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MANAGED CARE

State Approaches on Selected Patient Protections

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Managed Care: State Approaches on Selected Patient Protections

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss various approaches the states have taken to enhance consumer protections for the millions of privately-insured Americans who receive health coverage under managed care arrangements.[1] To control rising health care costs and to promote enrollee health, managed care organizations attempt to control or coordinate the use of health services by their enrollees, particularly for high-cost services, such as hospital emergency department services or specialty care referrals. At the same time, consumers have increasingly voiced concerns about the effect of such constraints on their ability to obtain appropriate care. As the primary regulator of private employer-based health insurance for about 76 million people, states have responded to these concerns by implementing various measures designed to protect managed care consumers. However, an estimated 48 million people are enrolled in health plans exempt from state regulation and thus not covered by state patient protections. Pending before the Congress today are a number of bills that would extend certain protections to these individuals.

At your request we reviewed selected state patient protection provisions already in place and congressional proposals under consideration. You specifically asked us to examine state statutes that relate to seven types of patient protection areas: coverage of emergency services, access to obstetricians and gynecologists, access to pediatricians, access to other specialists, continuity of care for enrollees whose providers leave the plan, drug formularies, and patient-provider communication (including prohibitions on "gag clauses").[2] We reviewed the health insurance statutes and regulations in 15 states that collectively account for about two-thirds of those enrolled in HMOs nationwide. In addition, we examined three Senate bills introduced in the 106th Congress--S. 6, the "Patients' Bill of Rights Act of 1999"; S. 300, the "Patients' Bill of Rights Plus Act"; and S. 326, the "Patients' Bill of Rights Act."

[1]Health maintenance organizations (HMO) are the most recognized form of managed care. Other prevalent arrangements include preferred provider organizations and provider sponsored organizations, many of which offer more open-ended access to providers than do traditional HMOs.

[2]Our 1997 review of HMO contracts with physicians found that none of the 529 HMOs surveyed used contract clauses that explicitly restricted physicians from discussing all appropriate medical options with patients. However, plans' ability to terminate physician contracts can bring significant pressure to bear on physician-patient communication. See Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, but Physician Concerns Remain (GAO/HEHS-97-75, Aug. 29, 1997).

My remarks today will focus on the 15 states' experience with crafting selected patient protection measures. In brief, we found that many states have responded to managed care consumers' concerns about access to health care and information disclosure. However, they often differ in their specific approaches. For example:

- Two states—California and Minnesota—have laws and/or regulations that address all seven types of protections we analyzed. Two other states—Colorado and Massachusetts—have laws that address three or fewer protections.
- The patient protection most common among the 15 states addresses open patient-provider communication. Provisions addressing coverage of emergency care and access to certain specialists were also prevalent among states. In contrast, only four states had specific provisions to guarantee direct access to pediatricians.
- Although several states have continuity-of-care provisions, they can differ markedly in the criteria for coverage and time period allowed for transition. About half of the states specify pregnancy as a condition subject to continuity-of-care coverage. Most of these states allow women in their second trimester of pregnancy to qualify for continuity-of- care protection if their physician leaves the plan. One state requires that women be in their third trimester to receive such coverage.

Background

Because the majority of privately insured Americans is now enrolled in some form of managed care and concerns have often been voiced about the associated controlled access to health services, legislators are increasingly addressing managed care issues. States and the federal government each have a role in regulating managed care plans. For individuals who buy insurance directly, state laws apply. For the 124 million people with employer-provided (group) coverage, the application of federal or state law depends on whether employers "self-insure" (that is, accept most or all of the financial risk for the coverage) or purchase insurance. The federal Employee Retirement Income Security Act of 1974 (ERISA) preempts the application of state laws for the approximately 48 million people who are enrolled in self-insured group health plans. Approximately 76 million people with private employer-sponsored group health insurance are in "fully insured" ERISA plans in which the employer purchases coverage from a health insurance issuer who assumes the risk of paying for covered items and services. State insurance laws cover individuals in such plans.

The three federal bills that we reviewed differ in the extent to which they would extend certain protections to managed care enrollees. All three bills would cover self-insured plans. S. 6 would also cover those participating in fully insured group and individual health plans. Certain provisions in S. 300 and S. 326 would apply to self-insured group health plans and other provisions would apply to all ERISA plans.

Overview Of Patient Protections In Selected States

Although all 15 states in our review have enacted legislation and/or implemented regulations addressing patient concerns about managed care, they do not all cover the same set of issues. As shown in table 1, two states—California and Minnesota—have provisions encompassing all seven protections. Two other states—Colorado and Massachusetts—have laws or regulations that incorporate three or fewer of the seven issues.

We found no direct relationship between a state's rate of HMO penetration and the presence of the seven protections in its laws for the 15 states in our review. Massachusetts, with an HMO penetration rate of 54 percent, the highest among the states in this study, addresses only one of the seven protections. Yet Vermont, with less than half the HMO penetration rate of Massachusetts, addresses six of the patient protection areas.

Table 1: Number of Patient Protections Adopted and HMO Enrollment Rates

State	Number of patient protection areas covered by state law or regulation[a]	Percent of population enrolled in HMOs, as of 1998
California	7	47
Colorado	3	36
Connecticut	5	43
Florida	5	32
Kentucky	5	35
Maryland	4	44
Massachusetts	1	54
Minnesota	7	32
New Jersey	6	31
New York	6	38
Ohio	4	23
Oregon	5	45
Pennsylvania	6	37
Texas	6	18
Vermont	6	21

[a]The number of patient protections credited to each state was determined by whether the state had a law or regulation that addressed all or some facets of the issue.

Sources: Information on number of protections for each state was determined by GAO. State HMO penetration rates are from InterStudy Publications, Competitive Edge Part 2: HMO Industry Report (8.2) (Oct. 1998). Vermont HMO penetration rates are from InterStudy Publications, Competitve Edge Part 3: Regional Market Analysis (8.2) (Dec. 1998).

Of the seven types of protections, open patient-provider communication, including prohibitions on gag clauses, is the only one addressed by all 15 states we reviewed. Also common is coverage of emergency care. Continuity of care is addressed by 9 of the 15 states and access to pediatricians is addressed by only 4 states. (See table 2.)

Table 2: Number of States That Have Addressed Selected Patient Protections

Patient protection provision	Number of states
Patient-provider communications	15
Coverage of emergency care	14
Access to other specialists	12
Access to obstetricians and gynecologists	11
Drug formularies	11
Continuity of care	9
Access to pediatricians	4

Because the legislative action in some of the 15 states has been relatively recent, implementation issues, cost implications, and actual benefits for consumers are not yet well understood. Furthermore, some state officials we interviewed indicated that the absence of certain patient protections in statutes or regulations may be an indication that they did not see a need for such regulation, given health plan practices in the state. It may be general practice among managed care plans to have policies that are concordant with consumer protections. For example, many officials told us that they have no requirements that HMOs classify pediatricians as primary care physicians because HMOs already generally do so.

States Often Varied in Their Specific Approaches

While we found some common ground among states in the types of patient protections they have addressed, the scope and standards of the provisions vary from state to state.[3] In general, when states address disclosure of information to plan members, their provisions were similar, while in the case of access issues, the provisions varied significantly in detail. These variations affect who receives protection and under what circumstances, as illustrated below. (App. II provides more detail on each of these seven types of patient protections and their comparison to three pending federal bills.)

Coverage of emergency services: Concerned about cost-effectiveness, most health plans attempt to manage enrollees' use of emergency services. One common approach is to require members to call the plan before

[3]To help standardize laws on patients' rights, the National Association of Insurance Commissioners has developed several model statutes addressing aspects of consumer protection that may be adopted by state legislatures.

seeking emergency care, unless the member has a truly serious, life-threatening emergency (such as a bleeding wound or heart attack). When there is no prior authorization and the emergency care provided is not found to have been medically necessary, then coverage can be denied.

Many states have attempted to define "emergency medical condition" in their statutes and regulations. They have used somewhat different terms, such as "prudent layperson" and "reasonable expectation," to specify what a nonmedically trained individual would reasonably assume to be an emergency.[4] However, three of the states that have adopted such definitional standards do not prohibit plans from requiring prior authorization for coverage of emergency care.

Access to obstetricians and gynecologists: Plan enrollees generally must obtain a referral from their primary care physician before obtaining services from a specialist. However, women may prefer to see a gynecologist for the provision of routine and preventive women's health care services.

States attempt to facilitate access to obstetricians/gynecologists (OB/GYN) through various means. One approach is to allow female enrollees to designate an OB/GYN as their primary care provider. Another approach is to prohibit plans from requiring authorization or referral for coverage of certain gynecological care and pregnancy-related services by an OB/GYN. Some states—such as Pennsylvania and Vermont--further stipulate that OB/GYNs must communicate with the patient's primary care physician concerning the services provided, while others—such as California and New York—allow plans to establish communication protocols between OB/GYNs and primary care physicians.

Continuity of care: Enrollees may be undergoing a course of treatment or be receiving pregnancy-related care when their health care provider leaves a health plan. In some circumstances, the departure of the provider can have an adverse effect on the enrollee. Some states have adopted measures to enable enrollees to continue seeing their original health care provider for a period of time.

[4]The prudent layperson standard refers to a person having an average knowledge of medicine and health and whether that person would believe that the absence of immediate medical attention would jeopardize health. The reasonable expectation standard specifies that the absence of immediate attention could reasonably be expected to jeopardize health.

States' provisions differed in the duration of the transition period and the circumstances under which individuals would be permitted to continue to be treated by their original provider. Only seven states specify pregnancy as a condition subject to this coverage. Most of these states allow pregnant women in their second trimester to qualify for continuity-of-care protection if their physician leaves the plan. However, one state requires that women be in their third trimester to receive such coverage.

Drug formularies: Managed care plans often provide coverage for prescription drugs through a formulary. However, some enrollees may require drugs that are not on the plan's formulary. States have responded in various ways to consumers' concerns about the inclusion of drugs and their desire for a process to consider exceptions to a plan's formulary.

Many states require that plans disclose the use of a drug formulary to plan members. Several states require plans to provide an exception process that allows coverage of nonformulary alternatives when medically indicated. Many of the states simply require plans that have a procedure to obtain nonformulary drugs to disclose the process. There is also a distinction in how states address cost-sharing requirements for prescription drugs. Oregon requires full disclosure of cost-sharing for plans with procedures to obtain nonformulary drugs. Ohio specifies that a plan may not charge more for a nonformulary drug than for a formulary drug, if a provider certifies that the formulary drug is ineffective or harmful for the patient.

Conclusion

States are responding in myriad ways to managed care consumers' concerns about the ability to get the medical care they need. In many cases, these state actions closely parallel each other, such as coverage of emergency care and open patient-provider communications. But it is also apparent that the states' approaches often vary in their scope and in the details, as they are tailored to the needs and priorities within the individual states.

Realizing the promise of managed care—especially its ability to constrain health care cost growth—is dependent upon many factors, including consumers' satisfaction with their ability to obtain timely, needed health services. Perceived or real undue obstacles to accessing needed care will undermine consumer acceptance and confidence in managed care. They could also lead to a backlash resulting in overly restrictive regulation that could thwart the advantages and efficiencies to be gained in a managed care environment. Balancing regulatory approaches, such as the assurance

of minimum standards, with quality-based competition among providers can be an effective approach that ensures quality and efficient health care for managed care enrollees. We will be happy to continue to work with you to monitor the further development and implementation of these and other issues.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other Members of the Committee may have.

Scope and Methodology

Our review focused on 15 states and seven types of patient protection provisions. The 15 states collectively account for about two-thirds of HMO enrollees nationwide. The criteria we used to select the states included (1) HMO penetration (the percentage of the state population enrolled in HMOs); (2) HMO enrollment; and (3) geographic diversity. The seven types of patient protections in our study were selected to include some of the types of protections in Senate bills 6, 300, and 326, and protections of particular interest to the Committee.

To obtain information on laws or regulations the 15 states used to address the seven types of patient protections, we (1) researched work done by others, such as the National Conference of State Legislatures; (2) searched databases of state laws and regulations in place as of January 1, 1999; and (3) contacted insurance and/or health department officials in all 15 states. Working with our Office of General Counsel, we analyzed the state laws and regulations to identify provisions relevant to the seven types of patient protections. We provided our summaries of the state provisions to officials at the state health and insurance departments for their review. We made technical changes as needed for the 14 states that responded with comments and provided additional documentation. In cases where state officials indicated they imposed requirements on managed care plans not documented in state laws or regulations, we based our analysis on the laws and regulations.

In doing our work, we did not determine whether managed care plans' practices complied with the state laws and regulations. Actual practices may either provide more protections than required by the states or violate the state laws and regulations. Also, we did not determine which of the state laws and regulations, if any, are being challenged in the courts, or whether those that have been decided had any bearing on our analysis and conclusions.

We conducted our review between January and March 1999 in accordance with generally accepted government auditing standards.

Detailed Comparison of State Patient Protection Provisions and Proposed Federal Provisions

All 15 states in our review have laws or regulations that place some patient protection requirements on health plans. The seven types of patient protections included in our review are addressed separately below. Collectively, the information we have developed shows considerable variation in the details of how the states have addressed these issues. In some cases, their different approaches lead to similar health care protections; in other cases similar provisions include subtle differences in language that lead to different health care protections. Also provided in this appendix are comparisons of state actions with Senate bills 6, 300, and 326.

Coverage of Emergency Care

Many states have laws or regulations intended to protect enrollees if a health insurance plan denies coverage for emergency services because the enrollee did not seek prior approval or because the condition was not, in fact, a medical emergency. Most states we reviewed:

- Specify a standard for determining when an emergency medical condition exists. For example, some states use a "prudent layperson" standard (a person having an average knowledge of medicine and health would believe that the absence of immediate medical attention would jeopardize health); other states use a "reasonable expectation" standard (the absence of immediate attention could reasonably be expected to jeopardize health), or a "life and limb" standard (the absence of immediate attention would be a threat to life or limb); and/or
- Prohibit plans from requiring enrollees to obtain prior authorization for coverage of emergency services, including screening and stabilization, in circumstances that meet the standard used to define an emergency.

As shown in table II.1, all 3 Senate bills and 14 of the 15 states use a standard for defining emergency conditions. Of the 14 states that use a standard, 9 use the prudent layperson standard.

As further shown in table II.1, all 3 Senate bills and 11 of the 15 states prohibit plans from requiring enrollees to seek prior authorization for emergency services. In some states, prior authorization for emergency care is not necessary if a prudent layperson would believe that the absence of immediate care would jeopardize health. While Maryland, Minnesota, and Oregon use a "prudent layperson" or "reasonable layperson" standard to define a medical emergency, these states do not prohibit a health plan from requiring prior authorization for coverage of emergency care.

Table II.1: Coverage of Emergency Care

	Standard used to define emergency medical condition	Prohibits prior authorization requirements for coverage of emergency care
Senate bills		
S. 6	Prudent layperson	Yes
S. 300, S. 326	Prudent layperson	Yes
States		
California	Reasonable expectation	Yes
Colorado	Enrollee believes it is a life- or limb-threatening emergency[a]	Yes
Connecticut	Prudent layperson	Yes
Florida	Reasonable expectation	Yes
Kentucky	Prudent layperson	Yes
Maryland	Prudent layperson	No
Massachusetts	No comparable standard	No
Minnesota	Reasonable layperson	No
New Jersey	Reasonable expectation	Yes
New York	Prudent layperson	Yes
Ohio	Prudent layperson	Yes
Oregon	Prudent layperson	No
Pennsylvania	Prudent layperson	Yes
Texas	Prudent layperson	Yes
Vermont	Prudent layperson	Yes

[a]The Colorado "life or limb" standard applies when enrollees use the local emergency medical system (911) to obtain emergency services. Colorado statutory law is not clear on what standard, if any, applies in other situations.

Access to Obstetricians and Gynecologists

Although plan enrollees generally must obtain a referral from primary care physicians before obtaining services from specialists, many states have enacted laws and regulations that make it easier for women to obtain care from obstetricians and gynecologists (OB/GYN). For example, some states

- require that health plans provide women enrollees the option to designate an OB/GYN as their primary care physician, or have an essentially equivalent requirement that health plans include OB/GYN physicians in their definition of allowed primary care physicians; and/or

- require that plans allow women direct access to obstetricians and gynecologists for specific services, such as annual gynecological examinations, routine gynecological care, and obstetrical care during pregnancy.

As shown in table II.2, Senate bill 6 and 7 of the 15 states require plans to provide women the option to designate an OB/GYN as their primary care physician. Senate bill 6, and five of these seven states also have provisions that provide women direct access to an OB/GYN under certain circumstances, such as for an annual exam or pregnancy care, even if a woman decides not to designate an OB/GYN as her primary care physician. Senate bills 300 and 326 and eight states do not require plans to provide women the option to designate an OB/GYN as their primary care physician, but these Senate bills and four of the eight states do have provisions requiring plans to provide women direct access to an OB/GYN for certain types of services, such as annual examinations, prenatal care, and treatment of gynecological conditions.

Table II.2: Access to Obstetricians and Gynecologists

	Explicit option to designate OB/GYN as primary care physician	Direct access without a referral	Comments
Senate bills			
S. 6	X	X	
S. 300, S. 326		X	Does not preclude the health plan from requiring that the OB/GYN notify the primary care provider or the plan of treatment decisions
States			
California	X	X	Direct access required, but plans may establish protocols for communication between OB/GYN and primary care physician regarding treatment
Colorado		See comment	Plans have the option of granting direct access or developing timely referral procedures

	Explicit option to designate OB/GYN as primary care physician	Direct access without a referral	Comments
Connecticut	X	X	Direct access required for care related to pregnancy, all active gynecological conditions, and all primary and preventive OB/GYN services
Florida			
Kentucky	X		
Maryland	X	X	Direct access required for medically necessary and routine care; in certain circumstances, the OB/GYN must confer with primary care physician for nonroutine care
Massachusetts			
Minnesota	X	X	Direct access required for annual exams, medically necessary follow-up care, maternity care, and gynecological conditions and emergencies
New Jersey	X		
New York		X	Direct access required for at least two exams per year for primary and preventive OB/GYN services or care related to pregnancy and any follow-up care; if required by the plan, the OB/GYN must confer with primary care physician for follow-up services
Ohio			
Oregon	X	X	Direct access required for annual exams and pregnancy care
Pennsylvania		X	Direct access required for annual exams, medically necessary and appropriate follow-up care, and referrals related to pregnancy and gynecological care; OB/GYN must inform primary care physician of such services

	Explicit option to designate OB/GYN as primary care physician	Direct access without a referral	Comments
Texas		X	Direct access required for annual examinations and care related to pregnancy and active gynecological conditions
Vermont		X	Direct access required for at least two visits per year and for all follow-up care for problems identified during such visits; OB/GYN must furnish all relevant information to the primary care physician

Access to Pediatricians

If managed care plans classify pediatricians as specialists, enrollees could be required to obtain referrals before taking their children to a pediatrician. To promote access to pediatric care

- Senate bills 300 and 326 prohibit plans from requiring enrollees to obtain prior authorization or referrals for pediatric care and
- Senate bill 6 requires plans to offer enrollees the option to designate a pediatrician as a child's primary care physician.

As shown in table II.3, none of the 15 states prohibit plans from requiring enrollees to obtain prior authorization or referrals for pediatric care; but, 4 states achieve the same objective--allowing direct access to pediatricians--by including pediatricians in their definition of primary care physicians. According to officials in many of the 15 states, health plans generally consider pediatricians to be primary care physicians. As a result, most of the state officials we contacted do not believe there is a problem obtaining direct access to pediatricians.

Table II.3: Access to Pediatricians

	Prohibits prior authorization or required referral	Requires option to designate pediatrician as primary care physician	Definition of primary care physician includes pediatricians
Senate bills			
S. 6		X	
S. 300, S. 326	X		
States			
California			X
Colorado			
Connecticut			
Florida			
Kentucky			X
Maryland			
Massachusetts			
Minnesota			X
New Jersey			X
New York			
Ohio			
Oregon			
Pennsylvania			
Texas			
Vermont			

Access to Specialists

Controlling access to expensive specialty care is integral to most managed care plans, but consumers are concerned that such controls may inappropriately restrict their access to specialty care, especially for chronic medical conditions such as diabetes or cardiac disease. Also, managed care enrollees with chronic conditions may find it particularly burdensome to repeatedly seek referrals to a specialist while receiving ongoing care from the specialist. To provide easier access to specialists, the majority of states we reviewed have laws and regulations that require plans to:

- Have and/or disclose procedures for referrals to specialists;
- Have procedures for designating a specialist to be an enrollee's primary care physician for enrollees with chronic, disabling, or life-threatening conditions or for allowing specialists to coordinate care for certain enrollees; and/or
- Have procedures for granting enrollees a "standing referral" to a specialist. Standing referrals allow enrollees to obtain ongoing care for specific medical conditions from a specialist without seeking further referrals from the primary care physician.

As shown in table II.4, all three Senate bills and 12 of the 15 states have one or more of these provisions, and 6 states have all three provisions.

None of the 15 states have provisions guaranteeing direct access to all specialists. As previously noted, some states provide direct access to OB/GYN and pediatric physicians. Some states may also require plans to provide direct access to other types of specialists. For example, Florida requires plans to allow enrollees up to five visits per year to a dermatologist without prior approval.

Table II.4: Access to Specialists

	Requires that plans have and/or disclose procedures for referrals to specialists	Requires that plans have procedures for designating specialist as primary care physician	Requires that plans have procedures for granting enrollees standing referrals to specialists	Comments
Senate bills				
S. 6	X	X	X	
S. 300, S. 326	X			
States				
California	X	X	X	
Colorado	X			Plans must have a process for timely or expedited referrals to specialists
Connecticut	X			
Florida	X		X	
Kentucky				
Maryland				
Massachusetts				

	Requires that plans have and/or disclose procedures for referrals to specialists	Requires that plans have procedures for designating specialist as primary care physician	Requires that plans have procedures for granting enrollees standing referrals to specialists	Comments
Minnesota	X	X	X	
New Jersey	X			
New York	X	X	X	
Ohio	X	X	X	
Oregon	X			
Pennsylvania	X	X	X	
Texas	X	X		
Vermont	X	X	X	

Continuity of Care

When a provider leaves a health care plan, the plan generally will not continue to cover services obtained from that provider. Enrollees may face the choice of changing providers in the midst of their treatment or paying out-of-pocket to continue care with the provider. To enable continuity of care in certain circumstances, many states have laws or regulations that:

- require managed care plans to cover care with a provider that leaves the plan if an enrollee is undergoing a course of treatment or has a specific condition; and/or
- require plans to continue coverage for a specific period of time.

As shown in table II.5, the 3 Senate bills and 9 of the 15 states have continuity of care provisions for enrollees in managed care plans.[1] However, all of these states have some continuity of care conditions that are different than those in the Senate bills. For example, the 3 Senate bills require continuity of care for enrollees in institutional care, but none of the 15 states explicitly require continuity of care for institutionalized enrollees. The Senate bills and most states require that pregnant women be in their second trimester of pregnancy to be eligible for continuity of care, while Florida limits eligibility to women in their third trimester. For states that require continuation of coverage during the course of a treatment or for patients with special needs, the duration of required coverage ranges from 60 to 120 days, though for a terminal illness, Texas requires coverage for 9 months, and Senate bill 6 has no duration limit. In Texas, however,

[1]These continuity of care provisions do not apply to situations where providers have been terminated by the plan due to concerns about quality of care.

continuity of care provisions for pregnancy, disability, acute care needs, and terminal illness apply only if discontinuing care with a provider that leaves the plan could harm the patient. Florida and New Jersey require continued coverage for non-pregnancy-related care only when preserving the relationship between the patient and the provider is "medically necessary."

States that do not address these specific continuity of care issues may have related provisions. For example, Colorado requires that plans provide 60 days continuation of coverage in cases where the plan fails to provide proper advanced notice to enrollees that their provider's contract is being terminated.

Table II.5: Continuity of Care

	Conditions for continuing care if provider leaves plan	Required duration of coverage	Comments
Senate bills			
S.6			
	Course of treatment	90 days	
	Pregnancy	Through postpartum care	Must be in second trimester to qualify
	Terminal illness	No limit	
	Institutional care	Until discharge	
S. 300, S. 326			
	Course of treatment	90 days	
	Pregnancy	Through postpartum care	Must be in second trimester to qualify
	Terminal illness	90 days	
	Institutional care	Lesser of 90 days or discharge	
States			
California			
	Pregnancy	Through postpartum care	Must be in second trimester or high risk to qualify
	Acute or serious chronic conditions	90 days	
Colorado	See comment	See comment	Plans must provide 60 days continued coverage if they do not give enrollee proper advanced notice that their provider's contract is being terminated
Connecticut			
Florida			
	Pregnancy	Through postpartum care	Must be in third trimester
	Life threatening disease	60 days	Only "medically necessary" conditions qualify
	Disabling or degenerative disease	60 days	Only "medically necessary" conditions qualify
Kentucky			
Maryland	Course of treatment	90 days	The state law has a discrepancy as to whether 90 days is a minimum or maximum
Massachusetts			
Minnesota	"Special medical needs"	120 days	
New Jersey			

	Conditions for continuing care if provider leaves plan	Required duration of coverage	Comments
	Course of treatment	120 days	Only "medically necessary" conditions qualify
	Pregnancy	6 weeks after delivery	
New York			
	Course of treatment	90 days	
	Pregnancy	Through postpartum care	Must be in second trimester to qualify
Ohio			
Oregon			
Pennsylvania			
	Course of treatment	60 days	
	Pregnancy	Through postpartum care	Must be in second trimester to qualify
Texas			
	Disability or acute care	90 days	Applies only if discontinuing care could harm the patient.
	Pregnancy	6 weeks after delivery	Applies only if discontinuing care could harm the patient or if the patient is past the 24th week of pregnancy when her provider leaves the plan.
	Terminal illness	9 months	Applies only if discontinuing care could harm the patient.
Vermont			
	Pregnancy	Through postpartum care	Providers must agree to abide by plan's payment rates, and special provisions exist for new members
	Life-threatening disease	60 days	Providers must agree to abide by plan's payment rates, and special provisions exist for new members
	Disabling or degenerative disease	60 days	Providers must agree to abide by plan's payment rates, and special provisions exist for new members

Drug Formularies

Managed care plans often use drug formularies (lists of prescription drugs normally covered by the plan) to reduce the variety of drugs they cover, thereby enabling plans to negotiate larger volume discounts with pharmacies and pharmaceutical manufacturers. Although plans may try to structure their formularies to include some varieties of most types of drugs, some individuals may require a specific drug not in the formulary because of the enrollees' individual characteristics (such as race, age, or gender), the complexity of their medical conditions, or unusual adverse reactions to

certain varieties of a drug. In response to concerns that a health plan's formulary may prevent coverage of a drug most appropriate to an enrollee's needs, states often have laws or regulations that:

- Require managed care plans to disclose the use of drug formularies and/or the drugs included in the formulary, upon request;
- Require managed care plans to disclose procedures for obtaining drugs not on a formulary, if the plan selectively provides coverage for nonformulary drugs; and/or
- Require managed care plans to have procedures for obtaining non-formulary drugs.

As shown in table II.6, the three Senate bills and 10 of the 15 states have one or more provisions regulating the use of formularies. Four states—California, Oregon, Pennsylvania, and Vermont—have all three of the above drug formulary provisions. Nine states require managed care plans to disclose the use of drug formularies and/or the drugs included in the formulary upon request by the enrollee, and six states require that plans have procedures for enrollees to obtain nonformulary drugs. Some states, such as Vermont, provide enrollees with access to nonformulary drugs under specific circumstances, including when a formulary drug is ineffective or may reasonably be expected to cause adverse reactions. Beyond these regulations of drug formularies, some states mandate coverage of some specific drug treatments and off-label uses of drugs.

Table II.6: Drug Formularies

	Requires disclosure of formularies	Requires disclosure of procedures to obtain nonformulary drugs	Requires procedures to obtain nonformulary drugs
Senate bills			
S. 6	X		X
S. 300, S. 326	X	X	
States			
California	X	X	X
Colorado			
Connecticut	X		
Florida	X		
Kentucky	X		
Maryland			
Massachusetts			
Minnesota		X	X
New Jersey			
New York	X		
Ohio			X
Oregon	X	X	X
Pennsylvania	X	X	X
Texas	X		
Vermont	X	X	X

Patient-Provider Communications

Concerned that health plans may try to prevent physicians from discussing certain issues with their patients, such as treatment options not covered by the plan and grievance and appeal rights, states generally have laws or regulations that

- prohibit "gag clauses" (restrictions on certain communications) in contracts between plans and health care providers, and/or
- prohibit plans from terminating or otherwise penalizing health care providers for discussing issues such as treatment options with their patients.

As shown in table II.7, the three Senate bills[2] and 13 of the 15 states have provisions that prohibit gag clauses in contracts between health plans and providers. While Massachusetts and New Jersey do not have these specific provisions, they do have other relevant requirements. Massachusetts health plans are prohibited from refusing to contract with or compensate providers who have discussed the health plan's rules with their patients as they relate to the patients' needs. Similarly, New Jersey regulations stipulate that enrollees are entitled to receive from their physician or provider an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives, whether or not they are covered benefits.

As further shown in table II.7, Senate bill 6, and 14 of the 15 states explicitly prohibit managed care plans from penalizing providers for discussing certain issues with their patients, such as treatment options not covered by the plan. Some states, such as Massachusetts, prohibit specific types of penalties, such as refusing to compensate a provider, while other states prohibit penalties without specifying any type of penalty.

Table II.7: Patient-Provider Communications

	Prohibits gag clauses in insurer/provider contracts	Explicitly prohibits penalizing providers for medical communications with patients	Comments
Senate bills			
S. 6		X	
S. 300, S. 326	X		
States			
California	X	X	
Colorado	X	X	
Connecticut	X	X	
Florida	X		
Kentucky	X	X	
Maryland	X	X	

[2]Senate bills 300 and 326 prohibit any restrictions on communications between health care providers and plan enrollees, in effect prohibiting gag clauses in contracts between plans and providers.

	Prohibits gag clauses in insurer/provider contracts	Explicitly prohibits penalizing providers for medical communications with patients	Comments
Massachusetts	See comments	X	Health plans may not refuse to contract with or compensate providers because of content of medical communications
Minnesota	X	X	
New Jersey	See comments	X	Members are entitled to receive from the member's physician explanations of the member's health conditions, treatment options, and similar issues
New York	X	X	
Ohio	X	X	
Oregon	X	X	
Pennsylvania	X	X	
Texas	X	X	
Vermont	X	X	

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