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**PUBLIC OVERSIGHT OF MANAGED HEALTH CARE
COVERAGE-CONSOLIDATION-COSTS**

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New Jersey Policy Forums on Health & Medical Care

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PUBLIC OVERSIGHT OF MANAGED HEALTH CARE COVERAGE-CONSOLIDATION-COSTS

THE ISSUE: As ongoing and rapid change continues to characterize the landscape of our highly competitive system of health care financing and delivery, the question of appropriate state regulatory oversight remains critical. How do lawmakers and policymakers sort out, assess and appropriately respond to the often conflicting needs of business, insurers, providers and consumers -- all against the backdrop of mergers, consolidations and concerns about costs?

INTRODUCTION

The “perfect” policymaker must possess the ability to juggle several balls in the air, simultaneously, with great skill, expertise, foresight and quick reflexes. At the same time, s/he must be able to anticipate that several new, unexpected balls will appear and some already-existing ones will drop out, with little or no warning. In the current expanding and contracting world of managed health care, the challenges to lawmakers and policy makers are significant as the stakes have been exponentially raised to find the right balance: how to preserve the integrity of a competitive health care system whose goal (from its outset) was to limit the costs of health care by managing its service delivery, while meeting their mandate to protect the public “good,” in this case, access to appropriate health and medical care of high-quality?

HEALTH CARE – AN INDUSTRY IN FLUX

Health economist James Robinson points out that over the past fifteen years, different models of managed health plans have evolved, covering the spectrum from not-for-profit group models -- such as the Kaiser Permanente Medical Care Program with its closed physician panels -- to broader for-profit network plans, many lifting restrictions and offering provider choice to enrollees (Robinson, 1999). Through his research, which includes interviewing key health industry stakeholders across the country, Robinson predicts that the emerging model of managed care is the multi-product, multi-market health plan. His views:

Public policymakers and industry analysts often assume that there exists somewhere a truly efficient form of physician and hospital organization, an optimal benefit package, an evidence-based set of clinical protocols, and one best method of marketing and enrollment. But even a

cursory examination of the medical marketplace quickly reveals that no one size fits all and that consumers do not agree on what they want, purchasers on what they are willing to pay for, and providers on what they are willing to deliver. The future of the health plan lies at the often conflict-ridden interface between consumers, purchasers and providers, in the development, pricing and distribution of managed care products that reconcile preferences with pocketbooks throughout the health care system (Robinson, 1999, at 9).

In responding to James Robinson’s viewpoint, George C. Halvorson predicts that in the environment of increasingly complex health plans, there will also be an increase in health care costs “that exceeds the rates of increase over the past decade” (*Health Affairs*, March/April 1999). In addition to identifying the increases in drug costs and new technologies as significant contributing factors, Halvorson singularly points to that fact that “both physicians and hospitals in many markets are merging, creating massive local market leverage that often gives providers absolute control over local health care pricing. In many markets the newly formed local provider monopolies are creating price increases of 20-50 percent.” How and in what ways do regulators “fit into” the health care industry marketplace whose activities have broad social, economic and legal impacts?

NEW JERSEY’S MANAGED CARE ENVIRONMENT

The emergence and evolution of managed health care and managed care organizations in New Jersey provides an interesting case study of the types of activities that states around the country are confronting both in their lawmaking and in their court

rooms. Although New Jersey can be characterized as a state to which the extensive practice of managed health care came relatively recently, the evolution of the state's HMOs, Preferred Provider Organizations and Point-of-Service plans has been swift and expansive.¹ In many ways, the numbers well illustrate the story in the case of managed care enrollment in New Jersey, as well as in the U.S. as a whole. In 1998, over 160 million Americans were enrolled in some form of managed health care. In New Jersey, over 4 million individuals are enrolled in managed health care plans, with approximately 2.3 million enrolled in one of the state's nineteen HMOs. Just three years earlier, in 1995, approximately 1.5 million New Jerseyans were enrolled in twenty-one HMOs operating in the state.

PUBLIC OVERSIGHT OF MANAGED HEALTH CARE – WHERE ARE WE GOING?

Many health policy analysts classify New Jersey's managed care laws and regulations as some of the most comprehensive in the nation. For example, in comparison to laws in other states, New Jersey has the strongest HMO net worth and deposit requirements of any other state.

In New Jersey, the Department of Health and Senior Services is the regulator of health facilities and works cooperatively with the Department of Banking and Insurance, which regulates the financial aspects of insurers. Throughout the country, primary regulatory authority varies at the state-level between the Departments of Health and Insurance. New Jersey's principal laws addressing managed health care include: N.J.S.A. 26:2J-1 et seq., Health Maintenance Organizations; N.J.S.A. 17:1-8.1 and 17B:27A-54, Selective Contracting Arrangements of Insurers; N.J.S.A. 17:48E-1 et seq., Health Services Corporations, and N.J.S.A. 26:2S-1 et seq., Health Care Quality Act.

At the beginning of March 1999 (31 N.J.R. 610), the Department of Health and Senior Services in consultation with the Department of Insurance proposed amendments to its rules on financial standards and reporting for health maintenance organizations (N.J.A.C. 8:38-2.3 and 11).² The rules were developed and proposed following a December 15, 1998 public policy forum which was held on initiatives to strengthen the regulatory oversight of the financial condition of HMOs operating in New Jersey. According to the *New Jersey Register* "Summary," the forum's purpose was to gather information and suggestions "on HMO financial reforms from organizations representing the State's hospitals, doctors and other medical providers, public interest groups and the HMO industry. Regarding oversight

responsibility, the amended rules will require that both the Departments of Health and Senior Services and Banking and Insurance conduct pre-operational audits of HMOs prior to issuing a certificate of authority. The rules include more stringent requirements which would increase the amount of money HMOs must keep on deposit with the state and would require them to submit financial reports every three months instead of every year.³

Scheduled to appear in the April 19, 1999 New Jersey Register are the proposed rules under the New Jersey Health Quality Act, N.J.S.A. 26:2S-1 et seq., which was enacted August 8, 1997. The proposed new rules and amendments to N.J.A.C. 8:38 have as their primary purpose the implementation of the provisions of the Act, which establishes standards for HMOs and all other health insurers, health services corporations, hospital service corporations and medical service corporations.⁴ Among the requirements set forth in the statute is the establishment of an Independent Health Care Appeals Program to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits of a covered person under a health benefits plan.

The Department of Banking and Insurance amended its rules at N.J.A.C. 11:4-37, Selective Contracting Arrangements of Insurers, in order to set forth procedures consistent with New Jersey's HMO regulations and to substantively amend requirements of these managed health plans for informing covered persons about their coverage benefits and complaint and grievance procedures. The amendments also applied more stringent drug formulary requirements.

In the New Jersey Legislature, there are several bills pending which cover a broad range of issues related to HMOs and other forms of managed health care, including proposals which would prohibit a health plan's limiting a female enrollee's direct access to an obstetrician/gynecologist (A695), and which would prohibit an HMO from imposing certain restrictions regarding the provision of health care services to enrollees (S734). In February 1999, A2863 was introduced and referred to the Assembly Health Committee. Titled the "HMO Assured Continuity of Care Act," the bill provides that "upon the issuance of a court order or liquidation, rehabilitation or conservation of an HMO with a finding of insolvency," the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services," shall implement certain measures to ensure that individuals maintain continuity of health care through enrollment in other HMOs or health plans.

WHEN REGULATORY SAFEGUARDS FALL SHORT

When compared to other states, New Jersey's laws and regulations possess some of the strongest health care licensing and operating requirements in the country. Yet, in recent months, the state has experienced the failures of two of its HMOs: American Preferred Provider Plan of Newark and HIP Health Plan of New Jersey.⁵ New Jersey's Department of Banking and Insurance Commissioner has stated that regulators view both "as separate incidents and two very different problems, not a trend."

New Jersey lawmakers and policy makers are not alone in grappling with the human, economic and legal impacts of the failure of a large HMO operating in its state. During the past year, state takeovers of failing HMOs and physician management groups have become increasingly common: earlier in March 1999, the state of California took over MedPartners Provider Network Inc., whose 1,000 doctors provide services to 1.3 million Californians through its contracts with HMOs and other insurance carriers (*The Los Angeles Times*, March 13, 1999). In February, the state of Texas' Department of Insurance took over a financially unstable HMO after the company became insolvent, as has been the case in the states of Florida, Arizona, Maryland and Mississippi. The financial instability of the health care industry is attributed to many factors, including mismanagement, overly aggressive expansion and low reimbursement rates (Ibid). This is particularly true in a region like southern California, where the consolidation of medical groups went further than anywhere else in the country, and at the same time, insurance premiums were held to lower levels than in any other state (Robinson, 1999). A 1998 National Health Policy Forum site visit report studying managed care operations and market dynamics in southern California found that: "markets there are locally driven and highly dynamic, with both managed care organizations and provider systems in great flux" (November 17-20, 1998).

In the state of New Jersey's takeover complaint of American Preferred, it has charged that the firm's owner allegedly transferred hundreds of thousands of dollars of funds to his other business interests. The company lost \$15 million in 1998 and failed to maintain \$3.7 million in reserves, which is required for an HMO of its size. In the case of HIP of New Jersey, its parent company -- PHP Healthcare Corporation of Reston, Virginia -- claimed Chapter 11 bankruptcy protection from creditors.⁶

In 1997, HIP Health Plan had entered into a contract with PHP to manage the health care of its

members, in exchange for a percentage of the premiums HIP received. The contract was approved by the state Attorney General and the departments of Banking and Insurance and Health and Senior Services. In November 1998, New Jersey state officials declared HIP Health Plan of New Jersey insolvent and placed the firm under its guardianship.

According to the plan submitted to New Jersey State Superior Court, HIP Health Plans of New Jersey, whose reorganization plan was rejected by New Jersey state regulators, is to be liquidated March 31, 1999. All of the state's health insurance carriers are required to offer open enrollment to HIP enrollees through the end of March and the state will assist HIP Medicaid managed care enrollees to transfer to another Medicaid-approved carrier.

A March 27, 1999 *New York Times* overview of the open enrollment period estimated that some 50,000 remaining policyholders were not enrolled in new health plans. Judge Jack Lintner, who is the Middlesex County Superior Judge overseeing the plan's liquidation, has scheduled a hearing for March 30, 1999 to consider extending the closure deadline for two weeks longer, or April 15, 1999 (Smothers, 1999). In response to the coverage issues, New Jersey's Department of Banking and Insurance has also ordered the state's other HMOs to expedite their handling of applications from HIP members (Voreacos and Washburn, 1999). The order sets forth that coverage will be provided as of April 1 as long as an HIP member has completed his/her application and has paid the necessary premium by March 31.

According to a March 10, 1999 *Star-Ledger* report, lawmakers are currently considering aspects of a bill that would require HMOs doing business in the state to contribute to a common fund that would "pay the debts of health firms that go out of business" (McNichol, 1999). Introduced on December 17, 1998, as the "New Jersey Health Maintenance Organization Guaranty Association Act (A2735), the bill would create an association of HMOs "to serve as a guaranty fund mechanism capable of insuring that the financial obligations of HMOs to their enrollees and health care providers are satisfied." Several other bills (now in committee) have been introduced in the New Jersey Legislature in recent months aiming to address some of the issues that are emerging in the managed health care market in the state: A2763, introduced January 7, 1999, establishes an open enrollment period for enrollees of insolvent HMOs; S1621, introduced January 7, 1999, provides for a supplemental appropriation of \$150 million to the Department of Health and Senior Services for the purpose of "reimbursing health care professionals and health care facilities who are participating providers of HIP

Health Plan of New Jersey and who have not been reimbursed for their services due to the insolvency of the health maintenance organization"; and A2750, introduced on January 7, 1999, which establishes a Managed Health Care Consumer Assistance Program to "prepare, educate and assist health care consumers about their rights in a managed health care system, particularly those who have chronic disabilities and are senior citizens."

THE LIMITS OF PUBLIC OVERSIGHT IN A COMPLEX, "DEREGULATED" HEALTH CARE ENVIRONMENT

The situation with PHP brought into focus a regulatory gap: although PHP had assumed the financial risk and responsibility of caring for HMO members, it claimed it was not held to the same standards as HMOs and insurance companies, such as in maintaining financial reserves (*The New York Times*, December 27, 1998). Criticism regarding state approval of the HIP and PHP deal also includes that fact that during the critical due-diligence period, negotiations and reviews were done in the absence of public hearings and public scrutiny. The issue of whether or not the "sale" of HIP was actually a sale of a nonprofit HMO -- thus requiring that a portion of the sale's proceeds would need to be placed in a charitable trust --, or was a contractual arrangement under which the medical services of HIP were turned over to PHP, thus putting it outside the regulatory purview governing sales of nonprofits, has not been resolved.

At present, federal prosecutors are investigating via a grand jury probe the possible misuse of "millions of dollars of premiums paid" to HIP by its New Jersey customers but never used to pay doctors and hospitals treating its patients (*New Jersey Online*, March 25, 1999). Within the New Jersey Legislature, Senate Health Committee Chair Jack Sinagra (R-Middlesex) has requested subpoena power so that his Committee could launch its own investigation of the failure of HIP. Other legislators have introduced resolutions seeking authority to interview witnesses and documents in an examination of the health plan's collapse.

CONCLUDING REMARKS

According to a 1999 legislative tracking survey conducted by the National Conference on State Legislatures, all 50 states have laws that address structural requirements of managed care organizations, including certificates of authority, financial solvency standards and periodic reporting and filing of operational plans. However, there is great variation regarding the specific requirements of these laws and their enforcement by regulators.

Although regulatory trends in the health care industry have focused on access, quality, consumer protection and delivery system issues -- ranging from any-willing provider laws to a range of consumer protection laws -- analysts predict that the next wave of lawmaking will focus on issues of solvency and the financial integrity of health plans. The continuing challenge is to create an oversight and monitoring system under which regulators can keep up with the "speed of light" changes taking place in the health care industry.

POLICY IMPLICATIONS

Almost monthly, a hospital system or health plan announces its intention to merge or form a close alliance. Physicians, as well, are involved in forming group practices and networks. As the market consolidation trend continues, what are the implications for scrutiny by state and federal regulators vis-à-vis antitrust issues in the health care industry? Health policy analyst William M. Sage identifies "gaps" in the knowledge base of the legal profession, the courts and the health care industry regarding antitrust oversight and the nature of competition in the managed health care marketplace. In a 1997 analysis paper, he points to an absence of empirical data on competition in the industry and calls for a research agenda to be developed in the field of health services research in order to study antitrust litigation and to remedy current "informational deficits" (Sage, 1997).⁷

In what may be a future trend in the ways business and regulators interact -- moving from a sometimes adversarial to a more cooperative, collaborative relationship -- the Pittsburgh Business Group on Health, comprised of 37 employers, is working with state and federal regulators to identify ways for all stakeholders to be responsive to changes in the health care industry regarding the consolidation and mergers of health care providers and third party payers. The firms represented in the PBGH are concerned that their efforts to offer affordable, accessible health care of strong quality to their employees was being undermined by mergers and acquisitions that "restricted their ability to shift to more efficient providers" (Moskowitz, 1999). The group, which asserts that "a mix of competitive and affordable alternative health plans and delivery systems is needed to improve quality, maintain access and assure affordability," is meeting with regulators to determine which officials have responsibility for which aspects of the health care industry and what might trigger an investigation of a proposed merger.

As a result of mergers and consolidations, and the evolving business transactions in the managed health care industry, the role of administrative law, which encompasses federal and state-level rules and rulemaking, is moving center stage. The challenges of discerning and maintaining regulatory authority in this environment continue to push the envelope regarding the gray areas where administrative law and contract law interface. What kind of mechanism can be effected through which regulators and policy makers from many different state departments and divisions can collaborate on monitoring already-existing and newly emerging "regulatory" issues in the health care industry?

What does the future hold for companies like PHP Healthcare Corporation -- who exemplify a class of businesses whose goal is to establish themselves as intermediaries between health plans and providers? How do regulators oversee in the competitive marketplace of health care, where companies like PHP may fall outside of the purview of their regulatory authority? What level of collaboration must be reached between and among insurance regulators and the offices of state attorneys general to monitor activities in such areas as health plan merger reviews and antitrust authority?

The failure of HIP Health Plan of New Jersey serves as an exemplary lesson of the "costs" in human, economic and legal terms when the delivery and/or financing of health care is compromised. The status of HIP's employees also carries a critical message about work force issues related to health care professionals and serves to illustrate their vulnerabilities in a free market system. What safeguards, if any, should be put in place for physicians, nurses, social workers and other health care professionals in order for health plans to attract and retain workers of high quality and credentials?

ENDNOTES

¹ Reference is made to New Jersey Policy Forum *Issue Briefs* published from 1994 to the present on managed health care in New Jersey, and laws and regulations affecting the industry, including consumer protection laws.

² The HMO rules fall under the statutory authority of N.J.S.A. 26:2J-1 et seq, Health Maintenance Organizations.

³ Currently, the HMO industry has \$250 million on deposit to protect creditors in the event that they no longer operate as a business; the proposed rule would require an estimated \$500 million in reserves and give companies up to three years in order to reach that level (*The Star Ledger*, March 11, 1999).

⁴ The proposed amendments and new rules do not implement section 18 of the Act, which requires certain employers to notify their employees on an annual basis in order to specify whether the employer's self-funded plans comply with New Jersey's mandated benefits laws.

⁵ American Preferred Provider Plan served approximately 44,000 individuals, most of whom were Medicaid enrollees; HIP of New Jersey has a much larger membership of approximately 194,000 members (many of whom were government workers in Mercer and Middlesex counties) (New Jersey OnLine, February 1999).

⁶ PHP owes tens of millions of dollars to New Jersey hospitals, doctors and other medical providers for their services delivered to HIP's patients served in its 23 health centers. At present, there is considerable litigation relating to this situation (*American Medical News*, March 22-29, 1999).

⁷ In his analysis, Sage examined the *Marshfield* case, a "landmark" antitrust decision between Blue Cross and Blue Shield of Wisconsin and the Marshfield Clinic. *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, 1995 U.S. App. LEXIS 29056 (7th Cir., 13 October 1995).

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