State Regulation of Managed Care: The Impact on Children

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Abstract

As more and more children enroll in managed care, states have responded to concerns expressed by their constituents by passing legislation and developing credentialing requirements to assist families with children in receiving appropriate care from managed care plans. Although most of the legislation and credentialing requirements apply to the population generally, a few provisions apply specifically to children. The legislation and credentialing requirements attempt to improve both access to medical care and the quality of care by enacting access-to-care and quality-of-care provisions, reducing the financial incentives for providers to offer inappropriate care, and providing families with more information about their choices and opportunities to redress their grievances. Although there is no empirical evidence, analysis of similar types of legislation suggests that certain approaches will be more successful than others; one obvious indicator of success is the ability of the regulatory agency to develop clear, unambiguous, enforceable rules. Existing legislation varies widely across states in terms of the issues addressed and the specificity of the laws. For the most part, this legislation has been piecemeal, addressing specific issues as they arise. In the long run, state legislatures may not have the time or the expertise to regulate the managed care industry, and other regulatory bodies may be better equipped to address concerns about managed care. If utilized, however, existing regulatory bodies, which historically monitored fee-for-service medicine, will need to be redesigned to monitor managed care.

With the rapid increase in enrollment of families with children in managed care plans, state officials are becoming concerned that some managed care plans might not offer services that are appropriate to children, especially those children with chronic illnesses. In response, most state governments have undertaken a series of legislative actions to regulate certain aspects of the managed care industry. Although state jurisdiction over managed care is somewhat limited by the federal Employee Retirement Income Security Act (ERISA), which exempts self-funded (that is, self-insured) plans from state laws and regulations, few, if any, managed care plans have only enrollees covered by ERISA. As a result, all or nearly all managed care plans must comply with state legislation.
In 1996, state legislatures introduced more than 400 proposals to regulate the managed care industry—twice as many as in 1995 and four times as many as in 1994. Based on legislative activity in early 1997, this exponential growth rate appeared likely to continue through 1997 and into 1998. In 1996, state legislatures in 35 states passed 56 bills regulating the actions of managed care plans. Although the level of interest in regulating managed care varies considerably from state to state, nearly all states have passed some form of legislation regulating managed care during the past three years. It is clear that most of these laws will directly affect children enrolled in managed care plans.

States have developed various approaches to credentialing managed care plans that want to participate in the Medicaid program. In 1996, Medicaid programs in 23 states contracted with any plan that met the state’s qualifications and was willing to accept the price established by the state. Medicaid programs in 12 states contracted with selected plans using a competitive bidding process. The competitive bidding process usually required that managed care plans interested in participating in the Medicaid managed care program meet defined criteria (for example, financial solvency and provider networks) established by the state. The credentialing requirements sometimes covered other topics, such as whether children were given access to certain pediatric specialists.

This article summarizes the efforts by state governments to regulate managed care and examines the various actions that states have initiated to credential managed care plans that desire to provide care for Medicaid beneficiaries. To investigate the types of legislation and credentialing requirements that states are enacting, the author reviewed state legislation governing managed care. The legislation was identified by consulting an online service, LEXIS-NEXIS, and searching for the keywords “managed care” and “health maintenance organization.” Legislation governing health insurers more broadly was not examined. In addition, rules governing the participation of managed care plans in state Medicaid programs were reviewed. All states with managed care programs were contacted directly. Finally, proposed and enacted federal legislation, congressional hearings, and related literature were consulted.

Because of their relatively recent enactment, it is impossible to determine whether any of the legislative initiatives or credentialing requirements that will be discussed are having a substantive impact on cost, quality, or access. The initiatives are simply too recent and too varied to warrant a comprehensive review at this time. It will most likely be three to five years
before any preliminary evaluation can provide definitive information. As a result, it is necessary to use comparisons to other, similar types of regulation (peer-review organizations, survey and certification, state insurance mandates, and so forth) to speculate about their potential effectiveness.7–9 Some of the initiatives are designed to change the process of care, while others are more focused on health outcomes. An indicator of an initiative’s likely impact is its ease of administration and monitoring. Evaluations of the effects of regulation in other areas suggest that the easier a provision is to administer and monitor, the greater the impact it will have.

Most of the managed care legislation and regulations can be grouped into four categories: access to care, quality of care, financing, and consumer protection. Figure 1 summarizes the number of bills governing managed care passed in each state prior to May 1997. A more detailed list of legislation that has been passed in individual states can be found in Table A1, at the end of this article on pages 88–89. An analysis of this legislation suggests that some states are more actively monitoring managed care activities than others. A number of factors may influence a state’s willingness to regulate the managed care industry. These include the level of managed care penetration in the state, the state legislature’s willingness to regulate industrial activities generally, and the overall actions of the managed care industry in that state. In this article, the specific legislative and credentialing activities initiated by states with respect to children are examined more closely, and the potential impact of these laws is discussed.

**Access to Care**

Numerous newspaper and other media reports have noted that some managed care plans have denied children access to specialty providers, experimental treatments, or other services. Most states have responded to these concerns with legislation designed to improve access to care. State legislation has attempted to ensure access to health plans, certain types of providers, specific services, experimental treatments, and emergency care.

**Access to Health Plans**

**Mandatory Open Enrollment Periods**

Seventeen states have passed legislation requiring managed care plans to have open enrollment periods. For example, Arkansas\(^{10}\) and Colorado\(^{11}\) require all managed care plans in operation for more than 24 months to have open enrollment periods during the year. Most states do not allow a managed care plan to cancel or refuse to renew an individual’s enrollment solely on the basis of the enrollee’s health status. For example, Delaware law states, “No health maintenance organization may cancel or refuse the enrollment of an enrollee solely on the basis of the enrollee’s health.”\(^{12}\)

Other state legislation is more specific and protects individuals with particular illnesses, most likely in response to one or more instances in which a person was denied access to insurance. Some of these provisions are directed toward children with specific illnesses; for instance, legislation in North Carolina requires managed care plans to enroll applicants with sickle cell trait or hemoglobin C trait.\(^{13}\)

**Managed Care Plans Prohibited from Excluding Children with Preexisting Conditions**

Some states have laws prohibiting managed care plans from excluding children with preexisting conditions. For example, under the Connecticut Healthcare for Uninsured Kids and Youth (HUSKY) Plan, which provides health care for uninsured children, no managed care plan may apply a preexisting condition exclusion.\(^{14}\) Similarly, the Children’s Health Care Statute in Pennsylvania states that enrollment in a managed care plan may not be denied on the basis of a preexisting condition, nor may diagnosis or treatment for the condition be excluded based on the condition’s preexistence.\(^{15}\)
Other states have adopted preexisting condition clauses specifically for adopted children or children placed for adoption, who otherwise may be at additional risk of denied coverage for preexisting conditions. In both Idaho and South Carolina, no managed care plan may restrict coverage under a health care contract of any dependent child adopted by a member, or placed with a member for adoption, solely on the basis of a preexisting condition, if that child would otherwise be eligible for coverage under the plan. Similarly, in Montana, managed care plans must provide benefits for adopted children of insured members to the same extent as for natural children of members, including the necessary care and treatment of medical conditions existing prior to the date of placement. Finally, both New Jersey and New Mexico prohibit health insurers offering group health plans from imposing preexisting condition exclusions on the following two groups: newborns who are covered as of the last day of the 30-day period beginning with the date of birth; and children who are adopted or placed for adoption before reaching 18 years of age, and who are covered as of the last day of the 30-day period beginning on the date of adoption or placement.

**Access to Specialists as Primary Care Providers**

By late 1997, some 22 states had enacted laws allowing health plan members either direct access to a particular type of specialist or the choice of having a specialist as a primary care provider, though no laws specifically allowed direct access to specialty care for children with chronic or disabling conditions. In 1987, Florida became the first state to pass a direct-access law by allowing chiropractors to be designated as primary care providers. Since the passage of the Florida law, most of
the direct-access legislation has focused on assuring women direct access to obstetricians, gynecologists, or other women’s health care providers. A review of the legislation indicates that as of November 1997, at least 19 states had passed laws assuring women direct access to obstetrician/gynecologists. States also have granted health plan members direct access to specific types of specialists, such as optometrists or ophthalmologists in Arkansas, dermatologists in Georgia, and chiropractors in Kentucky.

Specific Levels of Access to Health Care

Some states have specified the level of access that managed care plans must provide, and most have adopted variations of the American Academy of Pediatrics (AAP) guidelines for appropriate access to preventive pediatric health care. The specific age range, and the number and types of services required by legislation, are often defined. Children in California, for example, are entitled to 18 visits for comprehensive preventive care, including periodic health evaluations, immunizations, and laboratory services in connection with periodic health evaluations, based upon AAP guidelines until they are 17 years of age. In Florida, children from birth to 16 years of age are allowed periodic visits for physician-delivered or physician-supervised services at approximately 19 different age intervals (for example, newborn, one month, two months, and so forth) based on AAP guidelines. Covered services in Florida include a history, a physical examination, developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. In Colorado, children under 13 years of age are entitled to preventive services and immunizations. In Georgia, children from birth to six years of age are entitled to child-wellness services and visits according to the AAP guidelines. Children up to three years of age in Montana are allowed nine visits according to the AAP guidelines. Finally, in New York, children from birth to 20 years of age are entitled to preventive and primary care services.

The intent of these laws is to ensure that children have access to at least minimum levels of preventive and primary care services based on professional standards. For example, the Florida law states that “such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the recommendations for preventive pediatric health care of the American Academy of Pediatrics.” Even though many states have adopted recommendations from the AAP, there are variations in the number of visits children are eligible for and in the age range of children specified in the legislation. Some of this variation may be explained by states relying on additional guidelines published by such entities as the American Academy of Family Physicians and the Advisory Committee on Immunization Practices. The specifics of the legislation also may depend on when the laws were enacted; clearly, guidelines change over time, states may interpret guidelines differently, and they may have to set priorities. Traditionally, coverage has declined as the child’s age increases.

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Referrals to Specialty Services

To assure health plan members appropriate access to specialty services, states have enacted requirements governing how managed care plans select specialty providers and handle referrals to specialists. Children with chronic illnesses, for example, are much more likely to require home health services and durable medical equipment than other children. Without legislation in place, managed care plans that wanted to discourage the enrollment of chronically ill children could make access to these services more difficult. To guard against such practices, states such as Connecticut and Washington require managed care plans to offer coverage for the rental of durable medical equipment. Similarly, Minnesota’s 1997 Patient Protection Act requires each health plan to establish a procedure by which an enrollee may apply for a standing referral to a specialist. This legislation will enable children with chronic or disabling conditions to obtain access to pediatric specialists if their treatment plans require frequent visits to these providers.
Ten states have passed legislation requiring appropriate specialists to develop criteria for utilization review standards. Although most state legislation is vague on this topic, the legislation sometimes refers to generally accepted utilization management activities. According to the AAP, the features of utilization management usually include precertification, concurrent review and discharge planning, “gatekeeping” or case management, preauthorization, physician practice profiling, and high-cost care management. The legislation, however, does not specify how the specialists should develop the utilization review criteria. Also, the legislation typically does not specify who the appropriate specialists are; for example, are adult specialists adequate to develop utilization review criteria for children? States are beginning to be more specific about some of these issues. For example, Louisiana will phase in a pilot program to establish standards for preventive health services and providers, as well as comprehensive insurance benefits appropriate to children, with consultation from relevant professional organizations.

**Mandated Services**

Most state legislatures have mandated that managed care plans offer specific benefits for enrollees, although these laws may not apply to self-funded health plans under ERISA. In self-funded plans, the employer assumes risk for the health care costs of its employees. In effect, self-funded arrangements are usually considered *employee benefit plans* rather than *health insurance plans* for the purposes of state laws governing insurance. However, courts are inconsistent in their application of ERISA preemption. As of 1993, self-funded plans covered more than 44 million people in the United States, but few, if any, managed care plans served only employees covered by ERISA.

Many states have enacted laws mandating minimum hospital lengths of stay for mothers and newborns following childbirth. Most maternity care legislation requires that health plans cover minimum inpatient stays of at least 48 hours after normal vaginal deliveries and 96 hours after cesarean sections. In other states, the laws require only that maternity hospital length-of-stay benefits be appropriate according to guidelines issued by professional organizations such as the American College of Obstetricians and Gynecologists or the AAP. Some states have extended pregnancy-related benefits to cover other services as well. Hawaii, for example, requires that managed care plans offer a one-time-only in vitro fertilization benefit if they provide for pregnancy-related benefits.

**Coverage of Experimental Treatments**

Some states require that managed care plans provide access to “experimental” treatments such as bone marrow transplants or organ transplants, particularly for individuals with potentially fatal illnesses. At least 10 states, for example, require that managed care plans cover bone marrow transplants for the treatment of certain cancers, such as breast cancer, if specific medical criteria are met. Other states have mandated that managed care plans follow a predetermined process to determine whether a service is experimental or medically unnecessary before denying the service. For example, Minnesota requires each managed care plan to establish “an expedited fact finding and dispute resolution process to assist enrollees of health plans with contested treatment, coverage, and service issues.” Minnesota also requires each managed care plan to establish an “expedited resolution of complaints about medically urgent services.” Washington law requires managed care plans to define what constitutes “investigational” or “experimental” medical care, and to specify who determines which services fall into these categories. California requires a managed care plan that denies coverage for experimental treatment to an enrollee with a terminal illness to provide the individual with the following: the medical and scientific reasons for denying coverage; a description of alternative treatment, services, or supplies covered by the plan; and copies of the health plan’s grievance procedure and/or complaint form. The California law also allows the enrollee to request an emergency conference to discuss the denial of coverage.
Out-of-Plan Emergency Care
Many states have passed legislation regarding access to out-of-plan emergency care, and this legislation has important implications for the delivery of pediatric acute-care services. For example, parents whose child has a high fever or has had an accident are likely to make a trip to the emergency room. Parents with young children, especially, may not have the skills to accurately assess the seriousness of their baby’s illness or injury. In an effort to reduce inappropriate utilization of services, a number of managed care plans have refused to pay for these services if they were deemed unnecessary retrospectively. In response, many states have adopted regulations prohibiting retroactive denial for emergency care if a “prudent layperson” could have reasonably expected to suffer serious harm without this medical attention.

The criteria used by managed care plans to evaluate the prudent layperson standard vary considerably from state to state. Missouri requires managed care plans to cover emergency medical conditions that would lead a prudent layperson to believe immediate care was needed. California legislation requires managed care plans to pay for emergency services unless it is determined that the emergency services were never performed or that the enrollee reasonably should have known that an emergency did not exist.

Georgia law permits an emergency care provider to initiate necessary intervention to stabilize the condition of a child without seeking or receiving prior authorization by the managed care plan if the emergency care provider considers the treatment necessary. Illinois prohibits managed care plans from excluding coverage for emergency transportation as reasonably determined necessary by a physician, public safety official, or other emergency medical personnel. Minnesota requires managed care plans to analyze the following factors before determining whether to provide coverage for an emergency room visit: a reasonable layperson’s belief that the circumstances required immediate medical care, the time of day and day of the week, the presenting symptoms, the enrollee’s efforts to follow the managed care plan’s established procedures for obtaining emergency care, and any circumstances precluding the use of the plan’s established procedures for obtaining emergency care.

Enrollment of “Any Willing Provider” into the Health Plan
Although the major goal of “any willing provider” legislation is to protect providers, such legislation is also an attempt to promote access to care. “Any willing provider” legislation compels managed care plans to enroll any qualified health care provider who is willing to accept the plan’s payment system, credentialing system, and quality standards. Such legislation offers improved access to care because more providers may participate in managed care plans. Currently, 25 states have passed legislation allowing providers to join any managed care plan if the provider meets the terms of the plan. For example, South Carolina prohibits managed care plans from refusing membership to any licensed physician, podiatrist, optometrist, or oral surgeon who wants to become a provider in the organization on the basis of his/her profession. Idaho allows any family practice and general practice physicians, general internists, pediatricians, obstetricians, and gynecologists to be included in any health plan’s network of primary care providers.

Access to Care Under Medicaid
Medicaid programs vary dramatically with respect to how precisely they specify access to specialty services. The Delaware contract with managed care plans recognizes that “Because there are so many factors involved in judging the adequacy of specialty provider networks, specification of a single standard ratio of the number of specialists to the number of enrollees is inappropriate.” On the other hand, Florida is more specific about the range of specialists that Medicaid programs must provide. Florida’s contract states that “[t]he Plan shall assure the availability of the following specialists, as appropriate for both adult and pediatric enrollees, on at least a referral basis, cardiologist, orthopedist, urologist, dermatologist, otolaryngologist, chiropractic physician, podiatrist, gastroenterologist, oncologist,
radiologist, pathologist, anesthesiologist, psychiatrist, oral surgeon, physical therapist and a specialist in AIDS care (infectious disease specialist). The law states that a plan must use pediatric specialists when the needed care is significantly different from that which could be provided by adult specialists; for instance, pediatric cardiologists would be used to treat children with congenital heart defects.

State Medicaid programs have used the credentialing process to ensure that Medicaid beneficiaries—primarily women of childbearing age and children—have access to appropriate health care services that meet minimally acceptable standards. In addition, most states are developing even stricter credentialing requirements for managed care plans that want to enroll the Medicaid beneficiaries with the most complex health care needs, such as disabled children enrolled through Supplemental Security Income (SSI). Most Medicaid programs require that managed care plans provide access to services 24 hours a day, and some require that providers see patients within certain time limits—typically 24 hours for nonemergency urgent care and four to six weeks for routine care. Some Medicaid programs also require access to bilingual medical services.

Potential Impact of Access-to-Care Laws

The access-to-care provisions are likely to have some effect on care for children with chronic health conditions. The average cost of health care for children with chronic health conditions is anywhere from 2 to 120 times higher per year than the average cost of providing medical care services to all children. This variation in spending is true for both Medicaid and privately insured children. These higher expected costs provide an economic incentive for managed care plans not to enroll children with chronic illnesses and to disenroll them if they develop chronic illnesses, unless the payment system adjusts for their higher expected costs. Unfortunately, most of the payment systems that are used today do not adequately adjust the payments to reflect the higher expected costs of children with chronic illnesses.

In the absence of risk-based payments, certain access provisions may improve access for children. Open enrollment, marketing restrictions, and freedom of choice of providers are provisions that are relatively easy to implement and difficult to circumvent. Analysis suggests that these provisions will prevent some managed care plans from taking actions that might keep children—especially children with chronic illnesses—from accessing appropriate services.

Other access provisions—access to specialists, selection of specialists by the managed care plans, the specification of how specialty services will be provided, access to experimental procedures, and access to emergency room care—are more difficult to monitor. Moreover, the effect of regulations in these areas may be minimal because of difficulties
interpreting and enforcing the rules. There is considerable debate within the pediatrics profession, for example, over whether a general pediatrician or a pediatric specialist is necessary to monitor the care of children with certain chronic illnesses. This decision may depend on the skills of the individual pediatrician and the specifics of the child and the family.

Quality of Care
States have enacted several types of legislation designed to monitor and improve the quality of care provided by managed care plans. At a minimum, managed care plans are typically required to obtain a license or certificate of authority to operate in a specific state. The state insurance commissioner usually oversees the licensing process, monitors fiscal solvency, and oversees marketing practices. Most states require managed care plans to collect uniform data, conduct medical audits, and become accredited. Some states specify the level at which data are to be collected (for example, plan, individual provider, etc.) and the indicators to be used (for example, early and periodic screening, diagnosis, and treatment [EPSDT] participation, immunization rates, incidence of low birth weight). Florida, for instance, requires plans to provide the state with information on enrollment and disenrollment, service utilization, and a number of quality indicators. Florida legislation requires that child health visits be provided in accordance with prevailing medical standards consistent with the AAP's recommendations for preventive pediatric health care.

Quality Assurance Medical Audits
Currently, 47 states and the District of Columbia require some form of medical audit, which typically occurs every three years. These audits often include evaluations of quality assurance, utilization review, peer review, patient grievance procedures, and patient satisfaction issues such as wait times for appointments and specialist referral rules. Medical audits may examine all aspects of a plan’s performance or focus on specific indicators of performance. Much of the legislation governing medical audits is quite general. Maine, Wyoming, and the District of Columbia all require managed care plans to establish and maintain procedures ensuring that the health care services provided to enrollees are of reasonable quality, with professionally recognized standards of medical practice. Florida legislation requires that child health visits be provided in accordance with prevailing medical standards consistent with the AAP's recommendations for preventive pediatric health care. The District of Columbia conducts a universal medical audit that provides a single overall assessment of the performance of managed care plans. Maryland uses a more targeted approach, analyzing specific aspects of the managed care plans' performance, and then aggregating the data to reach an overall opinion. Specific aspects included in Maryland reviews include whether baseline clinical examinations are conducted, complaints of enrollees, an enrollee satisfaction survey, and other quality-of-care indicators.

Health Plan Credentialing Requirements
As stated previously, the process of credentialing health plans may be used to ensure some level of access and minimum quality-of-care standards. The Arizona Health Care Cost Containment System (AHCCCS) provides an example of how a Medicaid program has implemented a credentialing process to monitor and maintain health care quality. Arizona evaluates managed care plans in several broad categories: personnel qualifications, program standards, organizational structure, and plan network. A few of the criteria focus on children, including the network criterion, which ensures that children have access to qualified pediatric service providers. Each category in Arizona’s credentialing process is scored, and managed care plans are selected to participate based on both their score and their price. The number of health plans that meet the qualification standards varies from locality to locality. Statewide, however, fewer than half of the applicants are awarded contracts; the others fail either because they do not meet the credentialing requirements or because their bids are too high. In 1995 AHCCCS awarded contracts to only 39 out of 95 bidders.
A number of Medicaid programs have used similar processes to restrict the number of managed care plans that may enroll Medicaid beneficiaries. States vary considerably with respect to the emphasis placed on identifying either minimally acceptable plans or only the most highly qualified plans. Tennessee, for example, allows all managed care plans meeting a minimum standard to participate in the Medicaid managed care program. On the other hand, the District of Columbia has given an exclusive franchise to a single managed care plan to provide managed care services to all children with SSI eligibility. Other states have imposed criteria on providers of certain services. New Jersey, for example, requires all Medicaid beneficiaries with mental disabilities and addictions in a geographic area to enroll in a single managed care group. A managed care plan must fulfill the following requirements to provide services to Medicaid beneficiaries with mental disabilities: at least three years of experience providing publicly supported mental health and substance-abuse services; experience in risk contracting for mental health services; and experience with populations with other special health care needs, including enrollees from linguistic and cultural minorities, children with AIDS, and children receiving child protective services. This centralization of services for chronically ill children could provide access to appropriate medical care. Alternatively, it could lead to an unresponsive monopoly.

**Potential Impact of Quality-of-Care Laws**

Quality-of-care provisions will be difficult to monitor. There is little consensus on what constitutes appropriate medical care for many conditions. As a result of conflicting opinions, considerable judgment by regulators will be required. In addition, academic medical centers, children’s hospitals, and other centers of innovation in pediatric care frequently develop services that cannot be anticipated by legislators or regulators trying to monitor the quality of care. Rigorous enforcement may stifle innovations to improve health care quality for children (see the article by Bergman and Homer in this journal issue).

The quality-of-care provisions that have the greatest potential for positively affecting the quality of care for children are the medical audits and credentialing requirements. It is easier to determine whether a managed care organization is meeting certain quality standards overall than it is to monitor the care provided to individual children. An important public policy issue is whether the standards should require that all managed care plans provide a comprehensive range of services, or whether certain services should be concentrated into one or two managed care plans. For children, there has been considerable discussion over many years concerning the value of regional referral centers.

**Financing**

To become licensed, a managed care plan usually needs to show financial responsibility. Typically, the state commissioner will grant a managed care plan a certificate of authority upon proof of fiscal responsibility, adequate working capital, and/or other funding sources. Most states require financial information to ensure that managed care plans will remain financially stable and able to provide services to their enrollees. Financial statements may be required of managed care plans to show assets, liabilities, sources of financial support, and financial feasibility plans. Medical audits ensure that managed care plans provide financially sound prepayment plans for meeting health care costs.

**Currently, 46 states and the District of Columbia have enacted legislation governing the financial responsibilities of managed care plans.**

**Financial Incentives for Health Care Providers**

Currently, 46 states and the District of Columbia have enacted legislation governing the financial responsibilities of managed care plans, including capitalization and reserve requirements. Capitalization and reserve requirements are “money in the bank,” which is required both for initial purposes and for future protection against insolvency. States usually have minimum surplus and deposit requirements as a means of protection against insolvency for the managed
care plans. These requirements have no particular focus on children, though they could make it difficult for pediatric providers to establish their own managed care plans.

States are becoming increasingly concerned about the financial incentives for physicians paid on either a fully or a partially capitated basis. The impact of capitated payment systems, in which physicians are paid a set rate to provide all health care services under a managed care contract, is especially important in pediatrics. Theoretically, health care providers who are paid a capitated rate have an incentive to provide less care, since they are paid the same amount regardless of services rendered. Children, however, tend to be high utilizers of health care services, and preventive services for children are particularly important to reduce the incidence of chronic health problems during adulthood. Although no state has passed legislation prohibiting capitated reimbursement for pediatric health services, some state Medicaid programs have elected to preserve fee-for-service arrangements through primary care case management programs for this population (see the article by Deal and Shiono in this journal issue).

**Disclosure of Health Plan–Provider Financial Arrangements**

Some managed care plans have attempted to keep their financial arrangements with providers confidential, though a few states are requiring managed care plans to make these arrangements publicly available. Public disclosure assists consumers in making informed decisions by comparing health plans. Also, public disclosure forces managed care plans to be honest and open about their coverage with enrollees and potential enrollees. New Jersey, for example, requires managed care plans to give the Health Department copies of their contract agreements with providers.

**Potential Impact of Financing Laws**

Some of the financing provisions will be difficult to monitor and therefore are likely to have a minimal effect. Managed care plans that want to provide their physicians with financial incentives to act in certain ways will be creative and will be able to circumvent the intention of the legislation. The capitalization and reserve requirements are easier to monitor and therefore are more likely to have an impact.

**Consumer Protection**

States are enacting various laws to protect consumers. Many observers suggest that consumer protections may promote quality and restore consumer trust in the health care system.
Consumer protections may include disclosing information about health plans and participating network providers to enrollees and potential enrollees, ensuring the confidentiality of patient information, establishing systems to receive and process patient complaints, and monitoring marketing restrictions placed on managed care plans. Ensuring that individuals have full information about health plans to make informed decisions when purchasing policies, and ensuring that managed care plans fulfill what is stated in their contracts, are particularly important areas of consumer protection.

Providing Enrollees with a Complete List of All Covered Services

Most states require managed care plans to provide evidence of coverage to health plan members. Evidence of coverage and disclosure of information include providing enrollees with the following: information about material changes in coverage, a list of all available health services, a description of the managed care plan’s grievance and/or complaint system, and an annual statement of the managed care plan’s financial condition. This information is important for children and their families. For example, knowing whether—and to what extent—a plan covers ancillary services, such as physical therapy and durable medical equipment, can help families of children with special health care needs choose a plan that covers their unique service needs. The information may also tell these families who the specific providers are and where they are located.

Protecting the Confidentiality of Plan Members’ Medical Information

Many states require managed care plans to keep medical information confidential in order to protect health plan members. Currently, 41 states and the District of Columbia also require managed care plans to take specific steps to guarantee the confidentiality of medical information for health plan members. Rhode Island, for example, prohibits managed care plans from sending enrollee-specific information (which is not essential for the compilation of statistical data related to enrollees) to any international, national, regional, or local medical information database.

Mandatory Due Process and Consumer Complaint Systems

Some consumer protection regulations require managed care plans to develop due process procedures that safeguard consumers’ rights. When managed care plans are required to establish systems for receiving and resolving grievances, consumers are assured that they have a forum that will hear their concerns. When managed care plans deny treatment or services, due process procedures may be useful to guarantee the disclosure of information and compliance with the complaint process. For example, Florida created a statewide managed care ombudsman committee. The ombudsman committee receives complaints regarding the quality of care in managed care plans, and assists the state agency that has regulatory authority over managed care in investigating and resolving the complaints. Michigan
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### State Legislation Indicators Monitoring Managed Care, 1997

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**Key**
- X = Obstetrician/gynecologist
- * = Other (for example, optometrist, dermatologist, chiropractor)
- 1 = Maternity stay guidelines
- 2 = Mammography/cytologic screening exams
- 3 = Experimental (for example, bone marrow transplants for treatment of cancer)
- 4 = Mastectomy/reconstructive surgery

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a Alaska, Louisiana, New Hampshire, New Mexico, North Carolina, North Dakota, South Dakota, Texas: Any willing provider legislation is for pharmacists.
b Indiana: Emergency care is provided for Medicaid recipients.
c Massachusetts: Confidentiality of medical information protects communications made to psychotherapists.
d Michigan: Direct access is provided for Medicaid recipients.
e Montana: Any willing provider legislation is for dentists.
f Virginia: Any willing provider legislation is for podiatrists.
requires managed care plans to establish and maintain reasonable procedures for receiving, processing, and resolving enrollee complaints. Additionally, Michigan allows enrollees of managed care plans to file grievances with a task force after exhausting other grievance procedures. New Jersey has enacted legislation that allows health plan members to pursue nonbinding appeals with an independent utilization review body in grievance actions involving utilization review decisions. California, Missouri, and Texas have installed toll-free numbers for consumer complaints about managed care plans. Maryland requires managed care plans to provide “24-hour access by telephone to a person who is able to appropriately respond to calls from members and providers concerning after-hours care” and 24-hour toll-free numbers for use in hospital emergency departments. Arizona, California, Connecticut, New Jersey, and Rhode Island have all enacted some form of external appeals legislation for managed care grievances.

Restrictions on Health Plan Marketing Practices
Most states have placed restrictions on the marketing practices of managed care plans; these restrictions do not vary substantially from state to state. Prohibited marketing practices include deceptive advertising, providing misleading or factually incorrect information, and requiring special knowledge to understand which services are covered.

Potential Impact of Consumer Protection Laws
The impact of the consumer protection provisions depends on their implementation and enforcement. The provisions can be useful to identify patterns of consumer complaints. If the information is gathered scientifically, it can, for example, be analyzed to show that certain plans have fewer complaints from families about the care provided to their children. For families with specific problems with particular managed care plans, the ombudsman can provide information about their rights.

Conclusion
Many states are cautious about passing too many laws governing the managed care industry. Their concerns include the impact of legislation on managed care premiums, the anticompetitive nature of certain provisions, interference with the internal management of managed care plans, interference with the practice of medicine, and interference with attempts by managed care plans to develop treatment protocols that balance cost and quality-of-care considerations. One of the most persistent and overarching criticisms has been the intrusive nature of many of the managed care laws. Much of this criticism has been simplified into a sound bite—“regulation by body part.”

State legislatures may not have the time or the expertise to regulate the managed care industry in the long run. In most states, specific regulatory expertise is typically found in the executive branch or in independent regulatory agencies. State legislatures should consider giving more regulatory authority over managed care to their governors or to independent regulatory agencies. For example, a managed health care improvement task force brought together by Governor Pete Wilson of California recently recommended the creation of “a new state entity for [the] regulation of managed health care.” State legislatures also need to realize that the current regulatory apparatuses in most states are designed to monitor fee-for-service rather than managed care. As managed care continues to grow, states need to reevaluate the current roles of the insurance commissioner, the health department, planning agencies, and other regulatory bodies. States will need to determine how much regulatory discretion should be given to the new or existing regulatory agencies. Although regulatory agencies are not known for their flexibility or rapid decision making, such agencies are usually more adept at monitoring changing conditions than are state legislatures.


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