shifting costs. Defined contribution plans can take several forms. The most simplistic type of defined contribution plan is one where employers issue vouchers for employees to use to purchase their own insurance. A more realistic form is one where employers issue a medical spending account to employees and provide a catastrophic insurance plan that covers expenses after the employee has exhausted his or her medical spending account and also borne a set amount of out-of-pocket expenses. Consumer-driven plans can also take several forms, all of which involve some amount of employee selection or customization of health plan, and some of which include the use of a tiered benefit

design for medical services. These types of plans give insureds greater control, choice, and flexibility in return for assuming greater responsibility—financial responsibility and responsibility for their health and healthcare choices.

Regulation for Today and the Future

The challenges for managed care regulation are great. For at least the near term, regulatory efforts should focus on ways to allow managed care plans to be part of the solution to the current insurance crisis. This does not have to mean that the public good is abandoned, but it may require a shift in focus. Certainly, no one should be vulnerable to “abuse” by the managed health care system or be treated unfairly, but regulating to cover every contingency and health need comes at the cost of increasing the number of uninsured. New product designs and other innovations need to be viewed in their totality and in the current context. Plans that place more responsibility and decision-making on insureds are also a means of preserving the choice and flexibility that consumers have demanded and won. At a time when the likely alternatives are to have no insurance at all or to have plans that either offer fewer benefits or use more restrictive networks, we must be open to new ideas and to allowing market forces to determine what is acceptable to consumers—so long as the result is workable for industry and the product is understandable, not misleading, and offers net value to insureds. In order to remain a positive force, managed care regulation needs to complement, not stifle, market innovation.