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The Evolution of Managed Care and the Present State of the Backlash - Is a Patient Bill of Rights the Answer?

Suzanne M. Butler

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The Evolution of Managed Care and the Present State of the Backlash –
Is a Patient Bill of Rights the Answer?

Suzanne M. Butler

B.S., University of Connecticut, 1989

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The Evolution of Managed Care and Its Present State of the Backlash –
Is a Patient Bill of Rights the Answer?

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Introduction

Managed care has taken a dominant role in dictating the financing and delivery of care in the health care industry. While the dual goal of managed care is to contain costs while increasing quality, there is increasing concern that the cost-cutting measures of managed care are now having a negative impact on the quality of care. There is growing belief that the managed care pendulum has swung too far, and backlash has ensued.

In today's managed care environment, physicians are held financially accountable for their medical treatment decisions thereby placing them in potential conflict with their fiduciary obligation toward their patient. Patients are not always told of their treatment options due to clauses in physician's contracts that do not permit them to disclose non-covered or experimental treatments. The media and the press have exploited these concerns by sensationalizing HMO "horror stories", lending to the public's negative opinion of managed care. Anecdotal stories became more frequent in the media and popular press. As this occurred, the public began to loose confidence in the health care system because it hadn't lived up to its expectations. Public interest and the concern for protection of their rights increased. Politicians capitalized on the public's concern by proposing patient protection legislation as a solution.

In the absence of a federally established framework, a multitude of managed care laws has proliferated at the state level which vary in scope and application. Experience at the local level provides a context that may have important implications for
consideration at the national level. Federal legislation would have both positive and
negative implications for each of the major players (patients, physicians, employers, and
managed care organizations) and to the future direction of the funding and delivery of
health care. For these reasons, the debate remains open over whether, and to what
extent, the Federal government should regulate managed care.
Chapter 1:

Roots of the Problem: The Evolution of Managed Care

To better understand the dominant role that managed care plays in the industry today, it is necessary to trace its roots. The group health insurance industry has over a one hundred-year history, dating to the early 1900's. Group health insurance grew out of accident and sickness benefits that were developed for the railroad, mining and shipping industries in the mid- to late 1800's\(^1\). Montgomery Ward & Co. entered into one of the earliest group insurance contracts in 1910. From this point, the group health insurance industry was established as the National Convention of Insurance Commissioners developed the first model for state law, and when the Blue Cross Commission was founded in 1937\(^2\).

The traditional comprehensive indemnity plan was the predominant model group health plan into the 1970's when health maintenance organizations (HMOs) were formally introduced to the marketplace\(^3\). Under indemnity health care coverage, physicians were reimbursed retrospectively for each procedure or service rendered. There was little or no insurance company oversight of physician treatment decisions. Technology was ample and utilized frequently, justifying premium rate increases demanded by insurance companies. Health care costs rose year after year,

\(^1\) EBRI Databook on Employee Benefits, fourth edition, National Academy Press, Washington, D.C., 1993
\(^2\) Ibid.
\(^3\) Ibid. In 1973, the Health Maintenance Organization Act established requirements for entities seeking designation as federally qualified HMO. The act also required most employers who offer an HMO to offer a federally qualified HMO.
representing an increasingly larger proportion of the gross domestic product (GNP). Managed care was the industry's answer to eliminate unnecessary and inappropriate care that was abundant in an open-ended, unchecked health care system.

This chapter reviews factors that have lead to the evolution of managed care, including those in the medical community (i.e., the proliferation of medical specialties and the pervasiveness of technology) and in the corporate world (the corporate organization, oversight, and finance of health care). Managed care came about when these two spheres joined together, and flourished after a decade of inflation fueled by high technology and reimbursement of care on a fee-for-service basis.

Fee-for-Service Payment

Up through the early 1980s, the fee-for-service model of physician payment dominated the health care industry. As the name implies, this payment method reimburses physicians on a retrospective basis for each service performed. The production incentives inherent in this type payment rewards physicians for providing more services: the more services a physician provides, the higher his/her earnings.

Within the fee-for-service environment, there are no financial constraints on physicians to provide marginal or even unnecessary care. The propensity for over-treatment introduces an increased risk of adverse physical or mental effects, creating an imbalance between health and harm which, even when well-intentioned, conflicts with
the Hippocratic Oath\textsuperscript{4}. This phenomenon has been evidenced in studies showing over-use of antibiotics to treat colds, other viral upper respiratory tract infections, and bronchitis; conditions for which antibiotics are ineffective and may even cause harm or threat to the patient through adverse reaction\textsuperscript{5}.

The notion of "more is better" has been fostered by a society that has become accustomed to an aggressive medical culture, and is well suited to the production incentives of fee-for-service reimbursement. Our medical culture is curative in nature and its diagnostic precision is driven by expensive technology. As a result, the average patient has come to expect a lab test, X-ray, or at the very least a prescription drug as part of their medical evaluation.

\textit{Growth in the Number of Specialists}

The categorization of medical knowledge dates back to Darwin's publication of the \textit{Origin of Species}. The impetus behind the growth in specialization can be traced back to the Flexner Report, released in 1910. Abraham Flexner, together with the American Medical Association's Council on Education, proposed that radical reconstruction of medical education would lead to improved medical care in the United

\textsuperscript{4} O'Brien, L. \textit{Bad Medicine: How the American Establishment Is Ruining our Healthcare System} Prometheus Books, New York; 1999, pp.12-13. The Greek physician Hippocrates (460 B.C. – 370 B.C.) published the first guideline intended to govern physician behavior. Physicians profess the Hippocratic Oath in obtaining a license to practice medicine, which says in part: \textit{The regimen I adopt shall be for the benefit of my patients according to my ability and judgement, and not for their hurt or for any wrong.}

\textsuperscript{5} Gonzales, R., et al. \textit{Antibiotic Prescribing for Adults with Colds, Upper Respiratory Tract Infections, and Bronchitis. JAMA. 1997; 278:901-904.}

States. The Flexner Report was seen as a pivotal point in time during which American medicine became a scientifically based discipline\(^6\). This report supported the expansion of medical specialization in an effort to overcome the perception that medicine in the United States was "inferior" to European medicine. The promulgation of these recommendations, embraced by the medical guild, began the proliferation of medical specialties in the top universities.

Until very recently, surgeons and specialists are recognized as the premiere players within medical universities and hospitals. Specialists are portrayed to medical students as the most lucrative and attractive profession for a physician. Specialists and surgeons bring in the largest amount of revenue to the health care organizations and hospitals and they frequently receive the largest federal grants and other research monies. Family practitioners, who had been at the helm of American medicine, have come to be perceived as "second or third class players, and a source of some embarrassment to the profession"\(^7\). Another significant contribution of the Flexner Report on the medical community was his estimation of the proper ratio of physicians to the general population. In the 1910 report, he stated that the ratio should be 67 physicians to each 100,000 people. A startling comparison is the current ratio: 240 physicians per 100,000 people\(^8\). This number far exceeds Flexner's benchmark, and will only increase as medical schools continue to turn out more physicians who will select to

\(^7\) O'Brien, L. *Ibid*, p. 96
\(^8\) O'Brien, L. *Ibid*, p. 100
complete their residency in one of numerous existing or evolving medical specialties or sub-specialties.

The health care industry experienced the first boom in specialists immediately following World War II. Nearly two-thirds of doctors who had served in the War took advantage of their veteran benefits for continuing education, and developed themselves as specialists. Over the next twenty years, the number of specialists began to surpass the number of primary care providers so that by 1966, nearly 70% of physicians called themselves specialists. This explosion of medical specialties had the effect of driving generalist physicians out of the top ranks of medical professions.

As health care economics would predict, the abundance of specialists predicated the demand for their services, and fueled the perceived need and demand for high cost, specialized care. Within the traditional indemnity environment there were no controls to limit access to specialists or pre-authorization of services, thus contributing to the escalation of costs. Furthermore, within company-sponsored coverage, employers' contribution to increasing premiums was often not disclosed to the employee. However, employees were keenly aware of their premium contributions, which were indicated as deductions from their paycheck. This phenomenon had the effect of cultivating a sense of entitlement to health care. In this way, Americans molded their expectation of health care: receive the highest quality of care, without question, and with little regard or sensitivity to cost.

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9 Rothstein, WG. American Medical Schools, New York: Oxford University Press; 1978:187-188
Advancements in Medical Technology

Advancements in technology have enabled our nation to excel in medical and genetic science beyond any other nation in the world. Surgeons can perform minimally invasive surgeries with fiber optics that were once considered major operations requiring hospitalization. Our diagnostic capabilities have increased early detection of otherwise deadly cancers, are instrumental in identifying genetic disorders, and are used to screen and treat chronic diseases (e.g., cholesterol, diabetes, high blood pressure).

In the presence of such powerful technology, our view of death and dying has become that of technical defeat rather a natural occurrence of life. The medical community, taught to exhaust all technical means possible to preserve life, had made end-of-life decisions difficult in the face of even the slimmest possibilities. In the book *The Social Transformation of American Medicine*, Paul Starr refers to “therapeutic relentlessness” as a contemporary definition of death:

In its commitment to the preservation of life, medical care ironically has come to symbolize a prototypically modern form of torture, combining benevolence, indifference, and technical wizardry. Rather than engendering trust, technological medicine often raises anxieties about the ability of individuals to make choices for themselves\(^\text{10}\).

The pharmaceutical industry has made significant contributions to the world of medical technology. The endless number of drugs that have been developed over the past twenty years enable people to live longer, sometimes healthier and more productive lives. The large amount of research and development behind such advancements often come attached with a hefty price tag. Studies issued in 1999 indicate that health care costs are rising largely as a result of double-digit increases in the price of high-technology "break-through" prescription drugs, increased prescribing by physicians, and aggressive advertising by drug companies that stimulates patient demand\textsuperscript{11},\textsuperscript{12}. This growth trend is projected to continue into the next five years.

Advertising, used by health plans, hospitals, and pharmaceutical companies has raised the public's awareness of specialized services, high-tech equipment, and new prescription drugs. As a result, consumers, now more than ever before, have become acutely aware of their treatment choices. They ask for, and expect, brand name drugs or the highest technology procedure to be used by their physician. As more managed care organizations use restrictive formularies, pharmaceutical manufacturers have begun to use a controversial marketing techniques called direct-to-consumer advertising, or "DTC", in an effort influence physicians and patients. Advertisements for allergies, hair loss, depression, and high cholesterol, for example, are put before consumers and doctors in magazines, television, radio, and the Internet. In 1998, DTC spending was

\textsuperscript{11} William M. Mercer Incorporated, \textit{13\textsuperscript{th} Annual National Survey of Employer-Sponsored Health Plans}, 1999

\textsuperscript{12} Watson Wyatt Worldwide, \textit{Large Employers Projecting Double Digit Increases In Prescription Drug Benefit Costs}, July 13, 1999 Press Release
estimated to have doubled from $1 billion in 1997 to nearly $2 billion in 1998.\textsuperscript{13} This information has empowered consumers with increased knowledge about drug therapies or alternative treatments and has contributed to the increased utilization of expensive brand name prescription drugs\textsuperscript{14}.

Policy experts believe that abundance and excessive use of technologies are at the root of health care's escalating costs\textsuperscript{15}. One reason for this is that often times, the expensive nature of technology does not yield a return by reaching economies of scale\textsuperscript{16}. In the early 80's many states implemented "certificate of need" (CON) provisions. In addition to regulating the acquisition of equipment, states required health care facilities to obtain a certificate of approval for changes in the level of services of number of hospital beds\textsuperscript{17}. This required process was many states response to regulate the number of hospitals and facilities purchasing expensive equipment such as CAT scan or magnetic resonance imaging (MRI) machines.

Another reason that technology has raised the price of health care is that often times technological innovations substantially increases utilization, particularly when the new technology is quicker, easier, less invasive, or less traumatic to the patient than its


\textsuperscript{14} Watson Wyatt Worldwide, ibid.


\textsuperscript{16} Herzlinger, Regina, ibid.

\textsuperscript{17} Hansen, E., Carneal, G., \textit{State Regulation}, from \textit{The Managed Health Care Handbook}, second edition, Aspen Publications: Maryland, 1993, p. 404
predecessor. Examples of this include gall bladder surgery and laparoscopic cholecystectomy, where the rates of these procedures increased dramatically after the introduction of a less invasive surgery.  

Despite the advancements that technology may bring to bear, it contributes to the escalating price of health care, even when the cost of the procedure is lower using the new technology. This is because the price of the procedure is based upon an amount that an insurer is willing to pay, and to a lesser extent on the basis of the economic cost of the resources that the procedure requires. When the demand for health care services is determined by patient demand, the price will nearly always rise.

Financial incentives will also influence the type of care that is rendered more so than is reflected by the actual needs of the population. For example, in the United States, we own approximately 11 MRIs per one million people compared to one per million in England and Canada, or three machines per one million in West Germany. Similarly, American doctors perform more high-cost medical and surgical procedures. In 1991, U.S. surgeons performed 1,000 coronary bypass surgeries per one million people. This rate is roughly three times higher than Canada, which contrasts to only 400

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19 Herzlinger, Regina: ibid, p.21°3.

surgeries in France and 500 per one million in West Germany\textsuperscript{21}. Clearly, our health care costs are high not only because we use it more frequently than other countries, but because we also have more of it.

The rate of cardiac procedures in the United States may be viewed as excessive, especially in relation to other countries such as Canada. A 1994 study published in \textit{the Journal of the American Medical Association} compared rates of inappropriate use of cardiac procedures in New York State to those in Canada. The findings suggested that the U.S. performed more procedures, but few were deemed inappropriate, leading the reader to conclude that perhaps Canadians may have received too few cardiac procedures\textsuperscript{22}. The same study pointed out that those Canadians who did had a cardiac procedure performed waited longer, on average, than the American cohort. Presumably, this points to Canada's shortage of technology, and also to the fewer number of cardiologists available to treat these patients\textsuperscript{23}. Viewed in this light, many may argue that our abundance of technology has positive implications for Americans' quality of life.

On the other hand, critics of our system claim that the supply of medical technology creates its own demand, which renders the medical market irrational\textsuperscript{24}. Studies have been conducted to understand whether the availability of medical

\textsuperscript{21} Ibid, pg. 217.
\textsuperscript{22} McGlynn, E., et al., \textit{Comparison of the Appropriateness of Coronary Angiography and Coronary Artery Bypass Graft Surgery between Canada and New York State}, JAMA 272 (12):934-40, Sept. 28, 1994
\textsuperscript{24} O'Brien, L., Ibid, p. 10
resources creates unnecessary demand. In one particular analysis, treatments of ten thousand New York heart attack patients were tracked. The findings revealed that patients who were admitted to hospitals with facilities equipped to provide angioplasty or bypass surgery were more likely to receive these services than those patients admitted to hospitals without this technology. While the study may support critics' claim, the author of the study was careful to point out that the hospitals with high availability of technology did not infer that the services rendered were unnecessary. Without clinically justifiable rates of service use, the study could not conclude that these patients received unnecessary care.

Positive aspects of technology are reflected in our nation's average life span, which is longer, albeit marginally, in comparison to Germany and the United Kingdom, but lower than Canada. Technology has enhanced the quality of life for many chronically ill Americans, and has sustained the life of millions of prematurely born infants.

The pervasiveness of technology has also contributed to increased costs. Health plans and hospitals often purchase the most up-to-date technology to attract the best doctors and will market to the public their leading edge equipment and facilities. The capital expense of equipment, when used infrequently outweighs a return that may be achieved through larger economies of scale. In order to recoup costs, providers and

\[25\] Blustein, High Technology Cardiac Procedures: The Impact of Service Availability on Service Use in New York State, JAMA, Vol. 270, no. 3 (July 21, 1993), 344

hospitals have raised their prices accordingly.

**Government-Sponsored Health Insurance**

In the mid-1960s, Medicare and Medicaid were developed to provide federal money to fund the cost of health insurance for the elderly and the poor. These programs were not equal in design or contribution. Reimbursement to providers for Medicaid was paid at a lower rate than Medicare or commercial insurance. As a result, fewer providers accepted Medicaid patients, forcing them to use clinics or expensive emergency room care.

In the ensuing years, the Medicare population grew in size and age and also gained political clout. The elderly leveraged their status to raise the standard of their health care coverage to be more in line with that of private insurance, thus widening the disparity from Medicaid coverage. With the predominant reimbursement being fee-for-service, the Medicare and Medicaid programs also contributed to the inflation of the 70s and 80s.

After ten years of unchallenged health care inflation, the Health Care Finance Administration (HCFA) devised a prospective payment scheme based upon length of stay limits and payments specific to diagnosis, called diagnosis related group (DRGs). This pre-payment mechanism was implemented to contain rising hospital costs of the Medicare population. If hospitals effectively managed their admissions to HCFA’s predetermined length of stay, they would break-even financially. If, on the other hand, the hospital discharged the patient prior to the prescribed length of stay, the hospital was
rewarded by claiming the difference of the cost versus the Medicare payment as savings. Under the DRG prospective payment scheme, hospitals were financially incented to quickly treat and discharge patients\textsuperscript{27}. The upshot of DRGs was that the average length of stay decreased by 24\% and mortality remained unchanged before and after its inception\textsuperscript{28}. The down side of DRGs was the shifting of costs to privately insured patients that followed. This began a cycle of cost shifting whereby the privately insured population was brought to bear the cost of those with little or no health insurance\textsuperscript{29}.

*Corporate Management of Health Care*

The government has supported the corporate management of medicine through the passage of Title XIII of the Public Health Service Act, better known as the HMO Act of 1973\textsuperscript{30}. This federal act played a key role in the expansion of managed care because it established organizational and operating requirements for HMOs\textsuperscript{31}. More importantly, the government funded the HMO Act through grant monies and loans that were earmarked to finance the development of HMOs. This served to boost the number of


\textsuperscript{30} Health Maintenance Organization Act of 1973: Public Law 93-222, 93\textsuperscript{rd} Congress, S. 14, December 29, 1973

HMOs and their enrollment. At the same time, HMOs were endorsed by the business community and also had bipartisan support. HMOs were appealing to these groups on the basis that they proclaimed to contain costs through free-market competition with little government intervention. As a result, managed care proliferated at the state level.

The introduction of Medicare and Medicaid in the mid-60s advanced the corporate practice of medicine. These federally funded programs stimulated the growth of investor-owned hospitals chains and medical university centers, creating a demand for management staff. Third party payers were regulated by the government in the delivery of health care services to the elderly and the poor, thus imposing more controls on physicians, hospitals, and patients alike.

The prospective payment system implemented by the government was initially targeted at hospitals, which represented a large portion of the elderly population's health expenditures. The government was also keenly aware of the physician's role in ordering ancillary services and also determining a patient's length of stay. For example, in 1985, approximately 19% of total health care expenditures were for physician services. However, another 50-60% of total health care expenditures was under physicians' wield. In 1985, a payment freeze was placed upon Part B of the Medicare program, which subsidizes payments for physician services. During this time hospital administrators were under increasing pressure to contend with doctors to contain costs.

33 Schramm, C., ibid, p. 88.
34 Schramm, C., ibid, p. 89.
Physicians and hospitals, albeit unwillingly, were forced to work together as they became jointly responsible for managing the cost of care.

Physicians banded together, leaving the traditional solo practice behind. By the mid-1990s, nearly one-third of all physicians practiced medicine in a group setting of three or more physicians\textsuperscript{35}. Physicians became increasingly exposed to corporate influences as they began to contract for their services with managed care organizations, particularly investor owned companies. In a for-profit organization, the mission is to enhance shareholder wealth, and there is a legal obligation toward its investors.

Physicians that contracted with investor-owned managed care organizations were subject to the administration's profit motives, financial incentives, cost containment programs, quality assurance initiatives, and method(s) of reimbursement. Physicians became exposed to other corporate influences such as mergers, acquisitions, buyouts, and having their services marketed to the public. Physicians were slowly losing their autonomy to freely practice medicine. The forces dictating the market, employers and insurance companies, were heavily invested in ensuring that health care costs were lowered. In order to fulfill this mission, insurance companies began to micro-manage physicians by influencing their treatment decisions right from the start.

In the corporate organization of health care, responsibility for the delivery of health care shifted from the individual physician to a corporate entity and raised ethical issues in the minds of physicians and patients. There is a potential conflict between physicians’ oath to do no harm and their professional obligation to the managed care

\textsuperscript{35} Schramm, C., ibid, p. 89.
organization. The corporate organization of health care delivery plays an important role in the structure of managed care, and has also contributed to its backlash. This is discussed further in Chapter 3.

**Employer-Sponsored Health Insurance**

Just after World War II broke out, the labor market shrunk, and employers were subject to strict wage controls. Employers began to offer health care coverage as fringe benefit to attract and retain employees. Labor union leaders negotiated for health care coverage and companies generally obliged. The number of people with employer-sponsored insurance increased from just 12 million in 1940 (less than one-tenth of the population), to 77 million in 1950, and up to 123 million in 1960 (representing nearly 60% of the population)\(^{36}\).

Health care benefits are considered part of an employee's total compensation package, and as such, can be a considered as a substitute for take-home pay. Employers pay a large portion of the group health insurance premium, with the remainder usually deducted directly from the employee's paycheck. Often times employees are only aware of their contribution toward the coverage, which currently tends to be less than 25 percent\(^{37}\). Employer-sponsored health care fostered two

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\(^{36}\) Health Insurance Association of America, *Source Book of Health Insurance Data*, Washington: Health Insurance Association of America, 1994,

unfavorable attitudes toward health benefits. First, employees felt entitled to health care because of their contribution toward the premium, and secondly, they were only aware of their fraction of the total cost, providing little sensitivity to the full cost of the health care coverage. For all intents and purposes, employer-sponsored health insurance became considered as an entitlement; an unending free resource.

As one of the largest sources of health care coverage, employers have had a profound impact on shaping the funding and delivery of health care as it stands today. With the enactment of ERISA (Employee Retirement Income Security Act) in 1974[^38], the federal government exempted "self-insured" employers from state insurance regulations. When an employer is self-insured, the employer pays the health care claims directly rather than purchasing a risk contract through an insurance company.

Being self-insured is especially appealing to large companies with multiple work locations crossing over state lines, which makes it difficult and expensive to administer health benefits. Employers have found that by funding their own insurance, cash flow is increased and positively impacts the bottom line. Being self-insured also affords an employer with the flexibility to craft benefit plans suited to their workforce's needs, rather than purchasing coverage from an insurance company and being restricted to state mandated benefits. Finally, under ERISA, self-insured plans are not subject to state-imposed taxes. Although the administrative costs associated with self-insured plans are

[^38]: Employee Retirement Income Security Act, 29 USC § 1003 (b)
typically higher than that of a traditional insurance coverage, the flexibility and burdensome state taxes are strong incentives for employers to self-insure.

Although ERISA has been intact for 25 years, the implications on the health care industry have been profound and lasting. Since ERISA permits freedom of plan design and coverage, bottom-line focused employers have engaged a variety of strategies to control health care costs. Some employers altered their contribution toward their employees’ monthly premium, or strategically priced their health plans to encourage selection of managed care plans over more costly indemnity plans. Other employers raised coinsurance and deductibles, or placed limits on certain benefits. Employers have made such drastic reductions to certain benefits that legislation was required to intervene. For example, many states, including Connecticut, have mandated minimum lengths of stay for maternity admissions. In 1997, federal legislation was enacted to require employers to equalize benefit provisions placed upon mental illness so that they are treated similarly to benefit restrictions placed on physical illness. The Mental Health Parity Act mandated employers to remove dollar limits on mental health care that are not in place for other medical conditions39.

Employer’s strategies alone were not entirely effective in controlling costs. Throughout the 60’s and 70’s, employers were very generous with their benefits, with some companies paying 100 percent of the cost of insurance. As national health spending rose by double digits in the 80’s, companies’ generosity waned, and they began to ask their workers to share in the increasing cost of health care. Employees did

39 Mental Health Parity Act, 42 U.S.C. 300gg-5
not take kindly to this change. During the recession of the late 80's, many of the labor strikes included health care benefits as a key bargaining issue.

Employers pressed on insurance companies to take a more vested role in managing the soaring costs and utilization. In response, insurance companies tried to reduce the price of health care by negotiating volume discounts with groups of providers. In return, doctors would benefit from the business generated by the insurance companies' covered population. This arrangement was called a preferred provider arrangement, or PPO.

Also at this time, published results from health services research provided statistical analysis that demonstrated considerable variation in physician practice patterns and inappropriate use of certain procedures. A study completed by John Wennberg showed tremendous regional variation in how doctors perform the same procedure. Robert Brook of the Rand Corporation, together with Mark Chassin, et al. completed an analysis that determined geographical differences could not explain the variation of inappropriate use of high frequency procedures such as coronary angiography, carotid endarterectomy, and upper gastrointestinal tract endoscopy. The notion that American doctors were operating too often was now empirically founded, providing the justification for managed care.

41 Wennberg, J., Gittelsohn, A. Variations in Medical Care Among Small Areas, Scientific American, April 1982
42 Chassin, M., Brook, R., Does Inappropriate Use Explain Geographical Variations in the Use of Health Care Services? November 13, 1987, JAMA 258(18): 2533-37
Insurance companies began to employ micro-management strategies. These programs were targeted at physicians and focused on reducing inappropriate and unnecessary care. Pre-admission certification, pre-admission testing, second surgical opinion, and utilization review commonly overlaid the traditional indemnity plan. It was during this time when insurance companies ventured into the management of health care by directing oversight activities on physicians and hospitals. However, as costs continued to rise, employers and insurers came to the belief that the only effective way to control costs was to intervene before doctors ever saw a patient. This concept became what is known as managed care.
Chapter 2:

What is Managed Care?

Managed care consists of various types of organizations characterized by different methods of delivering and contracting health care coverage. The basic tenet to maintain costs, increase access and quality, and provide affordable care, however, is common across all the organizations. As managed care has evolved and matured, the delineation of these organizations has become somewhat blurred. Therefore, the descriptions that follow reflect the five health care delivery systems that were in place in the initial stages of managed care. Also reviewed in this chapter are features that commonly define managed care, including: physician reimbursement methods and incentives that reward cost-effectiveness, utilization management programs to contain costs, quality processes and outcomes, accountability for performance, and affordability of coverage.

Organizational Features of Managed Care Plans

Managed care includes a range of delivery system alternatives to the traditional indemnity health insurance. The range of organizations can best be conceptualized by plotting cost control, accountability and quality along a continuum (see Figure 1). As the delivery system definition moves from left to right elements of control and accountability increase as does the potential for control of cost and quality. Managed indemnity is on the low end of the continuum (loosely managed costs, no accountability) and closed panel HMOs at the high end (tightly managed costs and full accountability).
The Managed Care Continuum

<table>
<thead>
<tr>
<th>Indemnity</th>
<th>Managed</th>
<th>PPO</th>
<th>POS</th>
<th>Open Panel</th>
<th>Closed Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity</td>
<td></td>
<td></td>
<td>HMO</td>
<td>HMO</td>
<td></td>
</tr>
</tbody>
</table>

*Increasing Quality/Cost Controls and Accountability*

**Figure 1**

*Managed Indemnity*

A managed indemnity plan is a traditional insurance plan superimposed with utilization controls such as pre-admission certification, catastrophic case management, and pre-certification of elective procedures. In a managed indemnity plan, providers are paid retrospectively on a fee-for-service basis, and therefore, do not assume any financial risk. Covered individuals are free to choose any provider.

The indemnity plan typically requires the covered individual to meet an annual deductible whereupon they become responsible for a certain percentage of charges (i.e., 20%).

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Preferred Provider Organization (PPO)

PPOs are entities through which employers or insurance companies contract for health care services from a select group of doctors, hospitals, or facilities\(^{44}\). PPOs are characterized by the claim that providers are selected, or preferred, to be included in a network. Preferred providers are usually selected on the basis of cost efficiency and reputation, and may encompass physicians, hospitals and/or diagnostic facilities. As a provision of their contract, participating providers agree to concede to the PPO’s utilization management programs. These programs are aimed at controlling the cost and utilization of health care services provided to covered individuals, and are discussed in more detail later in this chapter.

Providers in a PPO do not assume any financial risk. By participating in the PPO, they agree to accept the negotiated payment rate, and are reimbursed on a fee-for-service basis. Fees for the services are generally discounted from charges, but can also take the form of a per diem or DRG rate. In return, the PPO receives business from the individuals covered under the PPO plan. Employers will often structure their benefit plan to encourage use of preferred providers so that they, and the covered individuals, can benefit from the discounted charges. Although covered individuals are permitted to see nonparticipating providers, they generally will pay a higher coinsurance as a result of the higher charges.

Point of Service Plan (POS)

The POS plan, also referred to as an "open access HMO", permits covered individuals to choose a non-participating provider at the time that the medical care is needed. In a POS plan, the participating providers are part of a “network”. Networks are formed on the basis of the providers’ proximity to the residence of the covered individuals, which encourages ease of access. As such, higher deductibles and a larger coinsurance are typically applied to dissuade members from using non-participating providers. Members are free to seek care from out-of-area providers or services, but may be subject to utilization review or pre-certification of services.

A key feature characteristic of a POS plan is the primary care physician, or PCP. The PCP acts as a gatekeeper for referrals to diagnostic testing, specialty or institutional medical care, and authorizes emergency care. PCPs are generally reimbursed through a capitation payment, which is a fixed payment per member per month. Under this type of arrangement, the PCP assumes complete financial risk associated with managing the cost of care for a defined population. There is often an amount that is withheld from physicians’ compensation that is returned at the end of the year contingent upon meeting the plan’s utilization or cost goals. The capitation of payments for primary care services has innate cost controls, forcing the PCP to balance utilization and quality assurance. Capitation clearly differentiates the POS plan cost control and accountability from the more loosely managed indemnity and PPO plans.

There are a variety and mix of HMOs, but it is possible to classify an HMO on the basis of its relationship between the physician and the HMO’s administration. For all
intents and purposes, an HMO is considered to be a broker, serving as the intermediary between the employer or insurance company, and the providers of care. There are three different types of HMOs: Independent Practice Association (IPA), group, and staff model HMOs.

*Independent Practice Association (Open Panel HMO)*

The IPA model HMO contracts with an association of physicians (the IPA), which consists of individual or groups of doctors with their own private practice. The IPA model is considered an "open panel" HMO because any physician that meets the IPA’s or HMO’s credentials is eligible to participate in the HMO.

The IPA, which is a separate legal entity, may contract with one or more HMOs. Physicians in the IPA agree to provide health care services for an enrolled population. Participating physicians maintain their own offices and see private pay patients while also treating HMO patients.

Most HMOs compensate an IPA using an all inclusive capitation payment. The IPA then compensates its providers either on a fee-for-service basis, or a combination of fee-for-service and primary care capitation (see Figure 2). When physicians accept a capitated payment, they become accountable for managing the cost of treating their covered population.

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45 Ibid, Figure 2 adapted from E. Wagner’s description of HMOs in *Types of Managed Care Organizations*
Group and Staff Model HMOs (Closed Panel HMOs)

In a group model, the HMO's administration contracts with selected physician groups to provide all physician services to the HMO's members. In addition to their HMO patients, physicians in the group model may see other non-HMO patients, although their primary role may be to treat the HMO patients. The group practice may contract on the basis of a captiation or fee-for-service. The group model is considered to be a "closed panel" HMO because the physicians must be members of the group practice in order to participate in the HMO.
Under the staff model HMO, the administration employs salaried physicians as part of the HMO staff, and the physician treats only enrolled members of the parent HMO. Physicians receive a salary and may also receive incentive payments on the basis of productivity or performance. The staff model HMO is considered to be “closed panel” because participating providers must be employed by the HMO and community physicians are not able to participate.

**Physician Reimbursement Mechanisms**

The type of physician reimbursement, by virtue of their design, can influence the way in which health care is delivered. There are four basic payment vehicles that exist in managed care: fee-for-service, salary, discounted fee-for-service, and capitation. With the exception of the salaried physician, any given provider group or physician may receive payment in one or more of these forms.
Fee-for-Service

As discussed earlier, fee-for-service entails reimbursing physicians, retrospectively, for each service that is rendered. There are two significant problems with fee-for-service in the context of managed care. The first is called “churning”, which means that doctors perform more services or schedule more return visits than are necessary. From an outside perspective it seems legitimate to ask a patient to return in two weeks to have their blood pressure checked instead of one month. From the patient’s perspective, they are following the physician’s advice and few would argue against professional recommendation. From the physician’s standpoint, money is collected for the return office visit. This is not to say that physicians do this consciously or in an unethical way, but the potential for churning perpetuates itself when health plans’ fees are reduced. For example, a physician may feel compelled to see more patients in a given month in fear that the fees will be cut back even more in the next month. In managed care, utilization and peer review are two methods to ensure that physicians do not abuse what could become a potentially self-fulfilling prophecy in an unmanaged fee-for-service setting.

The second problem with fee-for-service in managed care is the potential for “upcoding” (using CPT-4 codes that reimburse at a higher rate) and “unbundling” (charging for services that previously were included in a single fee without lowering the fee). An increased trend of inappropriate physician billing practices has been

47 Ibid.
48 Kongstvedt, Peter R., Compensation of Primary Care Physicians in Open Panels, Essentials of Managed Care, Aspen Publications; Copyright 1995: pp. 88-89
49 Kongstvedt, Peter R., Ibid
experienced nationwide. Some believe that upcoding and unbundling may be some physicians' response to recoup reduced or discounted fees. This creates a vicious circle that ultimately results in inflated costs, and in turn unjustly punishes physicians who bill fairly.

Plans that use fee-for-service reimbursement try to control the inherent production incentive by incorporating various micro-management activities that are aimed at reducing unnecessary or inappropriate care (e.g., utilization review, pre-certification, or pre-authorization). These micro-management strategies are discussed in more detail toward the end of this chapter. Unfortunately, however, many of the utilization oversight activities counteract their cost effectiveness through increased administrative costs.

Pre-negotiated Discount Arrangements

This type of arrangement typically coexists within an indemnity environment, as is the case with preferred provider organizations (PPOs), or point of service plans (POS). The employer or health plan that contracts with a hospital or group of physicians within a PPO receives a discounted fee for a given group of procedure or types of service (i.e., lab, x-ray, or chiropractic services). Since payment is made retrospectively, the same production incentives exist as with the fee-for-service model.

Pascuzzi, Elizabeth, Claims and Benefits Administration (p. 229); Ward, David, Operational Finance and Budgeting (p. 292) from Essentials of Managed Care, Aspen Publications; Copyright 1995
Salary

An HMO may pay their physician staff an annual salary. These physicians are considered to be employees of the managed care organization. Although there are no overt incentives to see more patients or to provide more services, as within the fee-for-service environment, there is a perverse incentive inherent in a fixed salary to limit the number of services provided to a patient. In fact, there is little financial incentive to provide more than the minimum of care, and little incentive to provide preventive care. Preventive care requires consultation, subsequent visits, follow-up test results, and maintenance of accurate records. Compliance with this type of regimen is not tied to a physician’s income, nonetheless, there have been many large staff model HMOs such as Kaiser Permanente and Tufts, for example, that have employed full-time physicians. These highly regarded HMOs were successful in providing a high level of preventive service to their enrolled members.

Capitation

Capitation is a fixed monthly fee paid to a managed care organization for each enrolled member. Over the course of a year, the capitation amount is used to fund all aspects of the enrolled population’s health care needs, regardless of whether the members use services and regardless of how expensive those services are. The most

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commonly capitated services are those rendered by a primary care physician (PCP).
Slightly more than half of all HMOs reimburse over 60% of primary care services through capitation arrangements\textsuperscript{53}. The capitation amount covers services that a PCP is expected to deliver, including preventive care, outpatient care, and hospital admissions. Diagnostic testing and certain surgical procedures may also be included in the scope of primary care services, however these services may be carved-out and separately capitated. Finally, payment for referral services to specialists and institutional services (e.g., radiology, pathology, and anesthesia) may come out of a capitation fund that is separate from the PCP’s fixed fee. As a PCP’s patients incur these services, an amount is drawn from the appropriate capitated pool. The PCP does not receive this money; the managed care organization will keep track of expenses incurred by a PCP’s members and will reconcile this against the various pools at the end of the year.

An important phenomenon occurs when a physician receives capitation. Since the payment is fixed, the risk of the population is shifted from the health plan to the physician. In accepting this financial risk, the HMO or physician group hopes that the premiums it collects will outweigh the costs of the health care utilized by the enrolled population, resulting in profit. Physicians are under scrutiny via financial incentives, withholds, and the like, to not exceed expenses allocated for their population. In essence, the provider or physician has taken on the role of an insurance company. Moreover, by blending the finance and delivery of health care, the physician has an allegiance to their managed care organization, a personal motive to succeed, and a

professional obligation to make treatment decisions without the undue influence of financial incentives.

Physician Incentives

In managed care plans the PCP is the point of entry into the healthcare system. By and large the economic viability and success of the health plan is largely dependent on the physician's ability to practice cost effective, efficient medicine. Since the physician has a critical role as the gatekeeper, managed care organizations will target financial incentives to encourage and reward the preferential practice of cost effective care.

Incentives may take the form of rewards or penalties, or may be a combination of both. Withholding is a popular form of incentive in which a percentage of a physician's fee is withheld. If the HMO has a deficit year, the amount is withheld and returned at the end of a profitable year. Withhold amounts can range from one percent to as much as over 30 percent, although most typical is in the area of 11 to 20 percent\(^{54}\). Certainly the size of the withhold amount exerts some amount of influence on a physician's decision to provide services (or not). This illustrates a controversial issue of managed care that raises the question of 'at what point does a financial incentive create a conflict between the patient's best interest and the physician's pecuniary interest?'

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\(^{54}\) Hillman, AL. *Financial Incentives for Physicians in HMOs, Is There a Conflict?*, NEJM, 1987; 317:1743-48, p.1745.
Beyond withhold percentages, physicians can be placed at further risk through other mechanisms. Examples include increasing the withhold amount for the coming year, placing liens on future earnings, decreasing the amount of the capitation for the following year, being excluded from the program, and/or reduction in the distribution from fund surpluses. Risk pools are yet another form of incentive. Risk pools are applied to primary care physicians and their use of budgeted monies for referrals to specialists and/or hospital services.

There is considerable information about HMOs' use of financial incentives and their association to financial performance and use of resources, however the direct effect on physician decision making has not been clearly established, only postulated.

Managed Care Cost Controls

There are a number of utilization management programs used by managed care organizations and can be categorized into two broad categories: macro-management and micro-management techniques. Micro-management programs are directed at the individual case or physician level whereas macro-management techniques draw upon data and are applied broadly to influence physician behavior. Both forms of cost

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55 Hillman, AL, ibid.
58 Hillman, AL, "Financial Incentives for Physicians in HMOs", Ibid.
controls can be coupled with financial incentives to encourage cost effective practice of medicine and physician compliance.

*Micro-management tools*

Managed care companies use pre-certification to minimize unnecessary or inappropriate hospital admissions. Cases are reviewed against criteria and are assigned a length of stay. Failure to obtain pre-certification often results in a financial penalty to the physician or the patient. Pre-authorization for elective procedures is often required as well.

Utilization review encompasses a spectrum of case management techniques. After a patient is admitted to the hospital, the managed care company will concurrently review the case to monitor the patient's stay to ensure that it does not exceed the predetermined length of stay. For catastrophic cases, utilization review case managers will work with the patient and the physician to review alternative care settings. This is to assure that the patient's medical needs are met while also making use of the most cost-effective care. Discharge planning is yet another form of utilization management where case managers will assist the family with post-discharge services such as home health care or home infusion therapy.

In cases where the managed care plans also pay claims, retrospective claims review may be conducted to identify suspicious physician billing practices such as up-coding or unbundling (coding fragmentation). Retrospective chart reviews are also
conducted to profile cases with poor outcomes such as nosocomial (hospital acquired) infections or those that resulted in death.

Clinical guidelines are another form of micro-management. Practice guidelines provide optimal strategies for diagnosis and management of disease. Guidelines may be industry standards, or may be based upon the consensus of a panel of experts. Managed care companies implement clinical guidelines with the desire to improve care, reduce variation of physician practices, eliminate inappropriate procedures, and reduce costs. The premise is that by following a critical path with demonstrated optimal outcomes, cost will decline, and the quality of outcomes will increase. Physicians’ adherence to clinical guidelines is somewhat dictated by how the managed care organization enforces and endorses their use.

By design, capitation has inherent cost containment incentives. For example, by accepting a fixed feed for an undetermined number of comprehensive health care services, a physician is accountable for managing these costs within a budgeted amount. The incentive, therefore, is to manage the type and utilization of services vis-a-vis cost efficient and effective treatments, administration of preventive services, and avoidance of expensive specialty care. Proponents of HMOs claim that capitation and other ancillary incentives are vital to the HMOs success at containing costs. Numerous studies have pointed to managed care’s lower rates of utilization of services in

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60 Leavenworth, Geoffrey, Quality Costs Less, Business & Health, Special Report on Guidelines, 1995
comparison to traditional coverage\textsuperscript{61,62,63}. A 1994 Miller and Luft analysis reviewed the performance of managed care plans since 1980. The literature review found lower hospitalization rates, shorter average lengths of stay, and reduced intensity of tests and procedures of HMOs compared to traditional indemnity plans\textsuperscript{64}. A frequently cited analysis conducted by Manning, et al, is a controlled trial that demonstrated lower utilization rates for those persons who received care from an HMO (Group Health Cooperative of Puget Sound in Seattle) versus those who received care from a fee-for-service physician\textsuperscript{65}. Utilization rates in prepaid group practices were markedly less “hospital intensive and, consequently, less expensive”, according to the 1984 results published in \textit{The New England Journal of Medicine}.

\textit{Macro-management tools}

To foster accountability, some health plans publish report cards. Using claims data, medical records, or surveys, health plans report on performance measures in the areas of cost, quality, member satisfaction, and/or administrative efficiency. Public disclosure of report cards is used as a method of improving accountability of physicians

\textsuperscript{61} Christensen, S. \textit{"The Effects of Managed Care and Managed Competition"}, Washington, D.C., Congressional Budget Office, February 1995


\textsuperscript{63} Luft, Harold, \textit{How Do HMOs Achieve Their “Savings”?}, NEJM 298 24:1336-1342


\textsuperscript{65} Manning, et al. \textit{A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services}, NEJM 1984; 310:1505-10.
or institutions, but has benefits to other stakeholders in the health care system. For example, purchasers (consumers and employers alike) can use information in the report cards to make informed decisions when selecting a health plan. Some employers require plan performance data as a means of holding health plans accountable for the value of the coverage that they purchased. HEDIS, which is discussed in the next section of this chapter, is an example of such plan performance data. Many large commercial health plans voluntarily report performance data and publish select measures (i.e., immunization rates and patient satisfaction) to increase their reputation and position in the marketplace.

Another macro-management tool used by managed care companies to influence physician behavior is provider profiling. Standardized information regarding physician-specific outcomes are reported to the health plan’s physicians. The intent of furnishing this information is threefold. First, the profiles increase awareness of individual and peer practice patterns. Secondly, reporting of nationally accepted industry standard outcome measures foster awareness of, and adherence to, evidence-based medicine. Thirdly, profiles are used to provide confidential feedback to motivate professional self-improvement. Since this type of reporting is relatively new to managed care, its effectiveness in reducing costs or improving outcomes has not been sufficiently evidenced.

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Focus on Quality

Managed care plans have several means of ensuring that their members have access to, and receive high-quality care. These include: coordination of care by the primary care physician, clinical quality improvement, and research programs.

The role of primary care physicians includes maintaining an ongoing relationship with their patients, helping to arrange for services such as specialty visits, hospital care, and home health care as needed\(^{68}\). Another role of the primary care physician is to assure that patients receive medically-appropriate services in a timely manner. Coordination of services through the primary care physician promotes continuity of care, which is essential to quality.

Many managed care plans operate quality improvement and research programs to monitor trends in health care, determine which treatments produce the best health outcomes (known as clinical guidelines), establish quality improvement goals, and define the process for making any needed improvements. Larger commercial health plans have invested research and development costs to collect health care data. Among other things, health plans use this data to analyze their patient populations and to track the effects of programs aimed at improving the health status of high risk populations, or clinical outcomes for chronic conditions (i.e., asthma, diabetes, coronary heart disease). Reporting may also be done at the micro level to improve the health status of individual

\(^{68}\) Franks, P., Clancy, C. Gatekeeping Revisited – Protecting Patients From Overtreatment, NEJM 1992;6:424-427
members. For example, data revealing abnormal test results may indicate the need for follow-up, or a high-risk member may be targeted for intervention and education.

Since many health plans have extensive internal procedures in place to promote quality, it is not surprising that multitudes of independent studies have been published on the quality of care of managed care plans in comparison to traditional health care plans. In 1994, Miller and Luft reviewed studies on the quality of care that were published since 1980. This study reported that the quality of care received by HMO members was “roughly comparable” to traditional coverage (14 of 17 findings reflected similar or better process and outcomes of care in HMOs)\textsuperscript{69}. However, three years later the same researchers performed another literature review on quality of care studies published between 1993 to 1997, and found an equal number of significantly better and worse results for HMOs compared to traditional coverage\textsuperscript{70}.

**Accountability**

There are many points of accountability in managed care. Health plans are accountable to meet required statutory and regulatory standards. Health plans are also accountable to their members and their customers (i.e., employers) to measure and report performance in the areas of access, satisfaction, solvency, network adequacy, and quality of care. Furthermore, in a capitation arrangement, the physician is fully accountable to the health plan to effectively manage the health care costs of their patient

\textsuperscript{69} Miller RH, Luft HS, *Managed Care Plan Performance Since 1980*, ibid

\textsuperscript{70} Miller RH, Luft HS, *Does Managed Care Lead to Better or Worse Quality of Care?* Health Affairs, September/October 1997; 16(5): 7-25.
population within an allocated amount per year per patient. Finally, in employer-sponsored health plans, employers are accountable for decisions regarding benefit coverage, whereas physicians are accountable for quality of care that they administer.

Licensed health plans are held accountable for the quality of care they provide. This is accomplished not only through member satisfaction surveys and internal quality improvement programs, but also by complying with the extensive statutory and regulatory requirements associated with state HMO laws, the Federal HMO Act, Medicare and Medicaid standards, and requirements of the Federal Employees Health Benefits Program (FEHBP)\(^1\).

In addition to meeting these requirements, health plans have responded to consumer and employers' demands for objective, standardized information about health plan performance. The most well known and widely used system for reporting health plan performance data is the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a performance measurement system developed with collective input from employers (including Xerox, GTE, Digital), consumer and labor representatives, health plans, and quality experts. Borrowing on the concept of total quality management (TQM), this group developed a set of quality (process and some outcomes) and member satisfaction measures. These performance measures have been adopted by the

\(^{1}\) William L. Roper, M.D., M.P.H., Senior Vice President, Statement on Health Care Quality and Consumer Protection, Prudential HealthCare for the American Association of Health Plans Before the Senate Committee on Labor and Human Resources, Washington, D.C., March 6, 1997
National Committee for Quality Assurance (NCQA), a non-profit managed care accreditation body, as part of their rigorous accreditation process, and have been used by more than 350 health plans throughout the country\textsuperscript{72}. HEDIS includes detailed information on health plan performance in the areas of quality, access to care, patient satisfaction, membership stability, use of resources, financial soundness, and internal management systems\textsuperscript{73}.

Looking at accountability from a different perspective, individual or groups of physicians are held accountable when they belong to a managed care plan that is paid a capitation amount. In this type of financial arrangement, a physician or provider group accepts a prepaid capitated fee on a monthly basis, and in doing so has also taken on a dual responsibility. First, the physicians are accountable to their patients to provide appropriate, efficacious, and timely care. Second, physicians are also accountable to the health plan for managing these fees within the allotted amount for their base of patients.

**Affordability**

Numerous studies have demonstrated managed care's effectiveness at reducing costs and hospitalization. A widely recognized study is the Health Insurance Experiment conducted by the RAND Corporation\textsuperscript{74}. This study demonstrated that physicians in


\textsuperscript{73} NCQA, ibid.

\textsuperscript{74} Brook, RH et al., *Use of Medical Care in the RAND Health Insurance Experiment*, Medical Care 1986; 24:SupplS1-S87
prepaid plans hospitalized their patients as much as 40 percent less than their fee-for-service counterparts, which resulted in HMOs overall lower expenses. The Health Care Finance Administration (HCFA) has reported similar findings. HCFA reported that health care expenditures reached a record high of more than one trillion dollars in 1997, whereas the rate of growth (4.8%) was the slowest recorded in more than 35 years\textsuperscript{75}. At 13.5%, the percentage of gross domestic product (GDP) has remained unchanged since 1994, whereas between 1960 to 1994 the percentage of GDP rose from 5.1% to 13.5%. The slowed growth in national health care spending noted in 1994 was due to a slowed growth rate of insurance premiums which has been attributed to the increasing enrollment in lower-cost managed care plans\textsuperscript{76}.

Consider the following scenario faced by a new family expecting their first child. Under an indemnity plan, the family would be required to pay 20% coinsurance for nine or more prenatal office visits. The cost of the hospital stay might include a deductible of $500, for example, plus 20% of the remaining costs. Since well-baby care is not traditionally covered under indemnity plans, the family would be also be responsible for 20% of these expenses as well. In comparison to an HMO plan, the same family might pay a $10-$25 co-payment for pre-natal care, and similar co-payment for the hospital stay and well-baby care visits. The out-of-pocket expenses are less burdensome in the HMO plan compared to the indemnity plan. Affordability has played a significant role in the popularity and growth experienced among managed care plans.

\textsuperscript{75} Health Care Finance Administration, Highlight of National Health Expenditures, 1998. \url{http://www.HCFA.gov/stats/nhe-oact/}
In sum, the attractive attributes of managed care plans, including increased access to preventive care, low out-of-pocket costs, and no claim forms, led to the popularity and growth of managed care during the 80s and 90s. The federal government introduced managed care health plans to both the Medicare and Medicaid programs. Many cost-conscious employers embraced the concept of managed care and encouraged their employees (through cost incentives or through limiting choice) to select a managed care plan. As a result, enrollment in managed care plans has grown tremendously over the past two decades.
Chapter 3:

Factors Contributing To Managed Care Backlash

As managed care plans gain an increasing foothold in the health care market, the trend toward integrating the finance and delivery of care has generated concerns about the implications for quality of care. There are fears that cost containment vehicles such as capitation, physician incentives, and oversight activities have negatively influenced physician practice behaviors to under-serve, or even deny care. This has lead to many other controversial issues that have cast managed care under a black cloud. There is concern that quality of care has suffered because managed care organizations have put doctors in a tenuous position to have to consider profit in the same vane as the patient’s best interest. The notion of "profit before the patient" has tainted the patient-physician relationship and has instilled distrust in the system. The public has denounced managed care, resulting in what is referred to as the ‘backlash’.

As consumers of health care, patients feel entitled to health care services and strongly believe that physicians should not be subject to HMO’s profit goals. The public has demanded that their rights as patients be protected by law. This chapter will discuss the facets of managed care that have contributed to the current state of managed care backlash, including: corporate management of managed care companies, negative media, public perceptions and confusion of managed care, changes in the socio-demographics of the health care consumer, and employers’ sensitivity to price.
Profit Motives of Health Care Organizations

In 1998, membership in for-profit HMOs totaled approximately 53.9 million members, and represented nearly two-thirds of total HMO membership. The charter of for-profit organizations is to maintain a desirable profit and/or satisfy its stakeholders. Profits can be positively affected by increasing revenue streams (i.e., premiums from membership) or by reducing costs (e.g., administrative fees, salaries, health care services). The less money that a managed care organization spends on patient care, the lower their premiums, and the more cash can be put aside and returned to shareholders. Controlling expenses also affords marketability and membership potential. Respondents surveyed in the 1998 HMO Industry Report rated price competitiveness as the most important factors in retaining and generating enrollment growth.77

Publicly traded managed care organizations calculate and publish a "medical loss ratio" in their annual report. This ratio indicates the percentage of each premium dollar spent on the delivery of health care, which, ironically, is regarded as a loss78. To provide perspective, in the late 1970s, leading non-profit HMOs spent 94% of its premiums on health care. The few non-profit HMOs that existed in the early 90s (e.g., Kaiser Permanente, Tufts, Harvard Community Health Plan) maintained their medical loss ratio in and around the 90 percent mark. Conversely, it was not uncommon for


investor-owned managed care organizations to boast of medical loss ratios of 75% or lower.\textsuperscript{79}

Since managed care companies compete on the basis of price (in order to increase market share), it is imperative that expenses are contained to a minimum. One of the largest and most variable costs arise from physicians' treatment decisions. Since nearly all decisions regarding patient care are made at the discretion of the primary care provider (PCP), managed care organizations have targeted financial incentives to deter unnecessary or marginally necessary care. In extreme cases, managed care cost containment strategies have conflicted with doctors' decision to treat vis-a-vis nondisclosure clauses and penalties contained in the physician contract with the health plan. Naturally, this raises the question as to whether the role of care provider and business manager is opposed, and moreover, to what extent this contention influences a physician's treatment decision.

The public's dismay and the corporate management of health care is evident in the increasing number of cases against managed care companies being brought to court. In 1998, the Texas attorney general sued six HMOs accusing them of penalizing doctors that did not limit patients' medical care and illegally compensating those who did. Each lawsuit said that the HMOs created conflicts of interest for doctors by giving them budgets for certain services (e.g., hospital admissions) in order to maximize profits. Doctors were given a percentage of the surplus if they came in under budget and were

\textsuperscript{79} Anders, G. Ibid, p.62
expected to compensate the HMOs if they went over budget\textsuperscript{80}. In January 1999, a $120 million civil suit was brought against Aetna U.S. Healthcare of California. The judgement was in favor of the cancer patient, who had been delayed (or refused) certain recommended cancer treatments, and later died\textsuperscript{81}. These are two examples exemplify the public's anger with the overriding profit motives of managed care organizations.

Also fueling the backlash of managed care is the publication of managed care organization's executives' salaries. The public views this as unethical and insidious because the money could have been spent on patient care, instead of going to high level executives. To add to public outrage, even top executives of companies that failed, such as Columbia/HCA (a hospital chain) and Oxford (an HMO), were rewarded with lucrative severance packages\textsuperscript{82}. When HMO executives decided that their mission was to make as much money as possible, they also invited scorn and distrust from those on the receiving end of health care, the public. A more overt sign of this backlash is the decreasing value of managed care organizations' stock during over the past year.

\textsuperscript{80}Vertuno, James, "Attorney General Sues Six HMOs Accusing Illegal Contracts with Doctors", Associated Press, 12/16/98. Humana was accused of illegally penalizing doctors or physician groups up to $2,000 for each member who left the HMO after a doctor advised them an alternative plan might provide better coverage. The lawsuits asked the court to order the HMOs to pay civil penalties and stop the alleged practices.


\textsuperscript{82}The Associate Press reported that the president of Columbia HCA Healthcare Corp. received a $10 million severance package and that Oxford's former chairman, Stephen Wiggins, would receive severance of up to three times his annual salary plus bonuses for a total of more than $5 million.
Negative Media Coverage of Managed Care

Concerns of cost, quality and access have been heightened in the public's eye through increased media attention and unfavorable press of managed care. The media has focused on the negative aspects of managed care by featuring “horror stories” of people being denied life-saving care. The media has played a role in contributing to general distrust in the health care system by instilling lack of confidence that managed care can deliver quality care while decreasing costs. This phenomenon is supported by the numerous newspaper headlines and cover stories featured in Time Magazine (Playing the HMO Game: Denied Viagra and, Inflamed by Horror Stories, Consumers Put Health Reform Back on the Front Burner³), U.S. News & World Report (Healing the Great Divide: How Come Doctors and Patients Ended Up on Opposite Sides?, How HMOs Decide Your Fate⁴), and USA Today (HMO Love Affair over? Relationship Between Money, Health Hits Skids)⁵. While these stories may be interesting reading material, they have contributed to the public's negative image of managed care.

Due to media's reach, it is believed that such negativity may be responsible for propagating the backlash of managed care⁶. A study was

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³ Time, Playing the HMO Game: Denied Viagra and Inflamed by Horror Stories, Consumers Put Health Reform Back on the Front Burner, July 13, 1998


⁶ USA Today, HMO Love Affair Over? Relationship Between Money and Health Skids, October 20, 1999

conducted in 1998 to assess the potential bias of the media in its portrayal of managed care. The findings pointed to a noticeable trend in the critical tone of the coverage over time for the period spanning 1990 to 1997. In addition, the study found that the most visible media sources had negative stories in more than 50% of their managed care coverage, and that most coverage drew on anecdotes. This study provides empirical data to support the perception that the media has contributed to the public's negative view of managed care.

Public Perceptions of Managed Care

The Employee Benefit Research Institute (EBRI) conducted a survey to examine American confidence in managed care both now and in the future, as well as their attitudes toward health care reform. Contrary to what has been portrayed by the media, the 1999 survey indicated that the majority of Americans are extremely or very satisfied with the quality of medical care they have received. However, the level of satisfaction varies by type of health care plan, with the highest levels of satisfaction taking place for those in fee-for-service plans, as shown in Table 1. Similar results were reported in 1998: 80 to 93 percent of people polled stated that they were satisfied with their health care

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88 Brodie, M., Brady, and Altman, D.E., Media Coverage of Managed Care: Is There a Negative Bias? Health Affairs 1998; 17(1):9-25

89 Employee Benefit Research Institute, 1999 EBRI Health Confidence Survey, October 20, 1999. The EBRI is a private, nonprofit, nonpartisan public policy research organization. The survey was conducted through 20 minute interviews with 1001 individuals ages 21 and older. Random dialing was used. The sample yields a statistical precision of plus or minus 3 percentage points (within 95 percent certainty).
plan, with traditional plans yielding a higher score (approximately ten percent) compared to managed care plans\textsuperscript{90,91}. 

### Percentage of Extremely or Very Satisfied with Aspects of Health Care Received Over the Past Two Years, by Type of Health Plan

*Source: 1999 EBRI Health Confidence Survey*

<table>
<thead>
<tr>
<th>Aspect of Health Care</th>
<th>HMO Plan</th>
<th>PPO Plan</th>
<th>Fee-for-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Medical Care Received</td>
<td>35%</td>
<td>49%</td>
<td>48%</td>
</tr>
<tr>
<td>Ability to Choose Your Doctor</td>
<td>30%</td>
<td>54%</td>
<td>82%</td>
</tr>
<tr>
<td>Care You've Received in the Last 2 Years</td>
<td>46%</td>
<td>60%</td>
<td>71%</td>
</tr>
<tr>
<td>Hospitals You've Been Treated At</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Benefits Covered by Insurer</td>
<td>40%</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Cost of Health Insurance</td>
<td>40%</td>
<td>36%</td>
<td>21%</td>
</tr>
<tr>
<td>Health Care Costs Not Covered by Insurance</td>
<td>38%</td>
<td>32%</td>
<td>41%</td>
</tr>
</tbody>
</table>

*Table 1*

The survey also showed a high level of confidence in the health care system, a measure that was quantified through questions about confidence in their pharmacist to fill their prescription correctly, confidence in their plan to have a specialist visit approved, or to choose their own doctor or hospital. However, less than half of the respondents were very confident that their doctor's treatment


would be based upon their health care needs rather than the cost of their care, or that their doctor was up-to-date on information about medicine and medical conditions. These aspects of health care express potential concerns, since they were not necessarily founded on first hand experiences of the respondents.

The EBRI study offers interesting and compelling points about America's perception of managed care. First, in spite of lower overall satisfaction with managed care, there seems to be confusion about what constitutes managed care. The survey reported that even though nearly 87% of Americans are covered by some type of managed care plan, 54% of the HMO enrollees surveyed said that they had never been in a managed care plan. This finding points toward the public's confusion over managed care, and furthermore, indicates a lack of awareness of participating in a managed care plan. Secondly, the general lack of confidence in doctors' treatment decisions conveys the public's uncertainty and distrust of the physician-patient relationship within managed care.

In 1998, the Kaiser Family Foundation and the Harvard School of Public Health conducted a poll entitled, National Survey of American's Views on the Consumer Protections Debate. In this survey responses were collected to assess the public's attitude and experiences with managed care, as well as consumer protection.

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92 1999 EBRI Survey, ibid. Note: 21% of respondents identified themselves as enrolled in a managed care plan, and were also less satisfied with their plan compared to those respondents who were not aware that they were enrolled in a managed care plan.
alternatives. Survey data were collected from September 1997 to April 1999, a time during which there was intense debate and media exposure of managed care issues.

This survey was designed to understand the manner in which Americans develop their perceptions of managed care. Fifty-three percent of the respondents reported that they form their opinions of managed care based upon second-hand experiences of family or friends, the media, or on the basis of their own experiences, as shown in Figure 4 below.

Percent Who Say Their Views of HMOs or Managed Care Are Most Influenced by ...

Source: Kaiser Family Foundation/Harvard University School of Public Health

![Pie Chart](chart.png)

Figure 4

This finding, in conjunction with the EBRI survey regarding the public's confusion of managed care, demonstrates fragility of public opinion in areas where there is lack of understanding in the topic at hand. As indicated in Figure 4, the media has the ability to

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shape public opinion, and has negatively influenced approximately 18% of the public's opinion of managed care.

The Kaiser Family Foundation survey underscored other negative perceptions of managed care. Nearly 58% of the respondents were worried that if they become sick, their health plan would be more concerned about saving money than providing the best treatment (this percentage varied by type of plan, however, those enrolled in HMOs were more concerned than their fee-for-service counterparts). Other negative views expressed about managed care included: decreased time that doctors spend with patients, decreased access to specialists, and decreased quality of care for the sick. Finally, over half of those surveyed stated that managed care had not produced health care savings.

How is it then, that there can be high levels of satisfaction (as indicated by the EBRI survey) coupled with negativity about so many aspects of managed care? One interpretation might be that many people do have complaints but have reported them to their health plan and were satisfied with the response. Lacking this data and insight makes inferences difficult. Another more likely interpretation is that those expressing unfavorable opinions about managed care formed their view on the basis of someone else’s experience, or were influenced by the media. In either case, it is not surprising that nearly three-quarters of the respondents supported comprehensive consumer protection legislation including provisions such as increased access to specialists, emergency care, and suing their health plan. However, interesting to note is that

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94 Ibid, Kaiser Family Foundation, National Survey of Americans' Views on the Consumer Protections Debate
support for such legislation dropped to 46% when the potential for cost increase was raised.

Professional Opinions of Managed Care

Professionals who administer care have voiced their thoughts on practicing in an industry that has become dominated by managed care in a poll entitled, "Survey of Physician and Nurses". Designed and conducted by the Kaiser Family Foundation/Harvard School of Public Health, the survey found that almost nine out of ten doctors say that their patients have experienced some type of denial of coverage of services over the past two years. Across all type of services, doctors reported that between one-third and two-thirds of denial of coverage resulted (in their judgement) in a "serious" decline in a patient's health status (most frequently for mental health, specialist referrals, and diagnostic tests and procedures). Unlike the way in which the public's view of managed care is shaped, this study found that 79% of physicians' view of managed care is based on their first-hand experience as a doctor (see Figure 5).

95 Kaiser Family Foundation/Harvard University. Survey of Physician and Nurses, July 1999. The survey was administered by mail to a random sample of 1053 physician and 768 registered nurses (drawn from the AMA's Masterfile). Data were stratified by PCP and specialist. Data presented on the consequences of health plan denials represent judgements, not clinical reviews. The margin of sampling error is +/- 3% for the physician survey and +/- 4% for nurses.

96 Ibid.
What Shapes Providers' Views About Managed Care?
Percent Saying Each Shaped Their Views “A Great Deal”

Source: Kaiser Family Foundation/Harvard University, Survey of Physician and Nurses

![Pie chart showing percentages]

Figure 5

The New England Journal of Medicine published the findings of a survey entitled “NEJM Views of Managed Care: A Survey of Students, Residents, Faculty, and Deans at Medical Schools”

When physicians were asked about specific aspects of care, fee-for-service medicine was rated better than managed care in terms of access (by 80.2 percent of respondents), minimizing ethical conflicts (74.8 percent), and the quality of the doctor-patient relationship (70.6 percent). With respect to the continuity of care, 52.0 percent of respondents preferred fee-for-service medicine, and 29.3 percent preferred managed care. With respect to care for patients with chronic illness, 41.8 percent preferred fee-for-service care, and 30.8 percent preferred managed care. Faculty members, residency-training directors, and department chairs responded that managed care had reduced the time they had available for research (63.1 percent agreed) and

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teaching (58.9 percent) and had reduced their income (55.8 percent). Overall, 46.6 percent of faculty members, 26.7 percent of residency-training directors, and 42.7 percent of department chairs reported that the message they delivered to students about managed care was negative.

Clearly, physician and nurses have concerns or have formed unfavorable opinions about managed care which are largely shaped by their own practical experiences as health providers. When asked if they would be worried that a health plan would be more concerned about saving money than determining the best treatment for a sick family member, 46 percent of the physician respondents (50% of nurse respondents) said that they would be very worried98.

**Socio-Demographics of the Health Care Consumer**

The number of educated people and the level of education has increased dramatically over the last 30 years. Generally, the average consumer is better educated, and has access to data to make informed buying decisions. Education and information equates to knowledge. Knowledge is empowering -- it fosters a certain self confidence that has lead consumers to be assertive in their purchasing experiences, from buying cars and books, to purchasing health care and participating in their treatment decisions.

The double-income families prevalent of today leave very little or no time to shop. Families are burdened with child and elder-care responsibilities, work, school, etc. and

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value their free time. Consumers demand choice, convenience and expect quality – attributes that seem logical, but are often difficult to implement in concert.

Convenience in health care is a factor that may be shunned as an attribute necessary of a grocery store, not of a doctors' office, albeit health care is probably the largest service industry in the United States. Convenience translates into ease of access, hours of operation, location, wait time, and integration of services. Taken together, these attributes can positively impact important things such as increased levels of immunization and preventive care, appropriate use of services, centralization of services to cater to the multi-faceted needs of those with chronic diseases and compliance with treatment regimens. When there isn't convenience, people are more likely to defer preventive care and/or seek care when an emergency arises – both instances are costly and potentially inappropriate (and does not contribute toward increasing health status).

Well-informed consumers have changed their relationships with doctors. Rather than rely solely on the knowledge of their doctor, they do research to understand their illness, treatment options, and outcomes. If they don't confer with their doctor's opinion, they may seek another opinion until they get what they are looking for.

Advertising is now permitted by health plans, hospitals, and pharmaceutical companies (direct to consumer marketing, or DTC), and has been used to raise the public's awareness of their specialized services or pharmaceuticals and are used very simply as a competitive marketing tool. As a result, consumers, now more than ever before, have become more acutely aware of their choices. They ask for, and expect brand name drugs or the highest tech procedure to be used by their physician.
Information on drug therapies, treatment options, surgeries, etc. are all fairly accessible to most consumers via the Internet.

Finally, the activist culture of the 60's and 70's was instrumental in shaping this generation's views about the legal system, and about protection of their rights. As these baby boomers age and more enter the health care system more frequently, they are exercising their political clout by proclaiming that their rights as consumers of health care be protected.

**Employer's Sensitivity to Price**

Health insurance premiums increased by double digits in the late 80's and early 90's, during a time when the economy was experiencing a recession. Employers were less willing and able to offset the cost of premiums to their employees and began to look for alternatives to the open-ended fee-for-service plans. Some employers passed off increases in the form of larger deductibles and higher coinsurance amounts. Other employers strategically priced their plans to make the managed care plans most appealing to their employees. The lower out-of-pocket costs and smaller monthly contribution toward premiums was intended to entice employees to enroll in the less costly managed care plans.

Throughout the 80's and into the 90's, employers began to employ strategies to shift employees from expensive indemnity plans into less costly managed care plans. The central driver of managed care was a reduction in the amount of freedom of choice that patients enjoyed and expected in the 'free-for-all' world of indemnity insurance. By moving into a managed care plan, members submitted to having their care "managed" or
regulated by the health plan or HMO. In doing so, they sacrificed unbridled choice among providers and services that was otherwise the norm in the indemnity plan. The loss of choice and the impingement of the managed care organization on the doctor-patient relationship are two important factors that have contributed to managed care's backlash.
Chapter 4:
The Present State of Managed Care

Advocates of managed care believe that HMOs, by virtue of their design, offer an ideal mix of cost containment, access and quality features, including: pre-paid care, absence of claim forms, reduced financial barriers, increased access to preventive care, and coordination and continuity of care through a primary care physician. These attributes have made HMOs an appealing choice to consumers, the government, health plans, and employers alike as witnessed in the fivefold increase in HMO enrollment since 1982\(^9\).

Over the past decade managed care has gained support by large employers and by the government, the two largest purchasers of health care. Health maintenance organizations (HMOs) and point of service (POS) plans were both introduced to the Medicare population during the past five years (currently, there are 6.2 million Medicare recipients enrolled in managed care). In the mid-'90s, employers began to offer HMOs to their Medicare eligible retirees to control the high costs often generated by an elderly population. In total, approximately 116 million people are enrolled in managed care plans (which includes the full spectrum of PPO, POS and HMO plans)\(^10\). As of July 1998, a total of 78.8 million people were enrolled in some 652 HMOs\(^11\). The number of HMO enrollees continues to increase, although the growth rate has slowed over the past


\(^10\) Barents Study completed for the American Association of Health Plans (AAHP)

year. The figure below shows the growth of enrollment by type of plan for companies with two hundred or more employees.\textsuperscript{102}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{national_employee_enrollment_by_plan.png}
\caption{National Employee Enrollment by Plan}
\end{figure}

\begin{flushright}
\textit{Source: KPMG Peat Marwick}
\end{flushright}

This graph illustrates the dramatic change in the distribution of enrollment by type of plan. In 1984, over 90\% of employees were enrolled in Blue Cross-like indemnity plans. Pauly and Nicholson refer to "pooling equilibrium"\textsuperscript{103}, which describes the offset effect that results from the combination of low and high-risk individuals. Throughout the 80's, pooling equilibrium existed in the indemnity environment, but was disjointed in the early 90's when enrollment split 50-50 between indemnity and managed care plans. Over the next four years, pooling equilibrium began to take shape among managed care


plans. By 1998, the market shares nearly reversed, with managed care plans representing over 87% of the market. In essence, the industry has come full circle, with implications that can only be postulated.

Managed care has been credited with controlling the inflation-ridden costs of the '80's via HMOs lower rates of inpatient hospitalization which resulted in their overall lower expenses\textsuperscript{104,105,106}. It is also the belief that early on, HMOs reaped the benefits of “adverse selection”. This term describes the effect of low risk individuals migrating from traditional indemnity plans to less costly HMO plans. The theory holds that high-risk individuals, unwilling to submit to the restrictive provisions of a managed care plan, remained in the more costly indemnity plans\textsuperscript{107}. In effect, the indemnity plans were left with a larger proportion of high-risk individuals and fewer people over which to spread the risk. As a result, indemnity plan costs rose at a faster rate than the managed care plan, as shown in Figure 7 on the next page.


\textsuperscript{105} Brook, R.H., et al., \textit{Use of Medical Care in the RAND Health Insurance Experiment}, Medical Care 1986;24:Suppl:S1-87


\textsuperscript{107} Pauly and Nicholson, ibid.
As illustrated in Figure 7, the trend of indemnity and HMO premiums mirrored each other, however indemnity premiums clearly grew at a higher rate. As indemnity premiums increased, higher risk people, perhaps reluctantly, moved into a less costly managed care plan. As movement into managed care plans occurred, premium increases began to decrease\textsuperscript{108}. Health insurance premiums fell compared to traditional insurance, premium rates for HMOs increased between two and five percentage points less per year (or 40% less) from 1988 to 1993. KPMG Peat Marwick, a management

\textsuperscript{108} Jensen, GA, et al. The New Dominance of Managed Care: Insurance Trends in the 1990s. Health Affairs. Jan/Feb. 1997; 16(1):125-137. The study showed that while enrollment in managed care increased to 73% of employer-sponsored coverage in 1995, HMO premiums increase the least (0.9%) compared to other less managed plans.
consulting company, reported that this trend indicated sustained managed care savings over time\textsuperscript{109}. This report was published in 1994.

Beginning in 1994, less than half of the members were enrolled in an indemnity plan. It is also during this time that premium increases for both indemnity and managed began to grow at about the same rate. This trend suggests that the cost benefit HMOs may have enjoyed via adverse selection diminished as higher risk individuals enrolled in managed care\textsuperscript{110}. In 1998, large employers saw the first significant rise in health care costs after consecutive years of relatively flat growth, as shown in Figure 8 below.

\textbf{Figure 8}

\begin{figure}[h]
  \centering
  \includegraphics[width=\textwidth]{Average_Cost_Per_Employee_of_Employer-Sponsored_Health_Care.png}
  \caption{Average Cost Per Employee of Employer-Sponsored Health Care}
  \label{fig:average_cost}
\end{figure}


\textsuperscript{110} Pauly, Nicholson, ibid.
At the end of 1999, health care costs were reported to have increased by 7.2% from 1998, with premiums projected to increase an additional 7.5% in 2000\textsuperscript{111}. The impact for small companies (i.e., those with 50 or less employees) was more severe, having experienced a 13.8% increase between 1998 and 1999.

Unlike prior years, employers have reportedly chosen to swallow the additional cost of health care. This is probably due to the influence of a tight labor market, and is a tactic to retain existing employees. Historically, employers have shifted cost increases off to employees in the form of higher premium contributions, or increased coinsurance amounts.

The HMO industry has also felt the pinch of increasing health care costs. In 1999, the HMO industry experienced a 45% decline in profitability (a collective net loss of $1.25 billion) representing a departure from typical positive performance\textsuperscript{112}. This trend points to the difficulty of sustaining a profit in an industry that has made a business out of caring for sick people. With managed care profits on the decline, investors have pulled out of the market, which in prior years generated a highly favorable return.

As managed care has taken a commanding position in the marketplace, there is growing fear that HMOs will continue to squeeze costs in order to return a profit to shareholders. There is concern that cost containment vehicles such as capitation, physician incentives, gag clauses, and oversight activities will influence physicians to under-serve, or even deny care. Americans drew a rhetorical 'line in the sand' with

\textsuperscript{111} William M. Mercer, \textit{Survey of Employer-Sponsored Health Plans}, 1999

\textsuperscript{112} A.M. Best Co., "1998 HMO Profitability" (a report based on data from more than 600 HMOs), December 1999.
managed care plans on the one side, and consumers of health care on the other. The public has cried out for legal protection of their rights whereas health plans vehemently oppose any type of government regulation. The other players, not sure of the implications of managed care policy, have been left to choose sides in the debate over a patient bill of rights.
Health care reform has occurred piecemeal at the state level and has also been mandated by the federal government. In addition, the health care industry has been 'revolutionized' by the natural forces of the marketplace, and the demands of its players. This chapter reviews both state and federal health care reform that have taken place over the past decade. Since Clinton's first proposal for global health care reform failed, many states have taken matters into their own hands and have implemented a patchwork of managed care laws. At the same time the federal government has devised their own version of a patient bill of rights, with different provisions and scope of application. Key provisions of the major pieces of patient protection legislation will be reviewed and discussed herein.

Health Care Reform in the Last Decade

In the early 90s, the Clinton Administration proposed to restructure the health care system through three broad goals: first, provide secure, uninterrupted health coverage for all Americans, secondly, place 37 million uninsured in a health plan, and third, cut the rate of medical inflation. The Clinton proposal was to be accomplished by providing a standard and affordable set of benefits to more working Americans and to the uninsured. Up to 80% of the premium cost would be paid for by employers and

113 The Hartford Courant, "A Primer: Clinton's Health Care Reform Plan, 1993

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ceilings would be placed on premium increases if costs were not lowered through the course of market competition. At the core of Clinton's health care reform proposal was the creation of buyers' market through the establishment of health insurance purchasing cooperatives (HIPCs). HIPCs were to foster what was first coined by one of the president's health care advisors, Alain Enthoven, as "managed competition". Health plans were to compete for membership on the basis of price and quality. The HIPCs were also charged with monitoring and improving quality and service. Guidelines, established by a national health board would promote quality of care, would also result in efficiencies and ultimately lower costs. Health care plans would be held accountable for providing services and coverage under these established guidelines.

Managed competition seemed logical in concept, but by and large, the Clinton Administration's complex proposal for re-organizing the health care delivery system never came to fruition. Under Clinton's model, health plans were to improve quality and consumers were to dictate and shape the market. However, the consumers that drive the market are also the biggest purchasers of health care -- large employers and the government (Medicare and Medicaid) and were more focused on price, and secondarily on quality. The cost-consciousness of these players bore a tremendous influence on the health care industry, as was discussed in Chapter 3.

Desperate to contain costs, health plans and employers began to make drastic plan design changes to high cost or high frequency benefits such as maternity and mental health. Consequently, legislation was called upon to

protect individuals from seemingly unfair or harsh decisions. In response to what became referred to as "drive through deliveries", many states began to mandate minimum lengths of stay (48 hours) for maternity admissions. Similarly, advocate groups cried out against the unfair limits placed upon mental health benefits, claiming that restrictions should be the same as those on physical illness. The Mental Health Parity Act of 1997 was the government's mandate that required employers to lift dollar limits (i.e., annual or per service maximums) from mental health benefits so that they were equivocal to other medical benefits.

Since Clinton's proposal, health care reform has not entered the political arena, nor has it been as publicly charged a topic until the mid-term elections at the end of 1998 and throughout 1999. Despite the lack of global reform, the health care industry has revolutionized itself in response to advancements in technology and medical knowledge. The industry has also responded to pressures from employers and the government to contain costs; to patient demands for choice and access to high-tech care, and to physicians' desire to retain their autonomy in delivering uninterrupted health care.

State Legislation

At the local level, there is significant interest in the increased regulation of health plans. Accordingly, a number of states have implemented a variety of managed care laws, varying in scope and depth. Many states have introduced patient protection laws aimed at safeguarding rights of managed care consumers. Examples of some of the key managed care issues debated at the state level include: health plan liability, external review, mental health parity, privacy of medical information, out-of-network access, and
collective bargaining for physicians. A brief description of these main provisions is summarized in Table 2.

Key Managed Care Policy Issues at the State Level

<table>
<thead>
<tr>
<th>Provision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plan liability</td>
<td>Allows health plan members to file suit against a health plan in a state court. Individuals would be granted access to non-economic damage awards if the plan's denial caused them harm.</td>
</tr>
<tr>
<td>External review</td>
<td>Allows individuals who have concerns with a coverage decision (medical necessity or experimental) to appeal to an independent review panel of medical experts.</td>
</tr>
<tr>
<td>Practice of medicine / medical necessity</td>
<td>Makes physicians the sole determinant of what should be or should not be covered, not the health plan. Establishes a universal definition of medical necessity based on “generally accepted principles of medicine”.</td>
</tr>
<tr>
<td>Mental health parity</td>
<td>Mandates that coverage for mental health-related services and treatments be the same as physical conditions. Federal act currently focuses only on annual dollar limits.</td>
</tr>
<tr>
<td>Privacy of medical information</td>
<td>Medical records and treatment discussions are private. Establishes requirements for obtaining authorization to use/disclose information for purposes of treatment, payment, and/or health plan operations (i.e., research).</td>
</tr>
<tr>
<td>Point of Service / Access Issues</td>
<td>Provisions including coverage of out-of-network providers, continuity of care, and direct access/standing referrals to specialists.</td>
</tr>
<tr>
<td>Collective bargaining for physicians</td>
<td>Allows individual physicians to collectively negotiate contractual terms with health plans.</td>
</tr>
</tbody>
</table>

Table 2

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117 Adapted from United HealthGroup, Public and Government Affairs, Federal & State Affairs, Second Quarter 1999
Every state, with the exception of Wyoming, introduced some type of managed care legislation during 1999. Managed care reform took precedence over other important topics such as tobacco settlements, children’s health care programs, and regulation of long-term care. The downside to this is that in the absence of a federal framework, a patchwork of inconsistent state laws regulating health plans has been developed. Below is a summary of 1999 state activity with regard to the managed care provisions outlined in Table 2.

### 1999 State Activity of Select Managed Care Laws

<table>
<thead>
<tr>
<th>Topic / Issue</th>
<th>Number of States with Legislative Activity</th>
<th>Number of States that Have Enacted Legislation in 1999</th>
<th>Name of State(s) That Have Enacted Legislation in 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan Liability</td>
<td>35</td>
<td>2</td>
<td>GA, CA</td>
</tr>
<tr>
<td>External Review</td>
<td>33</td>
<td>4</td>
<td>GA, IA, IN, VA (2 bills)</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>27</td>
<td>2</td>
<td>IN, ND</td>
</tr>
<tr>
<td>Privacy /Confidentiality</td>
<td>33</td>
<td>5</td>
<td>GA, MD, ME, ND, SD</td>
</tr>
<tr>
<td>Mental Health Parity</td>
<td>31</td>
<td>4</td>
<td>IN, SD, OK, ND</td>
</tr>
<tr>
<td>UR / Practice of Medicine</td>
<td>17</td>
<td>1</td>
<td>ND</td>
</tr>
<tr>
<td>Physician Collective Bargaining</td>
<td>1</td>
<td>1</td>
<td>TX</td>
</tr>
</tbody>
</table>

*Table 3*

Of all of the pieces of proposed legislation, health plan liability, or the ability to sue a health plan, remains the most politically charged topic. In 1999, there were a total of 35 states that proposed and debated health plan liability, and only two states, Georgia and United HealthGroup, Public and Government Affairs, Federal & State Affairs, Second Quarter 1999 Update, May, 1999.
California, have enacted legislation that year. Texas was the only other state with such liability legislation\footnote{119}.

Texas' liability law was enacted in 1997 and allows patients to sue their health plan for harm inflicted upon them as a result of a claims administrator, health care advisor, private review agent, or "any other person from a managed care entity's" failure to use "ordinary diligence".\footnote{120} The law in Texas requires a patient to make full use of external review procedures prior to bringing a case to court. Also under the law, the patient can sue for compensatory damages but not punitive damages.

**Federal Legislation**

State legislators and Congress have been debating nearly identical health care policy issues. After endless debate, the Senate and the House of Representatives passed two patient bills of rights in the fall of 1999. The two bills that were passed are very different in scope and application. The Senate bill is more limited than the House version in that it does not include the controversial provision of health plan liability and that it only applies to self-funded, employer-sponsored health plans. The House bill pertains to all health plans, individual and group, regardless of how they are sponsored. The House bill expands the scope of ERISA to allow patients to sue their health plans in state court with access to unlimited damages, provided that the patient first uses the plan's internal and external review processes.

\footnote{119} *Federal and State Affairs Update*, Ibid.

\footnote{120} Ibid.
The Democratic bill, although not passed, contains provisions that will continue to be debated and will most likely resurface as proposed amendments to the House bill (representing a compromise from the Senate version). The Democratic patient bill of rights applies to all health plans and contains provisions that would allow patients to sue their health plans. This bill also would permit physicians to determine the necessity of certain treatments, and not the utilization review staff of a health plan. Highlights of the key provisions of each bill are outlined in the following table:

Principal Provisions of Federal Patient Protection Legislation

Sources: Adapted from Families USA Foundation\textsuperscript{121},
American Association of Health Plans\textsuperscript{122},
National Association of Insurance Commissioners\textsuperscript{123}

<table>
<thead>
<tr>
<th>Sponsored by</th>
<th>Senate Bill S.6/H.R. 358 (Democratic)</th>
<th>House Bill 2723 (Bipartisan)</th>
<th>Senate Bill S.1344 (Republican)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Senate Democrats</td>
<td>House Republicans</td>
<td>Senate Republicans</td>
</tr>
<tr>
<td></td>
<td>10/7/99 &quot;Bipartisan</td>
<td>Passed 7/7/99 &quot;Patients' Bill of Rights Plus Act of 1999&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consensus Managed Care Improvement Act*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope</td>
<td>All individual and group health plans (approx. 150 million people)</td>
<td>All individual and group health plans (approx. 150 million people)</td>
<td>Self-insured employer sponsored plans (approx. 48 million people)</td>
</tr>
</tbody>
</table>

\textsuperscript{121} Families USA Foundation, *How Managed Care Legislation Affects You, 106th Congress: A Comparison of Congressional Leadership Proposals on Managed Care*, http://www.familiesusa.org/managedcare

\textsuperscript{122} American Association of Health Plans, *Summary of Major Provisions of S. 1344, the "Patients' Bill of Rights Plus Act of 1999,*, July 1999

\textsuperscript{123} National Association of Insurance Commissioners, *Comparison Chart of Patient Protection Bills, 106th Congress*, March 1999
<table>
<thead>
<tr>
<th>Health Plan Liability</th>
<th>Senate Bill S.6/H.R. 358 (Democratic)</th>
<th>House Bill 2723 (Bipartisan)</th>
<th>Senate Bill S.1344 (Republican)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expands ERISA to allow patients the right to sue health plans in state courts for personal injury and wrongful death. Employers or plan sponsors may be held liable if they exercised discretionary authority in coverage decisions and the exercise of the decision resulted in injury or death.</td>
<td>Expands ERISA to allow patients the right to sue health plans in state courts for personal injury and wrongful death. Employers or plan sponsors may be held liable if they exercised discretionary authority in coverage decisions and the exercise of the decision resulted in injury or death.</td>
<td>No provision</td>
</tr>
<tr>
<td></td>
<td>Plaintiff must exhaust health plan's internal and external review processes prior to filing suit in state court.</td>
<td>In certain circumstances, plaintiff may access courts before exhausting internal and external review processes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plans that comply with the external reviewer's decision may not be held liable for punitive damages.</td>
<td>Plans that comply with the external reviewer's decision may not be held liable for punitive damages. If plan violates review provisions will be held liable for $750 per day, not to exceed $250,000.</td>
<td></td>
</tr>
<tr>
<td>Independent External Review</td>
<td>Patients can appeal if the treatment cost exceeds a &quot;significant threshold,&quot; (to be set later) or if patient's life or health is in jeopardy.</td>
<td>External appeal allowed anytime a denial for benefits based on a decision that the service is not medically necessary, or appropriate, investigational, experimental, or in which the decision as to whether a benefit is covered involves a medical judgement.</td>
<td>For employer-sponsored ERISA plans, the following claims would be reviewed by a health-plan elected external review:</td>
</tr>
<tr>
<td></td>
<td>Decisions are binding on the insurer, but patients can choose to sue.</td>
<td></td>
<td>1. Claims of &gt; $1,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Denials of investigational or experimental treatments for</td>
</tr>
<tr>
<td>Senate Bill S.6/H.R. 358 (Democratic)</td>
<td>House Bill 2723 (Bipartisan)</td>
<td>Senate Bill S.1344 (Republican)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
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<tr>
<td>The insurer pays for the review.</td>
<td></td>
<td>life-threatening illnesses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Delays that pose significant risk of placing the life of health of a patient in jeopardy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The decision is binding on health plan, but patient can sue. Insurer pays the cost.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard of review is to decide whether the plan followed its own rules. Reviewer allows consideration of &quot;generally accepted medical practice&quot;.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Premiums will rise 4.8%, according to the Congressional Budget Office, or from 2.7% to 8.6%, (over 1999 – 2003) according to an analysis done by Barents Group for an insurance lobby, or by 1.2% (over 10 years) according to the CBO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Added Cost</td>
<td>Damage caps would reduce premiums by 0.3 to 0.5 percent, according to the Congressional Budget Office.</td>
<td>Premiums would rise 0.8% according to the Congressional Budget Office</td>
<td></td>
</tr>
</tbody>
</table>

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124 Barents Group LLC, *Health Economics Practice, Impacts of Four Legislative Provisions on Managed Care*

*Consumers: 1999-2003, April 22, 1998*

<table>
<thead>
<tr>
<th>Medical Necessity</th>
<th>Senate Bill S.6/H.R. 358 (Democratic)</th>
<th>House Bill 2723 (Bipartisan)</th>
<th>Senate Bill S.1344 (Republican)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(physicians determine coverage)</td>
<td>Patients and doctors decide the extent of treatment decisions, not the utilization review staff of a managed care plan.</td>
<td>Yes. If case is reviewed externally, reviewer must agree with the doctor’s determination of medically necessary.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>ER / Ambulance Coverage</td>
<td>Yes. Prudent layperson standard applies</td>
<td>Yes</td>
<td>Yes. Prudent layperson standard applies. Coverage with no prior authorization for screening and stabilization</td>
</tr>
<tr>
<td>Access to Out-of-Network Providers</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Prohibition of Financial Incentives to Limit or Deny Care</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Prohibition of ‘Gag Rules’ (disclosure of treatment options)</td>
<td>Yes, physicians will be able to discuss treatment options. If service isn’t covered by the health plan, the patient may be required to pay out of pocket. Patient also has right to refuse treatment.</td>
<td>Yes. There are no provider/patient communication restrictions.</td>
<td>Yes. There are no provider/patient communication restrictions.</td>
</tr>
<tr>
<td>Access to Clinical Trials</td>
<td>Yes</td>
<td>Yes</td>
<td>Depends. If patient is covered by a self-insured plan and only if patient is in a cancer clinical trial.</td>
</tr>
<tr>
<td>Continuity of Care (when patient’s physician leaves their plan)</td>
<td>Yes</td>
<td>Yes</td>
<td>Depends. If patient is covered by a self-insured plan and only if the patient is 1) pregnant, 2) institutionalized, or 3) terminally ill</td>
</tr>
</tbody>
</table>

*Table 4*
Medical Necessity

The basis for proposing a statutory definition of medical necessity is centered on quality. The goal is to protect patients from being denied care that may not be covered under their health plan, provided that it is deemed to be medically necessary by their physician. As mentioned earlier, employers who self-fund their health benefits have the prerogative (and protection by Federal ERISA laws) to make discretionary coverage decisions without intervention from state insurance mandates. Thus, under the provision of medical necessity, the locus of decision-making regarding coverage would shift from the health plan administrator or employer to the physician. It does this by replacing the health plans’ contractual definitions of medical necessity with a community standard definition.

Statutory definition of medical necessity is typically based on “generally accepted principles of medicine”. This broad definition reflects community standards of care, which means that its definition will vary in its interpretation depending on practice patterns that constitute the norm for a given region. Legislative proposals that include medical necessity seek to establish a universal definition ‘medical necessity’ in statute and would preclude health plans from arbitrarily interfering with a prudent physician’s decision of whether a service, procedure or treatment should be administered. Under this provision, the physician becomes the sole decision-maker regarding what should or should not be covered.

126 UnitedHealth Group, Talking Points: Statutory Definitions of Medical Necessity, July 1999

127 UnitedHealth Group, ibid.
The Democratic proposal seeks to guarantee that a patient's doctor, not the patient's managed care plan, will decide what treatment is necessary. The Republican law does not include a provision for medical necessity, advocating instead, a written internal grievance process for complaints of treatment decisions.

**Health Plan Liability**

The provision of health plan liability has been proposed as a means to hold health plans accountable for wrongful or inappropriate decisions to deny or delay treatment that result in harm to a patient. Currently, most consumers who receive their health insurance through an employer-sponsored plan cannot recover any compensatory (i.e., lost wages) or punitive (i.e., pain and suffering) damages. This is due to the exemption of these plans from liability, as granted through ERISA.

There have been many anecdotes written about by the popular press. For example, consider the following scenario: a 49 year old male, Mr. Jones, experiencing a severe headache and high blood pressure, goes to the emergency room. Upon examination, the ER physician recommends that the man be admitted to the hospital, whereas his managed care doctor, via phone consultation, determines that an admission is not necessary. As Mr. Jones leaves the ER to return home, he suffers the first symptoms of a stroke in his truck, which consequently leaves his left side partly paralyzed and renders him partially disabled for life. Mr. Jones decides to sue his health plan for damages that he has suffered as a result of the managed care’s decision not to admit him to the hospital. He is an auto mechanic by trade and will not be able to work in the same capacity as he did prior to the stroke. Mr. Jones finds out that his case will be pushed from the state court up to a federal court, where ERISA laws would protect
his employer-sponsored health plan from nearly all liability, limiting his recourse to recouping the cost of the denied treatment, and court fees. The impetus behind health plan liability and the limitations currently under ERISA laws are discussed in the next section.

Health Plan Liability and ERISA Preemption

Claims against a health plan are currently barred by ERISA laws, which in effect shield them from malpractice when the health care coverage is provided through an employer. The reasoning for this is that health plans administer health care coverage in accordance with the benefit plan design parameters. Health plans can influence the level of care provided to a patient through the determination and interpretation of health plans benefit provisions, or by following practice guidelines or standards of care. It holds then, that health plans do not directly administer care, they administer coverage and therefore cannot be held liable under ERISA laws. A patient’s recourse when covered by an ERISA protected plan is limited to recouping the cost of the denied treatment plus court costs and legal fees, if anything at all.

The current system of health plan liability under ERISA essentially follows contract law. Under a contract model of liability, damages are limited to what would have occurred if the contract had been kept. Furthermore, remedies are designed to compensate the injured party by protecting their economic interests, but are not intended to punish the other party from breaching of the contract. Tort law, on the other hand, aims at compensating people for injuries, and reflects society’s judgements about how
people should behave toward each other\textsuperscript{128}. As such, remedies for breach under tort law include compensatory for the defendant's wrongdoing, and may also include punitive damages to punish malicious, oppressive, or fraudulent behavior\textsuperscript{129}.

Another important aspect of ERISA is the preemption from state law 'causes of action'. This means that if a malpractice case were brought to a state court, the state is precluded from providing any different or additional legal remedies as determined by ERISA\textsuperscript{130}. The interpretation by the Supreme Court in the 1987 decision in the \textit{Pilot Life} case is often cited in ERISA cases. According to the Supreme Court decision, remedies for injuries due to payment denial are preempted because they affect plan administration, not quality of care decisions. Recently, however, courts have begun to distinguish between a plan's decision regarding business administration cases ("coverage cases"), which are preempted under ERISA, and disputes over a plan's direct involvement in the delivery of care ("quality cases") in which damages are not preempted. Many federal courts are indicating that managed care can be sued in state courts for issues of quality of care.

For many Americans receiving health coverage through their company, ERISA provides the only recourse to sue their health plan, which will not compensate for economic (compensatory) or non-economic (punitive) damages. The clause included in the Democrats' bill assures that all patients, even those with employer-sponsored health

\begin{footnotes}
\end{footnotes}
care coverage, can sue their health plan for compensatory and punitive damages if they are injured by a managed care organization's wrongful decision to withhold or deny treatment. This would be accomplished by expanding current ERISA laws to allow cases to be determined in state courts. Senate Republicans, on the other hand, defer to an external appeals process whereby grievances are assessed and recourse determined by an independent review board rather than a lawyer. The bipartisan bill allows individuals to sue their health plan, but bars from punitive damages when the plan complies with the external reviewer's decision. Some would argue that under this bill, the health plans could calculate in advance the liability cost of doing harm, versus the uncertainty if punitive damages were permitted.

It seems that the stark differences in these bills will ultimately serve to slow the process of negotiating a final version of a Patients' Bill of Rights within the Senate. In any event, there are significant political implications in the event that Congress seeks to preempt state laws in any federal legislation. The potential implications for each of the major players in the health care industry is the focal point of the next chapter.
Chapter 6:

Assessing the Implications of a Federally Legislated Patient Bill of Rights

Most Americans feel that the pendulum has swung too far in favor of managed care organizations. However, patients, physicians, employers and health plans have voiced different opinions and varying levels of support for the two major pieces of legislation under consideration. Regardless of which bill prevails, the next wave of change is likely to have a profound impact on each of the players in the health care industry.

Patients and physicians (including the AMA) advocate legislation to protect consumers’ rights and to return physicians to the helm of medical decision making. Conversely, managed care organizations, large businesses, including the U.S. Chamber of Commerce, are expected to mount major opposition campaigns to halt legislative proposals in Congress. Collectively, this group claims that premium hikes will result from patients suing their health plans and that quality will not increase in a defensive atmosphere.

Although the scope of a final version of a patient’s bill of rights is unclear, much of the debate and discussion has been centered on the most controversial provisions, including: health plan liability, medical necessity, and external appeals. Patients, physicians, employers, and health plans have publicly responded to how managed care legislation would affect their role and in turn, may impact the health care industry at large. These viewpoints are the purview of this chapter.
**Patients' Perspective**

By and large, the backlash responses to managed care stems from the public’s fear of the uncertain future of managed care and their ability to obtain quality care\(^{131}\). From this perspective, the public is reacting to unfounded fears\(^{132}\) and is seeking to protect what they fear they may lose. Furthermore, the public does not feel that they are served by current standards for patient protection within managed care. In effect the public would benefit from some assurances that managed care plans will “play fair”\(^{133}\). Educating the public about internal grievance processes and implementing standards for external review appeals would be useful steps toward achieving this goal.

Consumers’ trust has been shaken because of signals from the media managed care may be sacrificing quality health care in lieu of profits. Many believe that the media has conscientiously chosen to sensationalize anecdotal stories in which people have been injured or even have died because they were denied necessary care. Cost-conscious HMOs have been portrayed as the villain of the health care industry. Alternatively, the media can argue that they are serving the public by advocating issues and concerns about managed care. Either way, the negative publicity has had a hand in shaping the public’s view about managed care, as indicated in the results published by the Kaiser Family Foundation Survey (see Figure 4).

Patients and consumer advocacy groups such as Families USA, largely back the Democratic patient bill of rights. In addition to being able to sue your health plan and


\(^{132}\) Ibid. According to the authors, there is little persuasive empirical evidence that demonstrates that quality of care has deteriorated because of managed care.

\(^{133}\) Wilensky, G. ibid, p.1018.
allowing physicians to make medical necessity decisions, the Senate Democrat's bill proposes to eliminate nearly all of managed care's cost containment strategies that have contributed to its success, including: direct access to specialists, mandatory point of service offering, emergency room coverage, coverage of non-formulary drugs (when indicated), and direct access to OB/GYNs and pediatricians.

A 1998 Barents Group/KPMG Peat Marwick study analyzed the major provisions of the Democrat's patient bill of rights\textsuperscript{134}. The study, which was performed for an insurance lobby, derived cost estimates from the Congressional Office Budget\textsuperscript{135}. The Barents Group study found that premiums would increase between:

- 2.7% - 8.6% if health plans are exposed to greater malpractice liability,
- 2.2% - 6.9% if utilization review is deemed to be a medical treatment decision,
- 4.1% - 6.1% if plans are prohibited from determining medical necessity.

Taken together, an aggressive estimate of only three of the managed care provisions has the potential to raise premiums by 21.6%. While this bill has all of the attractive patient appeals (access, freedom of choice, ability to sue) it clearly would come about at a large cost to society. The EBRI survey showed that three-quarters of Americans support the notion of consumer protection legislation, however, when potential consequences such as cost increases or employers dropping coverage are

\textsuperscript{134} Barents Group/KPMG Peat Marwick, study results as published in Managed Care Magazine, July 28, 1998.
mentioned, support declines. The public would be better served from a clearer understanding of the potential implications, particularly in the context of what the implications are to each individual's pocketbook.

On the other hand, the Consumers Union, a non-profit publisher of Consumer Reports magazine and an advocacy group for the public, supports the bipartisan House bill that was passed in October 1999. The Consumer Union stated that this bill represented the most comprehensive bill that extends these protections to the millions of Americans with private health insurance coverage. The bipartisan managed care reform bill provides an external appeals process so that when an HMO makes a treatment decision, an outside review board can determine whether the health plan's decision wrongfully delayed, terminated, or denied care. At the same time, the Consumers Union denounced the Senate's version of the patient bill of rights by pointing out that health plans can choose the outside entity that appoints the reviewer for the patient's claim. The Consumers Union felt this to be inappropriate and equated it to the "fox guarding the hen house". The bill precludes external appeals over denials of treatments that cost less than $1,000, discouraging members from exercising their right for an appeal. Lastly, the Senate bill was put down by the Consumers Union because it excludes 113 million Americans from holding their managed care plan accountable for its decisions, through its lack of a health plans liability provision.

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136 Hahn, Adrienne, "Consumers Union Applauds Passage of Managed Care Reform Bill But Cites Serious Concerns About Access Package", Consumer Union Press Release, Thursday, October 7, 1999. The Consumers Union, publishers of Consumer Reports magazine, is an independent, nonprofit testing, educational, and informational organization serving only consumers.
Employers' Perspective

Employers represent the single largest purchaser of health care (an estimated 125 million people are enrolled in self-insured plans), and as stated earlier, employers' general concern with health care is cost first, quality and access second. From a cost perspective, The Congressional Budget Office (CBO) has published different estimates if the Democrat's version of the patient bill of rights (including the right to sue) were adopted and implemented. In July 1999, the CBO estimated that premiums would increase by 4.8% and that under the proposed legislation, the incremental cost per enrolled individual would be $9 per month (or $108 per year) or $22 per month per family ($264 per year)\textsuperscript{137}. Earlier in the year, the CBO had estimated an increase of only 1.2%\textsuperscript{138}. Furthermore, Democrats assume that employers will pick up the majority of the additional cost, which has employers very vehemently opposed to this bill. On the other hand, the Senate Republican bill was estimated to increase premiums by less than one percent (0.8%), or about $40 over a five year period for a family, according to the CBO\textsuperscript{139}. Either way, employers see an increase in their health care costs, which would be on top of double-digit increases projected for the next five years\textsuperscript{140}. The cost implication of implementing a patient bill of rights has spurred obvious reactions from the business arena, through which a large majority of the group health insurance is funded.

The small employers would suffer most from increased health premiums. Small employers’ response to such legislation will bear consequences to the nearly 40 percent

\textsuperscript{137} Karl, Jonathon, Senate Democrats, GOP Square Off on Patients' Rights, CNN Interactive, July 12, 1999
\textsuperscript{139} MacDonald, John A., “Senate Debate Could Change the Nation’s Path in Health Care”, The Hartford Courant, Volume CLXI, Number 193, July 12, 1999
\textsuperscript{140} Meyer, Michael, Oh No, Here We Go Again, Newsweek, December 14, 1998
of U.S. workers for which they currently provide health care coverage. The cost of health care may become increasingly unaffordable and may elicit employers to scale back coverage, pass the majority of the price increase to their employees (higher premiums or coinsurance amounts), or drop coverage altogether.

For large employers such as the Connecticut-based Pitney Bowes, the Medical Director explained the rationale behind why Federal legislation of managed care would be slow moving, and the potential implications:

"Employers moved to a D.C. (i.e., government) strategy for pension plans (i.e., ERISA) because of increasing costs and increasing administrative hassles. The same factors are present for employers with respect to health benefits. In particular, costs are expected to rise more quickly over the next few years than they have over the last several years. A downturn in the economy would also drive a move to D.C. for health benefits.

There will be a tremendous societal impact of a large-scale trend to D.C., for example it will create a great deal of "medical poverty" as individuals cannot afford the increasing costs of care. This will force public policy intervention, some sort of government-sponsored, baseline health benefit program, which is an unpopular idea in most quarters. Fear of this outcome may slow movement toward a D.C. solution. We are likely to see continued turbulence and gnashing of teeth over the next several years, as providers and hospitals find it more and more difficult to remain profitable".  

141 Mahoney, Jack, M.D., Medical Director, Pitney Bowes, October 9, 1999 phone conversation.
Physicians' Perspective

In the first half of 1999, the American Medical Association (AMA) spent over $200,000 in advertising fees\(^{142}\) to fund print ads with tag lines such as: *"Criminals all have rights. Why don’t patients?"*\(^{143}\). This is an attempt to counter the insurance industry blitz aimed at influencing the public's perception that the horror stories do not represent reality\(^{144}\). The AMA has publicly backed the Democrats' version of the patient bill of rights because it restores their autonomy through the medical necessity provision, provides external appeals and makes them binding on health plans, permits patient access to specialists, and doesn’t interrupt existing relationships with their patients\(^{145}\).

The AMA has withheld support for the Republican bill due to the lack of venues for patient recourse via the right to sue for medical malpractice, and would override patient protection laws already enacted in 43 states.

The AMA stands grounded in their position on a patient bill of rights. Exemplified in a February 24, 1998 letter to Richard Huber, President and CEO of Aetna US Healthcare, the AMA stated concerns about their physician’s contract provisions in the following areas:

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\(^{142}\) MacDonald, John A., *“Senate Debate Could Change the Nation’s Path in Health Care*", The Hartford Courant, Volume CLXI, Number 193, July 12, 1999


\(^{145}\) Fortin, Frank, *"Senate to Consider Patient Protection Bill in September*", The Monthly Member Publication of the Massachusetts Medical Society, September 1998
1) "Aetna interferes with physicians' ability to make medical decisions for their patients by retaining the authority to decide what services are medically necessary,

2) there are no appeal processes whereby a physician can challenge the plan's denial of a treatment the physician recommends,

3) the contracts contain gag clauses that can be used to automatically terminate a physician who informs a patient about a treatment option that is not covered by the plan, even when the physician believes that treatment is best for the patient, and,

4) the contracts violate patient-physician confidentiality by giving the plan co-ownership of patient medical records.\[146\]

Health Plans' Perspective

Generally, health plans have opposed the regulation of managed care, with claims that they are guaranteed to raise consumers' costs, reduce choice, and generate more federal bureaucracy. The health insurance industry has been running ad campaigns against both proposals. Collectively, the Health Insurance Association of America (a national trade association representing 115 million Americans through its 269 trade members); the American Association of Health Plans (AAHP, whose member plans provide care for more than 140 million Americans); and The Health Benefits Coalition (a group of business and insurance groups), generally oppose both versions of the patients bill of rights. These trade organizations stand firm behind the Congressional Budget Office projections that quantify the cost implication to the health care industry.

Managed care organizations have stated concern that increases in premiums will add to the ranks of the uninsured. Furthermore, these health plan organizations feel that there are adequate protections and grievance processes currently in place, and that federal regulation will only add bureaucracy and administrative costs. Finally, health plans oppose the liability provision because it encourages the practice of defensive medicine and will limit their ability to reduce inappropriate care; both of which will drive up costs.

The overriding fear for health plans stems from potentially damaging lawsuits, and the cost implication that has the potential to force even more people to go without health insurance. Health plans in opposition of liability frequently cite a figure developed by The Lewin Group which estimates that for each one percent real increase in premiums, small business sponsorship of health insurance drops by 2.6 percent, and approximately 400,000 individuals lose health care coverage\(^\text{147}\). Using the CBO's estimated premium increase of 4.8 percent this translates into an additional 1.9 million individuals at risk of losing health care coverage, in addition to the 43 million uninsured people who currently cannot afford to purchase health care.

A report released on July 13, 1999, by the federal Health Care Financing Administration (HCFA) indicates that national health care spending will grow by 6.5 percent each year for the years 1998 through 2008. According to the report, two of the factors responsible for this spending increase are the rising number of uninsured, and "... a continued trend toward increased state and federal regulation of health plans." The HCFA report also acknowledges that in recent years, managed care has played a

significant role in controlling the growth of health care spending. Members of Congress and of state governments should take into account HCFA’s report, and carefully consider the ramifications to consumers. Patient protections that impose more regulations on private health plans would exacerbate health care cost inflation and increase the number of uninsured Americans.

HIAA President (and former Congressman from Ohio) Bill Gradison said at a briefing that any legislative fix "would undermine the progress that has been made by managed care in controlling health care costs". Other cost drivers of the patient bill of rights are the provisions calling for mandatory external appeals and mandatory point-of-service requirements for HMO plans. While well intentioned, these requirements would increase costs by imposing a layer of heavy-handed government bureaucracy. Furthermore, a mandatory point-of-service option (a mandate that would require offering of a POS plan) would raise costs to consumers by anywhere from three to 11 percent (Coopers and Lybrand, Shields). In doing so, health plans feel that it would deprive consumers the choice of lower-cost coverage.

With regard to medical necessity, the two largest health plans in the United States, UnitedHealth Group ("UHG") and Aetna U.S. Healthcare ("Aetna") have recently taken strides to jump ahead of government mandated reform. In November 1999, UHG announced in a press release that it would eliminate the requirement of doctors to obtain pre-authorization and pre-certification for services that are currently approved 99.1% of the time, demonstrating a radical departure from past practices. UHG positioned their decision not as a political one, but as a natural progression in evolution in the delivery of health care. The program called Care Coordination, “makes obsolete certain programs associated with traditional medical management, such as pre-authorization for inpatient
hospital procedures, and enhances clinical decision-making between the patient and physician. UHG implemented the program in Tennessee first and later in six other sights. UHG's preliminary analysis has shown that costs decreased or remained the same after the program was introduced.

Speculation versus Reality

To balance speculation with real-life experience, two cases, the patient bill of rights for federal workers, and Texas' state law on health plan liability, are offered as examples from which more concrete implications might be inferred.

Federal Workers' Bill of Rights

In November 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry developed its recommendations for a Consumer Bill of Rights and Responsibilities to Congress. The Commission determined that protection of patients was warranted in order to "strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, and to reaffirm the importance of a strong relationship between patients and their health care professionals." The President fully embraced the Commission's proposal for patient protection measures, and in March of 1998 required that they be adopted by all federal

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148 Press Release: United HealthCare Introduces Care Coordination, November 9, 1999
150 AFSCME, Patients' Bill of Rights, Collective Bargaining Reporter, Number 3: 1998
health programs such as Medicaid, Medicare and the Federal Employees Health Benefit plan.

This bill imposed a broad set of patient protections on the 285 private insurance companies that provide health care coverage to approximately 9 million federal employees and their families\textsuperscript{151}. The President permitted a twelve-month period over which the effected insurance companies would be required to be in full compliance with the Democratic version of the patients' bill of rights. The bill includes provisions that enable patients to sue their health plan; requires health plans to disclose information about doctors' compensation; provide comparative information about the quality of treatment; furnish data on consumer satisfaction, and guarantee patients continuity of care.

Using this example as a basis for larger scale implementation, the cost estimates of implementing the Democratic Bill of Rights produce conflicting results. For example, the President announced in April 1999 that the federal workers' patient bill of rights would add a cost of less than $10 per individual per year enrolled in the plan (assuming 9 million enrollees, amounting to $90 million of additional cost). Three months later, in July, he stated that the Patients' Bill of Rights raised the cost of health insurance by less than one dollar a month per enrollee (or roughly $108 million). The Congressional Budget Office estimated that the Democrat's bill of rights would raise health care premiums by 4.8% or by $200 per year per family over a five-year period\textsuperscript{152}. A


\textsuperscript{152} Ibid
comparable figure of $4.75 per member per month can be arrived at using an average family size of 3.5. In relative terms, Democrat's patient bill of rights is four times as expensive when compared the federal worker's bill of rights. What makes this dollar comparison difficult, if not feasible, is that federal workers do not have the same rights for legal redress that are reflected in the Democrat's bill of rights. Presumably, this overage constitutes the difference between the two cost estimates.

Health Plan Liability in Texas

Legislation passed in Texas (1997), Georgia, and most recently California, allows all patients (including those covered under ERISA protected, employer sponsored health plans) to sue their plan for damages that resulted from health plan treatment decisions, or coverage denials or delays. This law makes health plans liable for harm that resulted from a claims administrator, health care advisor, private agent, or any other person from a managed care entity's failure to use ordinary diligence. Texas' law uses an "ordinary care approach", which is defined in the following manner:

Ordinary care holds health plans liable for damages arising from their failure or the failure of their employees, agents, ostensible agents, representatives, or individuals over whom they can influence to exercise ordinary care or ordinary diligence in making practical treatment decisions.

The law requires that members use and exhaust external review processes and procedures prior to taking their case to state court. In addition to being awarded compensatory damages, patients in Texas have access to punitive damage awards.

Proponents of health plan liability say that a health plan should not be exempt from making life and death decisions. The basis of this claim is that a managed care
organization is practicing medicine through its coverage decisions and by its
determination of medical necessity of treatments. Opponents of health plan liability cited
increased litigation and higher health care premiums as two major implications.
However, preliminary data from Texas shows virtually no increase in the number of
lawsuits since the time that health plan liability was enacted\textsuperscript{153}. As of September 1998
not one lawsuit had been filed; twelve months later in September 1999, only four cases
had been filed with the state of Texas.

Part of the reason for such a slow start on litigation has to do with the uncertainty
of whether the state law can override ERISA without congressional action. However, in
September 1998, a U.S. district Court ruled that the liability portion of the Texas liability
law was not preempted by ERISA because it concerns issues of quality of care
delivered, which is not considered the business of insurance, such as coverage
disputes\textsuperscript{154}. With case law establishing specific interpretation of ERISA in this area,
there may be increases in the number of lawsuits that challenge the quality of medial
treatment received under an employer-sponsored health plan.

A study conducted by Coopers and Lybrand investigated the economic impact of
lifting ERISA preemption\textsuperscript{155}. The approach used by the investigators included
calculating cost and incidence rates of litigation from three large non-ERISA populations

\textsuperscript{153} Reaves, Jessica, \textit{New Signs of Life for Patients' Rights}, Time Magazine, September 30, 1999

\textsuperscript{154} UnitedHealth Group Public and Government Affairs, "\textit{UnitedHealth Group's Position on Health Plan Liability}", January
1, 1999.

\textsuperscript{155} Coopers and Lybrand LLP, \textit{Impact of Potential Changes to ERISA: Litigation and Appeals Experience of CalPERS,
Other Large Public Employers, and a Large California Health Plan}; report was prepared for the Kaiser Family Foundation,
June 1998
(where members can sue their health plan) and inferred them to the ERISA population. At $100,000 per case, and an annual incidence of 0.3-1.4 lawsuits per 100,000 enrollees, the direct cost of litigation was estimated to add between three and thirteen cents per enrollee per month. The authors drew the conclusion that the additional cost of lifting ERISA preemption represented a "trivial percentage of premium"\textsuperscript{156}.

Another concern with health plan liability legislation is the potential it has to push health care professionals to practice defensive medicine. In this kind of atmosphere, physicians shield themselves from malpractice by ordering expensive tests and treatments that otherwise may be construed as unnecessary absent the threat of a lawsuit. For example, the medical director of a Temple, Texas HMO (Scott & White Health Plan), states that their HMO premiums have risen as a result of approving extra procedures and treatments to avoid potential lawsuits\textsuperscript{157}. He stated, for example, that "the HMO has been approving the higher cost of MRI technology over CT scans because of the accuracy and resolution that it affords, despite the fact that it costs $400 more". At the same time, figures reported to the state by health plans indicate that medical costs in Texas have not begun to spiral and that there have been fewer appeals of insurance rulings that expected\textsuperscript{158}.

A long-term effect of Texas' legislation is likely to cut into profits, although not as a direct result of increased litigation. Instead, HMOs may continue to practice defensive medicine and face raising the price of their premiums. In turn, HMOs may risk losing

\textsuperscript{156} Coopers, ibid.

\textsuperscript{157} Shapiro, Joseph, Suing Your HMO: Is it a Right or a Wrong?, U.S. News, September 27, 1999

\textsuperscript{158} Cropper, Carol Marie, "In Texas, a Laboratory Test on the Effects of Suing HMOs", The New York Times, September 13, 1998
market share from their inability to underbid competition. More importantly, quality of care concerns may resurface in light of fierce price competition. Finally, the uncertainty of the impact of health plan liability has implications unto itself. Uncertainty has the potential to breed passive responses by health plans (by absorbing the cost of insuring against lawsuits, for example) and employers (may choose to reduce coverage levels as opposed to increase premiums).¹⁵⁹

Chapter 7:

Is a Patient Bill of Rights the ‘Right’ Response to the Managed Care Backlash?

Managed care was the industry’s response to unchecked medical inflation in the 70’s and 80’s and to unsuccessful attempts by the government to reform the system and reduce costs. Over the past two decades, managed care has grown largely through its appeal to the purchasers and consumers of health care. Today managed care plans deliver care to over three-quarters of those with insurance, including Medicare and Medicaid.

Managed care became popular through its demonstrated ability to reduce inappropriate utilization, which lowered costs. Consumers benefited from lower premiums and low out of pocket costs. Not everyone, however, embraced managed care, particularly the providers of health care. Managed care kept costs in tact by placing boundaries on physicians’ otherwise unbridled treatment decisions. Limits were placed upon the fees which hospitals and doctors could charge for certain services. Patients’ choice of providers was confined to a network, and access to specialty care was managed through a gatekeeper. The restrictive nature of managed care also served to deter the high-risk, high utilizers of health care, who enjoyed the unchallenged, unlimited care available through a traditional indemnity plan.

The evolution of managed care and demise of the traditional indemnity insurance can be described by drawing upon the stages of the Rothschild-Stiglitz economic theory of
health insurance. Initially, managed care benefited from the migration of low risk individuals from the traditional plans. As movement into managed care continued, indemnity premiums increased as a result of adverse selection. Traditional insurance borrowed managed care techniques such as pre-admission certification and pre-authorization for elective surgery, in attempt to control runaway costs. By the end of the 80's indemnity premiums became so exorbitant that even the moderately high-risk individuals moved, albeit unwillingly, into lower cost managed care plans. The point-of-service (POS) concept became a popular plan because it combined a managed care network with indemnity-like coverage for use of out-of-network providers. Networks expanded their provider panels to accommodate the growth of managed care. The number of primary care physicians and hospitals per HMO nearly tripled between 1990 and 1995. As managed care grew provider restrictions and access limitations were lessened to adequately cover the majority of the enrolled population. As recently as the end of 1999, two national HMOs dropped pre-authorization requirements for many routinely performed procedures.

By the early 90's the pooling equilibrium that existed in the indemnity-dominated market of the 70's and 80's began to dissolve. Managed care was becoming less restrictive, and conversely, indemnity care was increasingly managed. Not surprisingly, as this occurred, premium costs in both markets began to decline, and at nearly the same rate. By 1995, over three-quarters of enrollment was in a managed care plan, and increased to 86% in 1998. In effect, the pooling equilibrium had completely switched to the managed care

\[\text{160} \quad \text{Pauly, M., Nicholson, S. Adverse Consequences of Adverse Selection, Journal of Health Politics, Policy and Law, Vol. 24,}\]
\[\text{No. 5, October 1999. The model explains that if potential insurance purchasers know their risk levels (but is kept from insurers), and if insurers are willing to offer any profitable contract, a process of self-selection can ensue.}\]
\[\text{161} \quad \text{Roussel, Hoechst Marion, Mean Number of Providers per HMO Plan, 1991-1998, Managed Care Digest.}]\]
market. As migration out of indemnity plans slowed to a trickle in 1998, an upward trend in premium costs emerged for the first time in five years.

The Rothschild-Stiglitz model offers an explanation for the public's discord with managed care. As high-risk people moved into a seemingly more limited managed care plan, their adversity toward such restrictions resulted in dissatisfaction, lending an explanation of the rise in the number of managed care complaints. By the same token, low-risk individuals began to shoulder an increasingly higher premium in order to subsidize costs generated by the high-risk population. The increase in managed care premiums was slight enough to have gone unnoticed over the past few years. However, this is not likely to be the case in the near future as managed care premiums have started an uphill climb and are expected to rise over the next five years. The pooling of high and low risk individuals into managed care has thus raised the potential for discontent.

The seeds of managed care backlash began to sprout as people were priced out of the indemnity market, and resentfully moved into managed care. As enrollment increased, more complaints were voiced. The media and the press highlighted HMO horror stories of a few, which continued to raise the public's anger and perpetuated a culture of blame. Despite American's first hand experience with managed care, polls and surveys indicate concern about managed care and the potential negative implications for quality.

Seizing on the public's confusion about managed care, politicians have made patient protection one of the hottest campaign topics for the 2000 election year. The debate over

\[162\] Pauly and Nicholson, ibid.
patient bill of rights has become as much about politics as it is about patients. Americans’ confusion with managed care makes a complex and multi-faceted issue such as patients’ rights more complicated by this basic lack of knowledge. Consumers and policymakers alike would greatly benefit from education about managed care. For example, although concern for the deterioration of quality in managed care plans is well established, its impact remains largely unfounded through controlled studies\textsuperscript{163}. Outcome studies performed in the late 80’s have shown equivalent quality of care and greater access to preventive care compared to traditional fee-for-service models. Additionally, analyses have demonstrated that managed care has been instrumental in controlling utilization and holding down health care costs, even though the general public does not equate cost savings to managed care.

More recently, The Institute of Medicine (IOM) released the results of a multi-year study of the quality of health care in the United States. The following excerpt from the September 1998 issue of the Journal of the American Medical Association (JAMA) is a statement from the National Roundtable on Health Care Quality:

\begin{quote}
Serious and widespread quality problems exist throughout American medicine. These problems…occur in small and large communities alike, in all parts of the country, and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans
\end{quote}

\textsuperscript{163} Miller, R., and Luft, H., Managed Care Performance: Is Quality of Care Better of Worse? Health Affairs, 1997, 16(5):7-25.
are harmed as a direct result. **Quality of care is the problem, not managed care**\textsuperscript{164}.

The IOM study published results indicating that as many as 98,000 people die every year in hospitals due to errors and accidents. This figure is higher than deaths caused by car accidents, breast cancer or AIDS\textsuperscript{165}. More generally, errors in medicine are estimated to account for 150,000 to 400,000 deaths each year. The cost of these potentially preventable fatalities is estimated to be between $17 billion and $29 billion each year\textsuperscript{166}. In spite of industry experts' claim that the managed care has wrung out all of the “easy” savings from the system, there is tremendous opportunity for improvement and cost reduction yet to be made.

There are other areas of the existing system that would benefit from improvement, many of which are contrast with America's knowledge of health care. Dr. David Lawrence, a member of the IOM's National Roundtable, offers the following recommendations:

- The structure of our medical delivery system is fragmented. More than three-quarters of physicians practice alone or in small, single specialty groups\textsuperscript{167}. Physicians should work and practice medicine in teams. They would greatly


\textsuperscript{165}Lawrence, David, MD, *The Future of Health Care*, Medscape Money & Medicine, Jan. 4, 1999

\textsuperscript{166}Ibid.

benefit from sharing of knowledge and drawing from the experiences of others, and will work more safely and effectively.

- Physicians must be re-certified on a regular basis, similar to pilots who are responsible for the safety of others. Standards for board certification vary widely by specialty. The rate at which medical technology and knowledge changes has made it increasingly challenging for physicians to keep up with current information. The inability to keep pace with emerging information contributes to the wide variation in medical practices, which is further influenced by the community standard, rather than founded upon medical science.

- Quality assurance and quality improvement systems are needed for outpatient care. Nearly two-thirds of medical care is delivered in an outpatient setting and the data and systems are not in place to analyze process and outcomes measures. Until there is data from which to build a foundation, physicians can not effectively monitor improvement, or learn from mistakes.

- Physicians would benefit from learning from their own or other's mistakes. Unfortunately, the American expectation of the medical society is that of perfection where mistakes are unacceptable. This unfortunately, has created a "culture of blame". When medical mishaps and tragedies occur, they are not show cased. Shared knowledge of these cases and development of safety systems would contribute toward reducing human errors.

If the public was educated with the above information there may be less inclination to "blame managed care" and pursue federal legislation as a means of addressing the quality of care concerns. Likewise, if the public were informed of the potential consequences, they might form different opinions about being able to sue their
managed care plan. Yet, some form of patient protection has been implemented in virtually every state. And with the election year on the horizon, politicians want to raise the issue to the federal level.

Two patient protection bills have been passed, and both vary in scope and application as well as the implication for the nation's health care costs. The Congressional Budget Office estimates that a one-percent increase in health insurance premiums could cause as many as 400,000 people to go without health insurance. Already, nearly 43 million Americans at any given time lack health insurance, and the Democrat's comprehensive version of the patients' bill of rights would add another 1.5 million to the total.

HIAA has projected that by the year 2007; the number of Americans without health insurance will grow to 53 million – one out of every five of the non-elderly. If economic conditions worsen, the number of uninsured Americans could grow as high as 60 million – one out of every four of the non-elderly. Therefore, this paper argues that providing affordable health coverage to the millions of Americans who desperately need it should be the first priority of Congress and the Clinton Administration. In spite of these facts, the statistics point toward raising the number of uninsured that would result from the increased cost of health insurance. The culprits of cost increase, health plans liability and medical necessity, would benefit providers and trial attorneys, while giving the short end of the stick to the uninsured, to businesses, and to the working poor who struggle to purchase affordable coverage.

Upon in-depth review of the major patient protection bills and the various provisions therein, this paper offers the following recommendations:
**Do Not Mandate Health Plan Liability**

Health care costs will rise if patients are able to sue their health plan. There is heightened potential for over-treatment when in fear of malpractice suits. This in turn has the potential to elicit inappropriate or unnecessary care and may have the unintended effect of placing a patient at risk for harm. This would make it difficult for health insurers to fight medical fraud and abuse, which account for approximately one-tenth of the nation's trillion-dollar annual health bill, according to government estimates. Each year an unrecorded number of Americans die or are injured due to medical mishaps, some of which are attributable to unorthodox or unnecessary treatment.

The controversy with health plan liability stems from the loophole of federal ERISA laws. Most health plans are able to escape liability through its restrictive policies and bear little, if any, culpability for the adverse outcomes that may be suffered by a plaintiff. At the state level, Texas serves as a proverbial laboratory to test the effects of health plan liability. Although the number of cases to reach the state's court were not nearly as high as anticipated, a trend is emerging in the interpretation of the law that may have broad implications. Recent case law has narrowed the extent of ERISA preemption. A distinction is being established between disputes over *benefit coverage* (which is preempted by ERISA plans) and those over the *quality of care* administered by the plan (which is *not* preempted by ERISA). The court's interpretation may provide an avenue of recourse for an estimated 125 million individuals covered by employer-sponsored health plans. Currently, these individuals covered under these plans are limited to recovering only compensatory damages for the cost of the service that was denied plus legal and court fees.
At the same time, trial lawyers are beginning to target managed care organizations for failing in their fiduciary duty to put patients' interests above the quest for profits. Despite the mass pursuit, few class action suits have been brought to bear due to the legal roadblocks presented by ERISA. In December 1999, for example, Connecticut's largest HMO, Physician Health Services (PHS) was strapped with a class action suit for denying patients reimbursement for drugs prescribed by their physicians that were not on PHS' formulary\textsuperscript{168}.

As an alternative to holding health plans accountable via expensive lawsuits, health plans can be effectively held publicly accountable through the release of performance information such as outcome measurements, preventive care, and patient satisfaction. On a micro-level, physicians benefit from individual report cards showing their performance stacked up against physician peers in the same network, and to industry-adopted clinical guidelines. This public accountability tool is discussed in greater detail later in this chapter.

\textbf{Do Not Mandate Medical Necessity}

Allowing doctors to make medical necessity decisions by loosening utilization review criteria will only lead our health care system back into the inflation-laden costs experienced in the 70s and early 80s. Under the medical necessity provision, providers can defend decisions to prescribe marginal or unnecessary care as being consistent with "generally acceptable principles of professional medical practice". This allows providers to determine

what services are covered, including treatments that may no longer be considered effective, and where and how those services are delivered.

If a standard ‘community of care’ approach toward medical necessity were implemented, variation in quality and increases in costs are sure to follow. Numerous studies have documented the tremendous regional variation in physician practice patterns, rendering this so-called “standard” open for interpretation and debate. Needless to say that it would also be difficult for health insurers to stop provider fraud and abuse.

In November 1999 UnitedHealth Group (UHG) announced that it would no longer require its physicians to receive pre-authorization or certification for routinely approved services. In doing so, UHG would eliminate the administrative costs of this utilization review function, estimated to cost nearly $100 million per year. UHG has been accused of political maneuvering, but countered these claims by stating that it was a cost-cutting measure. UnitedHealth Group’s pilot of their Care Coordination program in six sites showed that costs either remained flat or went down. While at the outset this appear to be a favorable outcome, it can be debated that these cost savings, in the long run, are not sustainable. The underlying tenet of managed care, to contain costs, would be severely compromised.

In lieu of medical necessity, the cost savings attributed to the removal of micro-management strategies should be applied to medical outcomes studies and toward establishing clinical care guidelines. These standards, which exist today for many illnesses

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169 Newcomer, LN, M.D., Senior Vice President, Health Policy and Strategy for UnitedHealth Group, The Hour News, October 9, 1999
and conditions are based upon valid scientific evidence, and provide a basis from which medical treatment decisions are made. More outcome studies are needed to draw consensus on best-demonstrated practices – these should become the benchmark against which health plans and their doctors' performance will be measured. Outcomes are reflective of the appropriateness of a physician's choice of a given strategy, and of the skill exercised in executing that strategy successfully. This also means that with the human element involved in decision-making, it is imperfect, and may also be affected by extraneous factors (i.e., age, gender, health belief of the patient, health status, etc.). To the extent that these factors are accounted for in the guideline, expected outcomes will follow. As standards of care are established and practiced, economies of scale will be realized through consistency and improved outcomes – costs will naturally decrease.

Physician Penalties/Financial Incentives Should Be Structured to Not Unduly Influence Physicians’ Treatment Decisions

Compensation methods encourage provider accountability by influencing physicians to optimize outcomes and appropriate practices, as well as eliminate unnecessary or inappropriate care. Although there is considerable information about managed care's use of financial incentives and their association to use of resources, the effect of these incentives on physicians' decision making has not been clearly established\textsuperscript{170}. It cannot go unnoticed, however, that in the 1996 Medical Outcomes Study, findings confirmed significantly worse

\textsuperscript{170} Hillman, ibid; Hemenway, ibid.
outcomes for chronically ill elderly HMO enrollees. This finding suggests that there is a need to understand better the relationship between different managed care plans impact on outcomes for sub-populations such as the elderly and the poor. Similar studies conducted prior to the Medical Outcomes Study were performed at a time when the pooling equilibrium of health risks between the managed care and indemnity markets was split. Additional studies are needed to re-evaluate outcomes in managed care settings that have changed over time. Further, the outcome studies should be stratified by risk category to account for differences in the mix of patients treated. Results will be helpful in determining the extent to which outcomes vary as a result of the shift of the pooling equilibrium that has occurred over the past 5 years.

Various forms of provider reimbursement have been used to encourage accountability. When done effectively, compensation can be used to influence physicians to eliminate unnecessary care, optimize outcomes through use of best-demonstrated practices, and encourage prevention and early intervention, all of which improve quality and reduce costs. Studies have demonstrated that reimbursement methods have been effective in changing physician practice behaviors when effective standards of care are in place.

Physicians should be awarded on the basis of their performance, not on how many or how few services or patients they treat. Performance measures should include quality of care and outcomes measures. For example, the number of heart attack patients that are

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171 Ware, JE et al. Differences in Four-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study, JAMA 276(13):1039-1047.

receiving beta-blockers, or number of patients with congestive heart failure that were
prescribed ACE inhibitors to improve circulation, or utilization rates of preventive screenings
for common conditions such as diabetes. Other performance measures can include patient
satisfaction, the cost effectiveness of group practices, or of individuals compared to their
peers. Paid in the form of a bonus, a certain percent (i.e., 10-20%) of physicians’
compensation would be paid at the end of the year.

The percentage of the physician's withhold should not exceed a reasonable amount
of any physician’s compensation. Financial incentives should encourage preferential
practices, and not perversely impose a conflict with treatment decisions. This is an
important consideration that needs further analysis. However, in the absence of any
financial incentives, research has demonstrated that physicians to not otherwise change
their practice behaviors in favor of more effective standards of care

UnitedHealth Group creates Clinical Profiles using medical and pharmacy claims
data to furnish real-time information about aspects of their physicians’ performance. Every
six months, each participating doctor is provided with an individualized, confidential report
that compares their practice patterns against clinically accepted guidelines. UHG also
provides the physician with information on patients who might benefit from suggested
therapies or tests. In August 1999, UHG released the second round of results that showed

an improved trend across six of the program's clinical measures\textsuperscript{174}. At least initially, this tool appears to be effective in improving the quality of care.

Establish External Appeals Process Standards

Providing members with access to a third party, independent appeals process offers a way to hold health plans accountable for coverage determinations. The review should be completed by an independent entity to avoid a conflict of interest in resolving health plan coverage disputes. In addition to promoting greater health plan accountability, it provides consumers with the assurance that disputes will be resolved in a fair and timely fashion.

External independent appeals policies should be implemented in all health plans. Those health plans that elect to implement an external process will be in a better position to respond to their member's concerns regarding health care coverage, and may also attract more members as a result.

A model process should be developed and endorsed by the National Association of Insurance Commissioners. An external appeals process should:

1. focus on the plan's terms and conditions for coverage,
2. be limited to expert reviews of medical coverage determinations,
3. require the enrollee to first exhaust the health plan's internal grievance and appeals process,

4. stipulate the qualifications and independence of the reviewers,
5. be expeditious by specifying strict timelines,
6. be impartial and fair,
7. make external reviewers' decisions binding on the health plan as well as the appealing party, and
8. operate on a confidential basis.

The HMO Industry Report, conducted by Interstudy, yielded results that were contradictory to health plans' belief that there are adequate protections and appeals processes currently in place. The survey reported that approximately 74% of responding HMOs said they do not refer appeals to an external body that makes determinations that are binding on the HMO. Moreover, of the plans that refer appeals to an external body, 69% are mandated by state law to do so175. Most health plans have internal grievance processes in place. However, it is believed that there is a conflict of interest when the review board staff is contracted or employed by the health plan.

The cost of implementing an external appeal process should be relatively low in comparison to unpredictable and potentially expensive legal proceedings. An external appeals process is more beneficial to the health plan member than health plan liability. According to the Rand Corporation, only 43 cents of every dollar spent on the plaintiff receives malpractice litigation. While administrative costs associated with an external review process are not firmly established, information from statewide established programs

175 Interstudy, Interstudy Competitive Edge, ibid.
ranged from $450 per appeal in Rhode Island to $867 in Florida\textsuperscript{176}. Additionally, few disputes reached external review, and once there, approximately half of the expert reviews upheld the health plan's coverage determination.

Conclusion

Even though the public is largely satisfied with their health care plan, they express concern regarding the quality of care in managed care. Although research shows no definitive problems with managed care per se, there is a need to respond to the perceived concerns of the public. The issue at stake is whether the public interest is best served by government intervention and control of health care, or by the natural market changes that respond to the demands of consumers. The majority leader of the 105\textsuperscript{th} Congress was quoted as having stated that "the market is rational, the government is dumb"\textsuperscript{177}.

The marketplace has begun to respond to consumer demands for protections, and should be allowed to continue to do so. The larger health plans are in the best position to pave the path for the others to follow suit. Those that cannot conform to the expectations of their customers will not succeed in maintaining market share and will go out of business. Federal legislation and regulation need not add to the multitude of state law already in place. Consumer protections should be allowed to continue to evolve in the voluntary marketplace and need not be federally legislated or regulated.

\textsuperscript{176} The Lewin Group, 1997.

\textsuperscript{177} Quote as cited from: http://armey.house.gov/axioms.htm
Consumers throughout the country are reaping the benefits of deregulation through lower airfares, lower phone bills, and through an increasing array of innovative new products and services. Federal patient protections will add another layer of regulation to the protections that exist at the state level and would subject the industry to federal micro-management of health plans. In effect, this will increase consumers' costs, raise the number of uninsured, and deter health plans from seeking to offer innovative new services.

A counter argument to allowing the marketplace regulate the health care industry may be that, if left alone, the perverted market forces of supply and demand will lead our nation to bankruptcy. The underlying premise is hardly refutable given that the suppliers of medical services, physicians, determine the demand for health care services. While this may be the case in a purely fee-for-service environment, this paper argues that the cost controls of managed care have placed limits on the open-ended and unchecked nature of the traditional indemnity market. Prospective payment such as capitation, contain inherent cost containment mechanisms. If physicians' capitation payments were appropriately adjusted to account for the varying levels of risk of their covered population, there may be less focus on withholding treatment. Risk-adjusted capitation is an important consideration in light of the shift in the pooling equilibrium into managed care and with the recent Medical Outcomes Study results.

Finally, as America looks to the future and considers proposal for health care reform, serious consideration should be heeded to the millions of Americans who would benefit tremendously from affordable coverage and access to basic health care. At the same time, the marketplace would benefit from Americans understanding and appreciating the true cost of health care. There is a need to restore the buyer/seller relationship to patients and their
doctors, so that patients rather than third-party insurers become the principal buyers of health care. This may be accomplished by creating institutions in which patients (through medical savings accounts) spend their own money, rather than someone else's, when they purchase health care.

Despite these opinions, the President stands firm in his support of comprehensive consumer protections at the federal level. As the minority party, however, Democrats cannot pass their own patient bill of rights, but hope to work out a compromise by amending different pieces of the package. Regardless of the outcome, the members of Congress and the Administration need to educate the American people about managed care, and point to the opportunities for improvement within our existing system before imposing reform. Federally mandating patient protections for those with health care coverage would benefit few at the greater expense of many.
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