

The Accountability of Managed Care The North Carolina Patient's Bill of Rights

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WHEN THE NORTH CAROLINA Patient's Bill of Rights was signed into law by Governor Mike Easley on October 18, 2001, press reports heralded a new era – one where consumers would have new rights in their relationships with Health Maintenance Organizations (HMOs). While the law has wide-ranging effect, perhaps the most meaningful change brought about by the Patient's Bill of Rights is that insurers can now be held accountable to enrollees for utilization management decisions.

Yet, before consumers can hold their insurers accountable, they must first understand their rights. Therefore, the Patient's Bill of Rights created the Managed Care Patient Assistance Program (MCPA), which Governor Easley placed in the Consumer Protection Division of the Department of Justice under Attorney General Roy Cooper. The mission of MCPA is to educate and advocate for health care consumers throughout the state. The Patient's Bill of Rights outlined six major functions of the Program: (a) to develop and distribute educational material to consumers, outlining their rights and responsibilities as managed care enrollees; (b) to answer consumer inquiries and refer regulatory inquiries to the Department of Insurance; (c) to advise managed care enrollees about utilization review; (d) to assist enrollees with grievances, appeals, and external reviews; (e) to publicize MCPA; and (f) to compile data on MCPA activities and to report annually to the General Assembly with recommendations of additional services to be provided by the office.¹

Statistically, the number of persons enrolled in traditional HMOs in North Carolina has most likely peaked. The statistic can be misleading, however, since "managing care" remains an active part of most private health insurance. As a result, the Patient's Bill of Rights remains a powerful ally

for health care consumers. Many health benefit plans still manage care by making utilization management decisions. Many of those decisions fall under the Patient's Bill of Rights. Even when consumers are enrolled in a "preferred provider organization" or a "fee for service" plan, sections of the Patient's Bill of Rights may govern the insurer's noncertification decisions. As health care costs continue to increase and insurers have been forced to regulate expenses, most plans engage in some form of utilization review, whether a length of stay certification, prior approval process, or case management program. Many of those decisions that are unfavorable to the enrollee will entitle the enrollee to appeal. When that occurs, the Managed Care Patient Assistance Program is available to help.

MCPA is designed to act as an advocate for health care consumers, both individually and collectively. Consumers who contact the office with questions do not have to be enrolled in a traditional HMO. Callers can be providers, relatives, advocates, or members of the general public. Their inquiries can be about traditional HMOs, self-funded health plans, or any other type of private health insurance. Calls to MCPA regarding public programs, such as Medicare or Medicaid, are generally referred to the agencies that handle those programs. MCPA has the flexibility to address all such inquiries because the Patient's Bill of Rights is not limited to enrollees of HMOs; many of its provisions pertain to all insurers offering health benefit plans that perform utilization review or make noncertification decisions.²

The Managed Care Patient Assistance Program gives North Carolinians a central location to find answers to their health insurance questions. Many callers have basic questions: Is my employer required to provide paid health insurance if I am laid off? Is an insurance company required to provide well-baby benefits? Those who deal regularly with health insurance know that the answer to both questions is "it depends." Different state and federal laws apply depending on the number of workers employed, or whether the health benefit plan is fully insured or a self-insured health plan.

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Patient Assistance Specialists of MCPA have extensive experience working with health insurance issues and know the right questions to ask. Specialists can explain general legal principles governing health insurance, although they cannot give legal advice. If a caller opts to appeal a noncertification decision by an insurer, specialists can offer information, guidance, and support throughout the appeals process. Providers can also contact MCPA to make similar inquiries or to advocate on behalf of individual patients.

The Patient's Bill of Rights requires insurers subject to the law to establish an administrative appeals process and to participate in an external review process. Such insurers (not just HMOs but most insurers that manage utilization) must develop either a one- or two-step internal appeals process that involves licensed physicians reviewing utilization decisions. In the event that a delay in the appeal could seriously endanger the life or health of enrollees, or jeopardize their ability to regain maximum function, enrollees can request an "expedited" appeal. This expedited process is designed to reduce the likelihood that members will suffer harm while awaiting a favorable appeals decision.

If enrollees do not receive a favorable outcome through internal appeals, they may request an external review. External review is administered by the NC Department of Insurance (DOI), which has contracted with several independent review organizations (IRO) to conduct reviews. The IRO assigned to the appeal must be neutral to the particular appeal. Once assigned, the IRO reviews all relevant records and makes an independent determination about the utilization review decision. The decision of the IRO is binding on the insurer, and the insurer bears the cost of the review, which is usually several hundred dollars. However, if the IRO decides in favor of the insurer, the enrollee then has the right to sue the insurer.

By giving the enrollee the authority to sue an insurer, the General Assembly dramatically changed prior law. Previously, the insurer could deny potentially life-saving surgery

based on a determination that the surgery was not medically necessary. Now, patients can sue to challenge that determination. But before enrollees can sue, they are required to "exhaust their administrative remedies," which means they must complete the appeals process. Only after exhausting all appeals, and only after all appeals have been decided in favor of the insurer, can the enrollee choose to file suit. As a result, the majority of disputes with insurers will not end up in court.

The Managed Care Patient Assistance Program is available to help patients and others during any stage of the appeals process until a lawsuit is filed, since the MCPA does not represent individual enrollees in court. The MCPA gathers data about managed care in North Carolina, consults with DOI on regulatory issues, advises enrollees of their appeal options, helps enrollees prepare appeals, and answers general questions about health insurance. The office is currently staffed by a Director and three Patient Assistance Specialists.

The vast majority of enrollees of health insurance will never file an appeal or grievance. Those who do will most likely only file one during their time with the insurer. As a result, most enrollees will have little exposure to the detailed appeals process. Furthermore, enrollees struggling with major health issues prefer to focus on their health, not on an appeals process. North Carolinians experiencing real health crises need an advocacy organization to assist them when they receive a noncertification decision from their insurer. Now, because of the Patient's Bill of Rights, patients and their families can turn to the NC Department of Justice to advocate on their behalf through the Managed Care Patient Assistance Program.

NOTES

1 NC General Statute § 143-730 (c)

2 See, for example NC General Statute § 58-50-75.