ST. SLYVESTER'S MEETING
November 4, 1999

1. TALK ABOUT TWO SUBJECTS TONIGHT

   MANAGED CARE AND THE PACE PROGRAM

   THESE ARE TWO OF THE TOPICS THAT ARE ON THE MINDS OF MANY OF THE PEOPLE WHO CALL MY OFFICE.

2. MANAGED CARE:

   ANY HEALTH CARE SYSTEM MUST HAVE THREE ELEMENTS

   ACCESS
   AFFORABLE
   QUALITY NEEDED FOR THE BEST CARE

3. IN THE EARLY NINETIES OUR HEALTH CARE SYSTEM IN THE US DIDN'T FARE VERY WELL IN TERMS OF THE THESE STANDARDS.

   MANY PEOPLE HAD ADEQUATE HEALTH CARE, AND SOME HIGH QUALITY OF HEALTH CARE, BUT MANY OTHERS PARTICULARLY IN URBAN AND RURAL AREAS DID NOT. BUT THIS WAS NOT THE DRIVING FORCE THAT HAS CHANGED THE FACE OF HEALTH INSURANCE AS WE KNOW IT. THAT ITEM WAS THE COST.

   WHEN IT BECAME VERY EXPENSIVE FOR THE BUSINESS OWNERS THEN ACTION STARTED TO BE TAKEN.

MANY BILLS ARE PENDING WOULD MAKE IT MUCH STRONGER; WHICH WOULD PUT PATIENTS AND DOCTORS ON AN EVEN FOOTING WITH THE INSURANCE COMPANIES.

• ONE OF BIGGEST PROBLEMS IS "REBUTTAL PRESUMPTION" SIMPLY PUT ANY DISPUTE BETWEEN YOU, YOUR DOCTOR AND YOUR HMO, THE DECISION MADE BY THE HMO IS PRESUMED TO BE CORRECT .. AND IT'S LEFT TO YOU AND YOUR DOCTOR TO PROVE THEM WRONG. MAKES IT KEEP IN MIND THAT HEALTH CARE INFLATION WAS TWO OR THREE TIMES HIGHER THAN THE NORMAL INFLATION RATE. ANYONE WHO HAD INSURANCE MOST LIKELY HAD A FEE FOR SERVICE PLAN.

SO THE HMO CONCEPT WAS TAKEN OFF THE SHELF, BECAUSE IT HAS BEEN AROUND SINCE THE EARLY SEVENTIES, BUT NEVER REALLY CAUGHT ON.

THE IDEA IS VERY SIMPLE, THE HMO, OR MANAGED CARE, IS SUPPOSE TO MANAGE YOUR CARE: PREVENTATIVE TYPES OF CHECKUPS TO DETECT AND TREAT ILLNESSES EARLY WHICH IS MORE SUCCESSFUL AND CHEAPER, THAN WAITING TO LONG.

AND TO CONTROL COSTS: BY INSURING THAT THE DOC'S PARTICULARLY THE SPECIALISTS ARE NECESSARY AND REASONABLE IN THERE CHARGES. THE CONCEPT OF THE GATEKEEPER WAS ESTABLISHED OR THE PRIMARY CARE PHYSICIAN WHO IS TO CONTROLL THE PATIENTS NEEDS.

BUT AS WE ALL KNOW EVEN THOUGH THE CONCEPT WAS WORTHY IN THEORY IN PRACTICE IT BECAME A MONEY MAKER FOR THE INSURANCE COMPANIES AT THE EXPENSE OF ACCESS AND QUALITY. INITIATIALLY THEY REDUCED COSTS SIGNIFICANTLY, WHICH IS NOW CHANGING, SO THE LARGE PURCHASERS OF HEALTH IN SURANCE WERE HAPPY BUT THE CONSUMERS WERE LEFT OUT OF THE EQUATION.

MANY PROBLEMS ~~STARTED TO ARISE~~ WERE CREATED:

- HOSPITAL STAYS FOR MAJOR EVENTS LIKE MATERNITY AND MASECTOMIES WERE MANDATED VERY SHORT

- NOT BEING ABLE TO KEEP YOUR OWN DOCTOR

- NOT BEING ALLOWED TO SEE SPECIALISTS OF YOU CHOICE

- DECISIONS ABOUT YOU MEDICAL CONDITION BEING MADE NOT BY YOUR DOCTOR, BUT BY AN INSURANCE EMPLOYEE, AND USUSLLY A CLERK WHO'S JUST READING FROM A MANUAL.

- AND NO GRIEVANCE PROCEDURE

- EMERGENCY ROOM CHARGES BEING DENIED BECAUSE WERE NOT DETERMINED AS EMERGENCIES

- AND MANY OTHER PROBLEMS

SO AS WITH MANY STATES AND THE U.S. CONGRESS WE PASSED WHAT HAS BEEN CALLED A PATIENT BILL OF RIGHTS. ACA 68 -

- SETS UP THIRD PARTY GRIEVANCE PROCEDURE THAT AT LEAST ALLOWS AN INDEPENDENT MEDICAL PERSON MAKE A JUDGEMENT ABOUT THE DISPUTE (Although Not As Strong)
- EMERGENCY ROOM PRUDENT PERSON RULE
- MINIMUM STAYS FOR VARIES MAJOR EVENTS SUCH AS MATERNITY AND MASECTOMIES.
- DIRECT ACCESS FOR MATERNITY AND GYNECOLOGICAL SERVICES WITHOUT A PCP REFERRAL
- OR HAVE ON GOING TREATMENT NEEDS CAN HAVE YOUR SEPECIALIST BE DESIGNATED AS YOU PCP
- AND OTHER KINDS OF THINGS THAT ARE A STEP IN THE RIGHT DIRECTION

BUT I MUST TELL YOU THAT ISN'T WASN'T NEARLY ENOUGH. THERE MANY OF US, UNFORTUNATELY NOT ENOUGH, WHO THOUGHT IT SHOULD GO FURTHER. BECAUSE OTHER STATES HAVE GONE MUCH FURTHER AND BECAUSE IT'S NEEDED. ALMOST IMPOSSIBLE TO HAVE DECISIONS REVERSED. —

- NO MECHANISMS FOR HMOS TO BE HELD ACCOUNTABLE FOR THEIR DECISIONS WHICH ARE DETRIMENTAL TO THE PATIENTS. NO LEGAL RECOURSE. ESPECIALLY ONEROUS WHEN THESE DECISIONS WERE MADE IN DIRCT CONFLICT WITH ONE'S OWN DOCTOR. IN PA THERE ONLY TWO GROUPS THAT HAVE TOTAL IMMUNITY IN COURT— FOREIGN DIPLOMATS AND HMOS.

  DURING THE DEBATE THE INSURANCE COMPANY MEMBERS ARGUED THAT IF COURT SUITS WERE ALLOWED THE COSTS WOULD GO THROUGH THE ROOF. BUT TEXAS DOES ALLOW SUITS AND HAVE SEEN ONLY A FEW LAWSUITS FILED. COSTS HAVE NOT INCREASED AND HMO'S HAVE BECOME MORE ACCOUNTABLE.

  *ANOTHER BIG HOLE IS OUR LAWS IS A LACK OF DEFINITION OF MEDICAL NESSESSITY. EACH HMO DEFINES THIS TERM IN IT'S OWN WAY. WITHOUT A LEGAL DEFINITION OF MEDICAL NECESSITY HMO'S WILL CONTINUE TO MAKE THEIR OWN RULES GOVERNING PATIENT CARE AND COVERAGE.

  THESE ARE JUST A FEW OF THE MOST GLARING THINGS THAT NEED TO BE DONE TO AFFORD PENNSYLVANIANS THE KIND OF HEALTH CARE THEY ARE ENTITLED TO.

4. NOW I'D TO TAKE A FEW MINUTES AND TALK ABOUT THE PACE PROGRAM.

AS YOU KNOW PACE IS AN ACRONYM FOR PARMACUTECAL CONTRACT FOR THE ELDERLY.

OVER THE YEARS SINCE IT'S INCEPTION, BEING PAID THROUGH LOTTERY IS HAS BEEN A WONDERLY SUCCESSFUL

PROGAM. AND FURTHER OVER THE YEARS DEPENDING ON THE SUPLUS OF LOTTERY FUNDS WE'VE BEEN ABLE TO INCREASE THE INCOME LIMITS.

*FOR PACE IT'S $14,000 SINGLE AND $16,000 FOR MARRIED.

WE HAD A BIG DEBATE A FEW YEARS AGO WHEN MANY OF US THOUGHT WE COULD RAISE THE LIMITS TO $16,000 AND $19,000, BUT ADMINISTRATION DIDN'T AGREE AND THEY SET UP WHAT IS CALLED PACENET.

*PACENET ELIGIBILTY IS INCOMES BETWEEN $14,000 AND $16,000 AND $17,200 AND $19,200 FOR MARRIED. BUT REQUIRES A $500 DEDUCTABLE BEFORE ONE CAN RECEIVE ANY BENEFITS AND AN $8 COPAY FOR GENERIC PERSCRIPTIONS AND $15 COPAY FOR BRANDS.

SINCE THE AVERAGE PACE USER ONLY HAS A $700 PERSCRIPTION BILL IN A YEAR MANY SENIORS HAVE NOT BOTHERED TO SIGN UP. AS A MATTER OF FACT WHEN THE GOV FIRST PROPOSED THIS PROGRAM THEY SAID THAT AN ADDITIONAL 50,000 SENIORS WOULD SIGN UP BUT ONLY ABOUT ~~11,000~~ 16,000 HAVE. AND THAT'S AFTER THEY SPENT $600,000 ADVERTISING TRYING TO GET PEOPLE ENROLLED.

WE THINK THERE'S A BETTER WAY, WHICH IS WHAT WE PROPOSED ORIGINALLY.

JUST RAISE THE PACE PROGRAM LIMITS TO $16,000 AND $19,000 AND INCREASE THE NUMBER WHO ARE ELIGIBLE. THERE IS A $97 MILLION DOLLAR SURPLUS IN THE FUND NOW.

Elements

Rep. Tom Tangretti
TALKING POINTS
MANAGED CARE IN PENNSYLVANIA

PATIENT PROTECTION:
What's been done; what remains to be done.

HMOs and other managed care plans have a two-fold responsibility. first, and most importantly, it is their job to manage your care – to make sure you receive the treatment you receive and that it is paid for. second, it is their job to manage the cost of health care for all members enrolled in the plan so that money is not wasted on unnecessary or unproven treatments. At times, these responsibilities seem to be at odds with each other, and this is when problems arise between patients, their doctors and HMOs.

Increasingly, HMOs have been seen as focusing too much on the cost-control side and not enough on patient care. In response, many states have passed legislation setting up minimum patient treatment and coverage standards for HMOs.

The Pennsylvania General Assembly passed Act 68 last year. The act, called the Quality Health

Care Accountability Protection Act, went into effect on January 1. Its new provisions became effective for your managed care health plan whenever your policy was renewed on or after January 1.

The new law gives you certain rights and sets up new procedures for resolving disputes that you and your doctor may have with your HMO. I want to take a few minutes first to talk about those new procedures, because I believe they are the aspect of Act 68 that most HMO patients are concerned with.

But I also want to spend a few talking about concerns I have with Act 68. I share the view with several other lawmakers in Pennsylvania that Act 68 does not go far enough – that patients and their doctors too often are still at a great disadvantage when it comes to disputes with HMOs. I will address some of the proposals now in the General Assembly for fixing these problems.

Most disputes with HMOs revolve around treatment or coverage that has been denied, but problems can also center around the quality of

care you are receiving from your doctor, your access to that care, and your share of the costs of that care. Act 68 sets up a specific procedure you need to follow when dealing with your HMO about any of these kinds of problems.

If you have a problem with your HMO, the first thing you should do is call your plan and try to resolve the problem in an informal way. Many times, treatment or coverage is restricted or denied because of a misunderstanding, and most HMOs' member services departments will work with you to solve the problem.

In some cases, however, you may need to file a formal complaint or grievance with your HMO. If your first call to the HMO does not resolve the problem, call them back and tell them you want to file a formal complaint or grievance. The nature of your problem will determine which one you want to file.

If your HMO is denying you treatment covered by the plan or is denying you coverage for that treatment on the basis that it is not medically necessary, you should file a formal grievance. Examples of when to file a grievance are if you

visit the emergency room and the HMO denies your claim because they say it wasn't a real emergency. Or, if you want to see a specialist for your problem but your primary care physician refuses to refer you because he feels he can treat your condition himself.

If your problem does not involve the denial of treatment or coverage, you should file a formal complaint. Examples of when to file a complaint include if you disagree with the kind of treatment your doctor has prescribed for your problem; if you are finding it difficult to get an appointment with your doctor; if you disagree with your HMO about whether a treatment is cosmetic or experimental; or if you have a complaint about a premium or rate increase.

Both complaints and grievances start out being handled the same way by your HMO. A first-level committee within your HMO will review your complaint or grievance. If you are not satisfied with its decision, you can appeal to a second-level committee. You have the right to appear before each committee and explain why you believe your disputed treatment or claim should be provided or why corrective action

should be taken. In the case of formal grievances, your doctor can file one on your behalf, but they must have your written permission.

If, after you go through your HMO's internal complaint or grievance procedure, you still are not satisfied, the new law lets you appeal within 15 days to an independent agency outside your HMO.

In the case of formal grievances, you should notify your HMO that you want to appeal, and your case will be forwarded to the state Department of Health. The Department of Health will assign an independent utilization review board to examine your case and make a ruling. The HMO is allowed to charge you a $25 fee for filing a grievance appeal. If your doctor files the grievance appeal on your behalf, the doctor or the HMO, whoever loses the appeal, will pay the $25 cost.

In the case of formal complaints, you can make your appeal directly to the Department of Health or the Insurance Department. They will review your appeal and make a ruling. If your

complaint involves an issue more appropriately decided by another agency or department, it will automatically be forwarded to them.

In addition to this new process for resolving complaints and grievances, the new law also gives you additional rights to coverage and treatment through your HMO.

All women enrolled in HMOs now have direct access to maternity and gynecological services; they do not have to be referred by their primary care physician.

If you are a special needs patient who requires on-going special treatment, you can designate a specialist as your primary care physician or receive an open referral to a specialist.

If you started a treatment before becoming a member of your current HMO, the HMO is required to provide limited continuing coverage for that treatment.

If a doctor who is dropped by the HMO is treating you, the HMO must continue to pay for that treatment for a limited time.

Finally, if you visit the emergency room under conditions that a "prudent layperson" would consider an emergency, your HMO must pay for that visit even if it did not grant prior approval.

Both the Health Department and the Insurance Department have publications available that can better explain these new procedures and rights, and answer questions about your particular HMO and whether it is covered by the new law.

Act 68 was a step in the right direction, but important provisions were left out, and the law still favors HMOs at the expense of patients and doctors. In fact, when Act 68 is compared to laws that many other states have passed governing HMOs, Pennsylvania's is indeed quite weak.

There are several proposals pending in the General Assembly to improve Act 68 and to put patients and their doctors on an even footing with HMOs and other insurance companies.

For instance, one of the biggest flaws in Act 68 is called the Rebuttal Presumption. Simply put, this provision of the law says that in any dispute between you, your doctor and your HMO, the decision made by the HMO is presumed to be the correct decision. It is up to you and your doctor to prove otherwise. This makes it nearly impossible for patients and doctors to have HMO treatment and coverage decisions reversed except in the most grievous circumstances.

Another problem is that there still is no mechanism to hold HMOs accountable for decisions they make when those decisions are detrimental to patients. If an HMO denies you coverage and you die or are seriously injured because of it, you have no legal recourse. This is especially troubling considering that in scores of these cases in the past, the decision by the HMO was made contrary to the advice of the patient's own doctor, who was much more familiar with the patient's condition than the HMO administrator making the final decision.

In Pennsylvania, there are only two groups of people with total immunity in court – foreign

diplomats and HMOs. This does not seem right. During debate on Act 68, HMOs argued that allowing patients to sue them would drive health care costs through the roof. But Texas does allow patients to sue their HMOs. That state has seen only a few lawsuits, costs have not increased, and HMOs have become more responsive. We need to give residents of Pennsylvania this same right.

Another big hole in Act 68 is the lack of a definition of medically necessary. Each HMO is allowed to define this term in its own way. Without a legal definition of medically necessary that applies to everyone, HMOs will continue to make their own rules governing patient care and coverage.

Another proposal would allow patients -- for a slightly higher fee -- to pick their own doctors and specialists even if they are not part of the patient's HMO network. Many older patients have been seeing the same doctor for years and are comfortable with them. It is not fair to make them switch doctors simply because they join or are placed in a managed care plan.

in a related proposal, many of us would like to see patients be allowed to choose their own pharmacy for their prescription drugs. In Philadelphia, 140 independently owned pharmacies had to close down when Medicaid managed care came to that area. Medicaid managed care contracted only with large national drug chains, small pharmacies were forced out of business and patients who used to be able to walk down the street to get their medications now have to travel by bus or other means halfway across town. Medicaid managed care is coming to western Pennsylvania now, so expect to see this same trend repeated in our area unless we make this change.

We also need to provide more information to Pennsylvania residents about the different HMOs that operate in our state. Many other states issue HMO report cards that list information such as fees, doctor and pharmacy networks, and the rate of complaints against each HMO. Pennsylvania should do the same so that its residents and businesses can comparison shop when making important decisions about health care coverage.

Finally, we need to improve the dispute resolution process that was put in place by Act 68, and that I already talked about earlier.

First and foremost, patients or their doctors should not have to pay $25 just to get their grievances heard by an independent panel, especially considering that the HMO is presumed correct to begin with.

Also, the arbitrary difference that the current law makes between formal complaints and formal grievances is confusing to patients. The dispute resolution process for all HMO-related problems should be the same, and patients and doctors should be allowed to start out going to an independent body first, without having to spend time going through two levels of the HMO.

And speaking of those independent utilization reviews boards assigned by the Department of Health, The current law allows them to be made up of employees of the same insurance company that the patient has the dispute with.

Pennsylvania residents are moving to managed care plans at a rate that is much higher than the national average. This is happening for a variety of reasons, but the end result is that Pennsylvania's efforts to protect its health care consumers is not keeping pace with the rate in which they are being shifted into HMOs.

We need to make sure that managed care companies are focusing just as much an managing care as they are on managing costs.

While Act 68 was a small, preliminary step in the right direction, Pennsylvania still has a long way to go.

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