



**THE FORUMS INSTITUTE**  
For Public Policy

**FREE MARKET OR "FREE-FOR-ALL":  
COMPETITION, REGULATION AND CONSUMER PROTECTIONS**

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**ISSUE BRIEF No. 26**

*New Jersey Policy Forums on Health & Medical Care*

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## FREE MARKET OR "FREE-FOR-ALL" COMPETITION, REGULATION AND CONSUMER PROTECTIONS

**ISSUE: In the nontraditional marketplace of health care service delivery and financing, comprised of multiple sellers, providers, purchasers, buyers and consumers – each with shifting roles and responsibilities -- who or what will bring together these various entities in the best interest of health care in New Jersey and for all players?**

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### INTRODUCTION

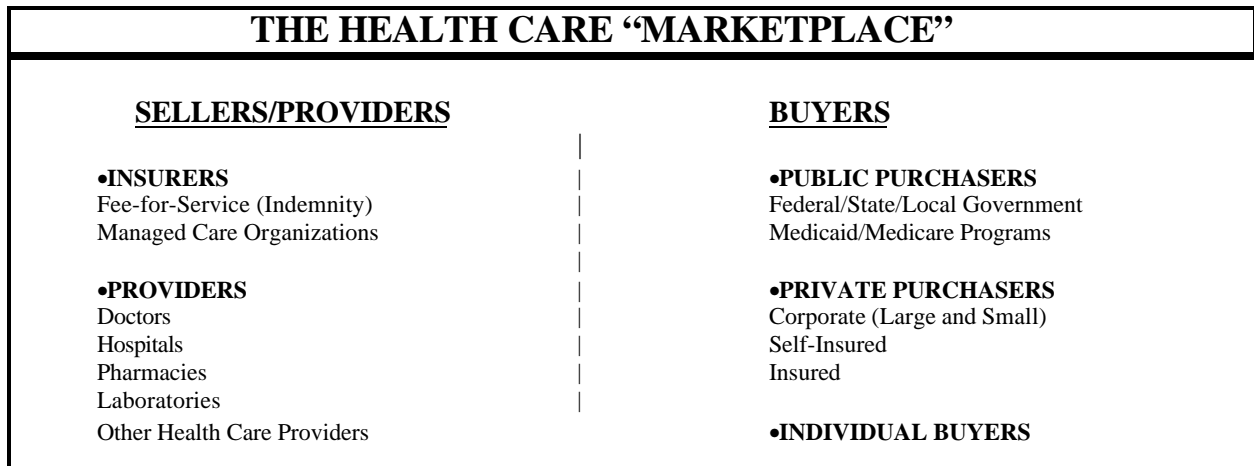
At this point in 1998, health care and public policymakers in the United States are confronted with the challenge of differentiating the facts from the probabilities as they grapple with the issues raised by a "new" competitive marketplace:

- Should government intervene and impose reforms and regulations on this health care market, or will the health care industry responsibly police itself and deliver accessible, quality-based health care without escalating health care costs?
- How is a balance found that meets the interests and needs of health plans and insurers (who promise to voluntarily honor consumer protections) and of

consumers and their advocates who are calling on government to ensure these protections?

- Is there an as-yet unidentified entity – possibly a public-private partnership – that should oversee consumer protections in health care?

The evolving health care marketplace is different from the classical marketplace model in which (usually) two players – a seller (provider) and a buyer (consumer) – sell and buy products and services. As the graphic below represents (in the simplest terms), the health care marketplace is a dynamic environment in which the traditional roles of seller, provider, purchaser and consumer are shifting and re-forming: e.g., providers are becoming insurers, and purchasers may also be regulators?



<b>CONSUMER'S PLACE</b>
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## THE RISE OF MANAGED HEALTH CARE

Managed health care, the keystone of today's health care marketplace, has become the leading form of health care in the United States, toppling traditional fee-for-service, indemnity health care from its primary position. Nationally, for employers in medium and large firms, managed care enrollment increased from 29 percent in 1988 to 81 percent in 1997 (Copeland, 1998). Managed care's dominance in our market-driven system has changed the organization, financing and delivery of health care.

While traditional fee-for-service (indemnity) health insurance plans were not above criticism -- specifically in the areas of undeveloped outcomes measures and escalating health care costs (resulting from over-utilization in the absence of utilization management) -- the rise of managed health care has brought to the forefront a myriad of new potential problems. Critics of managed care assert that the potential practice and ethical issues raised by managed care activities -- such as financial incentives to underserve patients and restricting access based on "medical necessity" as defined by health plan reviewers -- are of greater concern than under fee-for-service medicine.

## COMPETITION VS. REGULATION - - A NOT-SO-SIMPLE BALANCING ACT

In a recent *Newsweek* article entitled, "Making HMOs Play Fair," Michael Campbell, an attorney with the Pennsylvania Health Law Project, cautioned that within the basic structure of managed care operations, "there are incredible financial incentives to underserve members" (May 4, 1998). In response, managed care organizations assert that such financial incentives "produce a more efficient level of care without reducing its quality" (Copeland, 1998). Although reliable data have not shown that these incentives reduce the quality of care, states have implemented laws prohibiting the use of financial incentives because of their potential influence on physicians' decisions and behaviors (ibid; Miller, 1997). The Health Care Financing Administration (HCFA) has extended these prohibitions to the Medicare and Medicaid programs.

In 1988, health policy analysts Stuart Altman and Marc Rodwin proffered that the history of American health policy during the past 30 years has been a struggle between regulation and competition. Calling it "a political stalemate between halfway competitive markets and ineffective regulation," and identifying the barriers created by partisan politics and strong interest groups, they conclude that neither of these approaches -- as implemented -- has met the desired goals for cost control and improved access. Ten years later, with the

rise of managed care and with its increased presence in the health care market, there is a parallel increase in the number of consumer complaints about managed care practices -- both real and imagined. The balancing act continues between allowing the free market to do what it is supposed to do -- control costs and improve health care -- and regulating the industry in order to ensure that the public good is protected.

Gubernatorial and Congressional races across the country (including those in New York, California (a state with pronounced HMO market penetration), Texas, Florida and North Carolina), have consumer protections under managed care as their centerpiece campaign issue ("Voters' Anger at HMO's Plays as Hot Political Issue," *The New York Times*, May 17, 1998). Concerns by advocates for regulating managed health care focus on access issues, the freedom to choose physicians and the right to appeal to an independent review panel. On the other side of the issue, managed care organizations, insurance companies and employers have formed a coalition to restrain enactment of patient rights proposals in Congress, feeling that such laws (if put in place) would have a negative impact on the "successes" which managed care has achieved (*The New York Times*, May 17, 1998).

Organizations such as the American Association of Health Plans (which is the managed care industry's trade association) contend that critics of managed care are being shortsighted in their move to regulate and are missing the larger accomplishments of the industry: the stabilization of what had been escalating health care costs, the introduction of quality measures into the practice of medicine, and the integration of preventive care into the health care delivery system. In the simplest terms, managed care and insurance industry advocates assert that increased regulation will equate to increased costs.

In an article entitled, "Federal Regulation of Managed Care: An Impulse in Search of a Theory," Moran writes that there is no "contextual theory in which Federal regulatory activity is taking place" (*Health Affairs*, November/December 1997). In his analysis, he cautions that in an atmosphere filled with growing consumer complaints about managed care and a media currently fond of presenting a negative slant on the subject, the environment is ripe for political responses (especially in an election year) via regulation. Echoing Altman's and Rodwin's observations over ten years ago, he asserts that there is a need for government to proceed with caution in crafting new regulatory policies because of the pervasive and inherent difficulties of reconciling the conflicting imperatives that divide the consumer, provider and purchaser of health care.

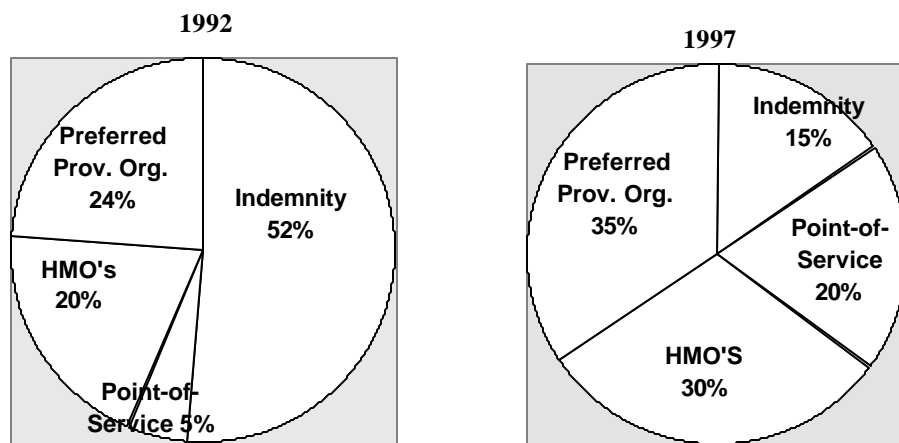
**SETTING THE STAGE -- WHY IS THIS ISSUE IMPORTANT NOW?**

It is now common knowledge that managed care enrollment has escalated dramatically throughout the country during the past decade. Chart I, "Percentage of Employees in Each Health Plan Type, 1992; 1997," illustrates the trend in enrollment in varying health plans: indemnity, Health Maintenance Organizations

(HMO), Preferred Provider Organizations (PPO) and Point-of-Service Plans (POS). While the chart indicates a steady increase in the growth of all forms of managed care plans (HMOs; PPOs and POS), it shows a dramatic decrease in fee-for-service (indemnity) plan enrollment during the same five-year period. In 1992, fee-for-service indemnity plans enrolled 52 percent of employees; by 1997, enrollment decreased to only 15 percent of employees (Copeland, 1998).

**Chart I**

**Percentage of Employees in Each Health Plan Type, 1992, 1997**



Source: EBRI Issue Brief, April 1998; A. Foster Higgins & Co. Inc./William M. Mercer, National Survey of Employer-Sponsored health Plans (New York: NY: A. Foster Higgins and William M. Mercer, various years).

In an April 1998 *Issue Brief* for the Employee Benefit Research Institute, Copeland points out that: "the expansion of managed care has coincided with the reduced growth in health expenditures, medical care inflation and employer health care costs." Health care spending increases during the past five years have slowed "dramatically," as a result of low general and medical-specific inflation, the growth of managed care enrollment and the capacity of health plans to negotiate discounts from a provider system of care (Levit et al., 1998). It still is unknown as to whether or not and to what degree this cost containment trend will continue, as recent media reports are announcing that health plans are beginning to increase premiums (ibid).

Under the title, "Back in Trouble," Wall Street Journal writer Ron Winslow reports on disquieting news from Minnesota that after a four-year success of

keeping health costs under control, the region's three major HMOs raised premiums as much as 15 percent in 1998 (*The Wall Street Journal*, May 19, 1998). Premiums for state employees and small businesses increased 22 percent and as much as 40 percent, respectively. The unpredictable state of the health care market lends significance to the issue as to whether market regulation may become an additional factor leading to an increase in premium costs across time

**PUBLIC REACTIONS -- INCREASED MANAGED CARE ENROLLMENT = MORE CONSUMER COMPLAINTS**

The increased enrollment numbers in managed health care have been accompanied by growing numbers of consumer and provider complaints. Concurrently, there is a growing level of consumer

mistrust of both plans and providers across the country. In a November 1997 Kaiser Foundation/Harvard public survey, 59 percent of Americans reported their belief that managed care plans make it harder for people who are sick to see medical specialists; and over 50 percent responded that managed care has "decreased the quality of care" for people who are sick (The Kaiser-Harvard Program on the Public and Health/Social Policy, 1997 *Report*). In the same survey, 55 percent reported that they are at least "somewhat worried" that if they are sick "their health plan would be more concerned about saving money than about what is the best medical treatment."

In another Kaiser-Harvard survey reported at the beginning of this year (January 1998), almost half of Americans (48 percent) responded that they personally, or someone whom they knew, had experienced at least one of the problems which current managed care consumer protection proposals aim to address. These problems included: needing more information about health plans (29 percent); difficulty getting permission to see a medical specialist (24 percent); problems getting a plan to pay an emergency room bill (19 percent) and being unable to file an appeal to an independent agency for a denied claim (17 percent) (January 1998 *Report*).

#### **FEDERAL ACTIONS REGARDING CONSUMER PROTECTIONS**

Throughout the individual states, public policymakers and lawmakers are responding to the public's concerns about their health and medical care. While managed care is regulated and licensed principally by the states, several federal agencies regulate some aspects of managed care: the Health Care Financing Administration (HCFA) manages federally qualified HMOs, and the Medicare and Medicaid programs; the Office of Personnel Management operates the Federal Health Benefits program that sets standards for health plans available to federal employees; the Office of Veterans Affairs oversees health services for veterans, and by extension, the Federal Trade Commission and Justice Department oversee antitrust laws by regulating health care industry mergers<sup>1</sup> (Butler, 1996).

During 1997 and the beginning of 1998, both Democratic and Republican members of Congress

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<sup>1</sup> In the field of study regarding state regulation of Medicaid managed care entities, reference is made to work conducted by the Center for Health Policy Development at the National Academy for State Health Policy, and by the Center for Health Care Strategies. Surveys conducted by the National Health Law Program (e.g., *Making the Consumers' Voice Heard in Medicaid Managed Care: Increasing Participation, Protection and Satisfaction*) are focusing on understanding consumer and consumer organization involvement in Medicaid managed care.

registered an interest in consumers' concerns about managed care. Supporters of a uniform national policy in the health care marketplace believe there is a significant need for it because the business activities of health care and health insurance, like many other industries, cross state lines. The call for uniformity and standardization is particularly strong from multi-state employers. Currently, there is great variation from state to state regarding the regulation of managed health care.

#### **The National "Consumer Bill of Rights"**

In November 1997, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a "Consumer Bill of Rights" and "adopted" eight areas of consumer rights and responsibilities:

- Information Disclosure (including that about health plans, health providers and health care facilities);
- Choice of Providers and Plans (including provider network adequacy and access to specialists and transitional care);
- Access to Emergency Services;
- Participation in Treatment Decisions;
- Nondiscrimination and Respect in the Delivery of Health Care Services;
- Confidentiality of Health Information;
- Consumer Responsibilities (including the responsibility to maximize healthy habits; become involved in health care decisions and work with health care providers in carrying out treatment plans.)

The Commission was unable to reach consensus about how its recommendations for consumer protections would be enforced, i.e., should they be promulgated as Federal law, or should they be voluntary. The Commission also was unable to reach consensus regarding the continued exemption of ERISA plans (overseen by the Department of Labor). In November 1997, however, President Clinton executed an Executive Order requiring all federal agencies that operate health insurance programs to bring their programs into compliance with the Bill of Rights ([www.familiesusa.org/](http://www.familiesusa.org/); April 28, 1998). These programs include the Medicaid and Medicare programs, the veterans' health programs and the Federal Employees Health Insurance programs, which cover almost 85 million people.

A recent Kaiser-Harvard survey regarding the public's views on the President's Consumer Bill of Rights found that while a majority of those surveyed were in support of the consumer protections, many were concerned that the measures may increase premium costs or cause employers to drop health care coverage (January 1998). Almost three-quarters (72 percent) responded that they supported passing the Consumer Bill of Rights into law; however, when presented with the possibility of premium increases, 43 percent would still favor it if their premium increases were small (\$1-5 per month); this percentage drops to 28 percent if premium increases were larger (\$15-20 per month).

Estimates vary as to how much the implementation of consumer protections would cost. A recent report by the Congressional Budget Office (the non-partisan entity which estimates costs of proposed legislation) found that the Consumer Bill of Rights would add only 0.3 percent to existing premiums in order to cover per-enrollee costs of a consumer right to appeal and other basic protections.

### The Response From Congress

During the past two years, Congress has responded to the public's requests for consumer protections. Laws receiving bipartisan support in Congress have addressed such highly visible issues as assuring at least 48-hour maternity stay and establishing mental health parity. On a more comprehensive level, Georgia Republican Representative Charles Norwood, who was a dentist before he was elected to Congress, has introduced The Patient Access to Responsible Care Act (PARCA). The bill has garnered a great deal of attention and bipartisan support,<sup>2</sup> and it is also supported by a wide range of consumer, provider and professional groups.

PARCA includes a range of consumer protection provisions, including emergency room access, plan choice, access to specialists and a grievance and appeals process before an independent entity. The bill also includes provisions to support providers, including a requirement that every managed care plan offer a "point of service" option in order for enrollees to access out-of-network physicians for their medical care.

A major controversial provision in the bill would allow for enrollees in plans regulated by the federal Employee Retirement Income Security Act (ERISA) to sue their health plans when they are injured as a result of an action by the plan. Currently, because ERISA plans are exempted from state insurance laws –

including personal injury laws -- employees are restricted from suing their health plans (*ASAP Update*, January 1998); (See ERISA section, below).

The Health Insurance Bill of Rights Act of 1997, introduced last year by Representative John Dingell (D-MI) (H.R. 820), offers consumer protections similar to many state-level consumer protection laws and includes more specific terms than the Norwood bill in areas such as access to specialist care. It also includes provisions for a "consumer assistance" program, which would provide ombudsman aid to educate and assist consumers in such activities as filing grievances.

Senator James Jeffords (R-VT),<sup>3</sup> who is chairman of the Senate Labor Committee, has introduced S. 1712, the Health Care Quality, Education, Security and Trust Act, which focuses on the information that plans must collect and disseminate to consumers. Under the Act, a Health Quality Council would establish benchmarks for quality and publish health care report cards. At present, however, Senate support for the Jeffords bill is not strong (Families USA at [www.familiesusa.org/](http://www.familiesusa.org/); April 1998).

A joint bill proposed by Democrats in both houses of Congress is HR 3605/S1890, known as the Patients' Bill of Rights Act of 1998. The legislation is comprehensive in scope and addresses issues that include access to physicians, emergency rooms and specialist care; patient information; an appeals process with a right to an external appeal. The legislation also allows patients to sue managed care plans for negligence or poor care. The bill is associated with Representative Dingell and Senator Kennedy, and it is supported by several Democrats, a few Republicans and numerous consumer and labor groups.

In other significant national legislation, pro-consumer legal protections are being considered for Medicare's 37 million elderly and disabled enrollees (Etheredge and Jones, 1997). Under the Balanced Budget Act of 1997, a number of consumer protections for Medicare and Medicaid beneficiaries enrolled in managed care plans are included.

As part of a national effort to gather information on consumer satisfaction and how individuals rate their health plans, the federal Department of Health and Human Services launched an initiative this year using the Consumer Assessment of Health Plans (CAHPS) survey tool. The Department and the Health Care Financing Administration distributed the CAHPS survey to over 130,000 Medicare HMO enrollees in

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<sup>2</sup> Senator A. D'Amato (R-NY) has introduced a companion bill in the Senate.

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<sup>3</sup> At the Federal level, the Senate Labor and Resources Committee has jurisdiction over consumer protections for private health plans; the Finance Committee has jurisdiction for consumer protections in the Medicaid and Medicare programs.

order to gather their assessment of their managed care plans. Currently, over 6 million Medicare beneficiaries are enrolled in 427 plans, with growth rates of 25 percent a year for the past three years ([www.ahcpr.gov/](http://www.ahcpr.gov/); May 1998). HCFA is planning to conduct a similar survey of Medicare beneficiaries in traditional fee-for-service plans and will compare research findings. The Balanced Budget Act of 1997 further expands the types of managed care options that will be available to Medicare beneficiaries; consequently, reliable research is critical for policy makers in order to ensure the health care for the elderly and disabled beneficiaries.

In the arena of consumer advocacy, a national coalition of nonprofit health plans and consumer groups in October 1997 endorsed a series of consumer protections in managed health care, such as information disclosure requirements, access to specialists and emergency room care, and elimination of physician gag rules. The coalition includes: Kaiser Permanente, HIP Health Insurance Plans, Group Health Cooperative of Puget Sound, Families USA and the American Association of Retired Persons (AARP).

#### **ERISA -- IMPLICATIONS FOR SELF-INSURED HEALTH PLANS**

While a thorough analysis of federal and state regulatory activity and its impact on ERISA plans is beyond the scope of this paper, it is important to note that while state insurance departments regulate commercial insurers, about one-third of the people in an average state are outside of state regulatory purview (Iglehart, 1997).<sup>4</sup> ERISA, or self-funded health plans, cover about one-third of the people in an average state. And the other one-third are those individuals who may be Federal employees (Federal Employees Health Benefits Program), or are enrolled in the Medicare or Medicaid programs, or receive veterans' health services.

Polzer and Butler researched ERISA's limits on health plan protections and found wide variation in the level of consumer protection afforded members of private-sector employee health plans, especially between those in self-insured plans (subject only to federal law) and insured plans (in which state laws apply); they also found wide variation from state to state. In a recent interview, the National Association of Insurance Commissioners' director Josephine Musser pointed out that concerns by state regulators regarding those enrolled in ERISA plans include: (1) that

enrollees receive accurate information about their plan; (2) that enrollees have no due process rights under their plan and often are not aware of this until a problem arises, and (3) that the plans must meet minimum financial standards (ibid). The state of Wisconsin, for example, requires that self-funded workers' compensation plans create a segregated pool of funds for the purpose of paying outstanding claims should the company declare bankruptcy.

In 1996, in a reversal of status quo, Congress amended ERISA to impose two specific types of standards on both insured and self-insured plans (Polzer & Butler, 1997). The Health Insurance Portability and Accountability Act limits all employee health plan use of preexisting condition exclusion periods and applicant health status information. Secondly, the 1997 appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development sets minimum lengths of hospital maternity stays and addresses parity between mental health and health care coverage.

#### **VIEW FROM THE STATES -- TRENDS AND ACTIONS: WHAT'S GETTING REGULATED?**

Historically, the focus of regulation of fee-for-service (indemnity) insurance focused on plan solvency, marketing conduct, and benefits. With the rise of managed care, regulation began to address issues such as access to services, quality assurance processes and outcomes measures regarding medical practices (Zatkin, 1997). In the past three years, changes in the delivery of health care and more aggressive cost containment practices by some plans have led to efforts at the state level to regulate provider contracts and other plan practices (ibid). Since last year, grievance and appeals procedures and medical necessity determinations have also become the focus of state regulatory practices.

Within the states, the spectrum of laws runs from the very broad -- such as comprehensive legislation addressing all types of managed care organizations -- to specific delivery system issues, such as access to care and disclosure of information about their health plans to consumers. Access to care laws and bills focus on areas of consumer's being able to receive referrals to medical specialists, to "experimental" or high technology procedures and to emergency care. Other significant areas of concern include: denials by plans that deem certain services "medically unnecessary," delays in the payment of claims by health plans; and questions regarding the definition of covered benefits. States are also grappling with issues surrounding quality of health care: how are quality measures to be standardized; what is the reliability of

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<sup>4</sup> The federal Employee Retirement Income Security Act of 1974 (ERISA) was designed "to establish uniform federal standards for pension and employee "welfare benefit" plans, including health plans offered through private-sector employers and unions (Polzer and Butler, 1997).



consumer satisfaction surveys, and by whose standards is quality to be measured?

During the past year, twenty-nine states have considered or implemented laws that give managed care enrollees greater access to specialists; fifteen states have established requirements that plans cover emergency room care if a "prudent layperson" would believe the condition required urgent care;<sup>5</sup> and nine states have addressed the creation of an external appeal mechanism for enrollees if coverage for a procedure is denied (Kaiser Family Foundation, *MarketFacts*, 1998).

Table 1 (Appendix), "Prominent Regulations of Health Plans by State," offers an overview of the types of areas in health care which are being regulated. According to a 1998 *Healthcare Trends Report*, state lawmakers introduced over 1,000 bills relating to health plans by mid-1997, of which 20 percent were enacted. The states of California, Minnesota, Wisconsin and Massachusetts have been some of the most "active" states in introducing managed health care related bills.

For the most part, the state laws, regulations and bills cover the following general areas:

- Access to physicians and specialists (laws vary as to the depth of access management);
- Appropriateness of "medically necessary" determinations;
- Access to emergency care;
- Any-Willing Provider/Freedom of Choice laws;
- Point-of-Service laws (allowing for patients to choose out-of-plan physicians);
- Length of Stay requirements and issues (e.g., births and mastectomies);
- Development of pharmaceutical and drug formularies;
- Right to filing patient grievances and access to appeals;
- Confidentiality and privacy of medical information;
- Nondiscrimination for those with chronic illness and/or disabilities (adverse risk selection issues);
- Mental health parity;
- Health plan liability (is the consumer's right to sue a "protection")?
- Financial incentives/reimbursement incentives for providers;
- Elimination of contractual "gag rules" for physicians and providers;

<sup>5</sup> These address the problem which arises when an individual with chest pains goes to the emergency room fearing that s/he is experiencing a heart attack and instead is found to have a case of heartburn or an equally non-emergent, benign condition. Managed care organizations have made a case that in such situations, the individual may be responsible for emergency room charges.

- Due process rights for providers and their participation in plans;
- Requirements for quality assurance plans and performance measurement indicators;
- Scrutiny of Plan Solvency/rating/underwriting;
- Marketing conduct of health plans.

### New Jersey

Of all the states across the country, most have created managed care protections via legislation. Historically, Texas and New Jersey have been using the broad legislative authority of Commissioners of Health and Insurance to promulgate specific regulations, as opposed to writing new legislation.<sup>6</sup> Recently, New Jersey has been a lead state in passing legislation and promulgating rules and regulations regarding managed care organizations.

Last year, close to four million New Jerseyans were enrolled in Health Maintenance Organizations (HMOs) and other managed care plans, including Preferred Provider Organizations (PPOs) and Point of Service (POS) plans. At present, 2.3 million New Jersey residents (or one in three [approximately 33 percent] insured New Jerseyans) is enrolled in an HMO (Commissioner Fishman's statements before Assembly Appropriations Committee, April 28, 1998).

The state's HMO rules became effective March 15, 1997, and a major feature of the rules is the inclusion of advanced consumer protections. A "consumer bill of rights" offers provisions such as a ban on gag rules (which would prevent doctors from discussing health care options not covered by the HMO) and gives consumers the right to an independent appeals process and access to an independent panel of medical experts if resolution cannot be achieved between the HMO and the consumer. In preliminary analyses of the appeals process (some 46 appeals submitted for review since March 1997), issues raised included length of hospital stays, use of out-of-network services and decisions as to whether surgery is medically necessary (ibid).

On August 7, 1997, The Health Care Quality Act (HCQA) (P. L. 1997, c. 192) was signed into law in New Jersey. HCQA (which became effective February 3, 1998) extends the consumer protections once afforded only to HMO members to all individuals covered by any form of managed care plan. It also establishes an Independent Health Care Appeals Program, which will be available to all individuals,

<sup>6</sup> Reference is made to New Jersey Policy Forums *Issue Briefs*, dated February 2, 1994 and October 19, 1994 (with a 1997 *Update* in [The Issue Brief Review](#)), analyzing public oversight of managed care entities, with an historical overview of federal and state regulatory trends regarding managed care.

regardless of the form of their coverage, for appeal of final decisions by health plans to deny, reduce or terminate benefits. Administrative rules for the Act, which includes extensive filing and disclosure, consumer protection and quality assurance requirements, are currently in draft form (N.J.A.C. 8:38A). The Department is also in the process of drafting amendments to its HMO rules at N.J.A.C. 8:38.

Although self-funded health plans continue to be exempted from state law by the Federal Employee Retirement Income Security Act (ERISA), under HCQA, employers are required to notify employees that they are covered by a self-funded plan which is not subject to state consumer protection regulations, including the right to appeal final decisions to reduce or deny treatment for a covered health service to an independent entity. Employers are also required to identify any state-mandated benefits not covered by the plan (such as benefits for treatment of diabetes (P.L. 1995, c.331), and benefits for prostate cancer screening (P.L. 1996, c.125)).

New Jersey's HMO rules and the Health Care Quality Act also require that managed care entities report on their performance. In the HMO sector, results from a consumer satisfaction survey of 6,000 members were published as an HMO report card in November 1997. While the report card showed that New Jersey consumer satisfaction was high regarding their physicians and referrals to specialists, lower than expected results were found regarding HMO performance in key health areas, such as immunizations and breast and cervical cancer screenings.

Both New Jersey and Maryland (which released its first HMO performance report in October 1997) used a report card format which covered both broad categories of service – such as providing patient care – as well as individual service measures – such as ease of getting an appointment or finding a personal doctor (*State Initiatives in Health Care*, January 1998.)

The Departments of Health and Senior Services and Insurance are currently studying the scope of state regulation for provider-sponsored organizations, which fall outside of the purview of existing state licensure categories for insurance risk assumption. Recommendations on this issue are due to the Legislature and the Governor by February 1999.

#### **FACT OR FICTION -- IS MANAGED CARE HAVING A NEGATIVE IMPACT ON HEALTH CARE DELIVERY AND FINANCING?**

The ability of managed care organizations to control costs is attributed to their methods of reducing wasteful spending by using utilization review to determine if procedures are medically necessary and develop guidelines for effective and efficient treatments of various illnesses. Cost management has also resulted from their ability to negotiate discounts from providers in return for increased patient volume. Yet, some policymakers, legislators and consumer advocates believe that some of managed care's successes in reducing costs have been achieved by denying coverage for medically necessary services or cutting back on the quality of services provided.

Health Insurance Association of America president Bill Gradison asserts that even a one percent rise in insurance costs (passed down to purchasers because of plans' compliance with imposed regulations) would prompt small businesses to drop coverage for an estimated 200,000 people (*Newseek*, May 4, 1998). Congressional Budget Office and Lewin Group research also finds that if regulations increased access, for example, there would be an increase in employer costs. These cost increases would in turn have a direct effect on the number of uninsured. The Lewin Group estimates that a one (1) percent increase in employer premiums would lead to an additional 400,000 persons' being uninsured.

The managed care plans claim they can voluntarily meet or exceed standards that consumer advocates want to legislate, such as providing comprehensive information about the plan's services. And what about quality? Is it being compromised? To date, a comparison of the quality of managed care plans with that of fee-for-service plans has not produced results that uniformly differentiate between these two plan types in either a positive or negative way. Research studies have found that MCOs, as a whole, provide quality of care equal to that provided in fee-for-service plans (Miller & Luft, 1994; 1997). The researchers point out that: "HMOs produce better, the same and worse quality of care, depending on the particular organization and the particular disease." They have strengths and weaknesses in the care of particular diseases. Measures of quality are needed to evaluate individual health plans in terms of specific diseases and conditions, rather than more broadly defined categories of health plans.<sup>7</sup>

<sup>7</sup> There may be a need to create more specifically tuned indicators in order to monitor managed care's practices. For example, consumer complaints are high regarding primary care physicians' reticence to refer to specialists, even when past relationships have been established with them -- such as nonreferral to an allergist for a patient with asthma. Should measures be developed to look at the number of specialist referrals in a practice? Is the answer the implementation of "standing referrals" for patients with chronic health care needs?

An April 1998 Employee Benefit Research Institute report reviewed Medical Expenditure Panel Survey (MEPS) data on access to health care and consumer satisfaction for the uninsured and insured populations, as well as within the insured populations (Fronstin, 1998).<sup>8</sup> Based on the MEPS survey, it was found that access to health care and satisfaction with medical services did not vary greatly between those insured via managed care plans and traditional fee for service indemnity plans. The researchers called on policy makers engaged in designing laws to regulate the managed care industry to focus on the importance of gathering nationally representative and standardized data on health care access and satisfaction. Acknowledging a media bias towards managed care, the author also cautioned against relying on anecdotal stories regarding access and consumer satisfaction as a basis for developing managed care regulations (ibid; Ignagni 1998; Brodie et al, 1998).

### CONSUMER ADVOCACY

Just as there is wide variation across the country in the scope and type of consumer protection legislation and regulation, there is also great variation in the range of consumer advocate activities. While some states, such as California and Massachusetts<sup>9</sup> have strong, proactive consumer advocacy targeting health care issues, consumer organizations in other states are often functionalized because of their specific goals and strategies and lack a unified consumer voice.

New Jersey's citizen advocacy groups for health care represent a broad array of age-specific (AARP; Gray Panthers; Association for Children) and illness-specific (both health and mental health) groups. New Jersey Citizen Action identifies diverse groups that, for example, joined together to make significant grassroots efforts to lobby for such legislation as the Health Care Quality Act: the United Seniors Alliance; the AFL-CIO; the Communications Workers of America (CWA); Health Professionals and Allied Employees; and the Medical Society of New Jersey (*Action for Universal Health Care Newsletter*, September 1997).

### A QUESTION OF BALANCE

The question of balance arises when policymakers are confronted by the inherent difficulties in imposing regulations on any type of industry. How can the conflicting needs that "divide" consumers, providers

and purchasers of health care be reconciled? If a balance is to be achieved, how is the appropriate scope of regulation to be established? And what entity or group of entities should be responsible for doing so? The voice from insurers and health plans echoes that of all regulated entities: the concern that overly stringent or burdensome regulation will end up increasing costs and essentially canceling out any cost savings created by managing health care services.

Karen Ignagni, the chief executive officer of the American Association of Health Plans (AAHP), believes that the regulators do not have to make a "simplistic choice between competition and regulation," but the real question is to analyze where the balance point should be (1998). Calling the current health care marketplace a "work in progress," she underscores the need for all parties -- consumers, health plans, purchasers and legislators -- to widen the debate and avoid health care "micromanagement" through inappropriate legislation.<sup>10</sup>

An innovative response to this challenge comes from certain consumer advocates and health policy analysts. Calling for a need for a promarket regulatory philosophy which offers a national approach to ensure quality-based and consumer-focused competition, Etheredge et al suggest that oversight be effected through a national, independent, nonpartisan association. This National Health Care Market Commission, would be based on the Security and Exchange Commission (SEC) and the private sector-sponsored Financial Accounting Standards Board (FASB) model, and its charge would be to set and enforce standards in the areas of consumer protection and information disclosure (1997). The Commission would cooperatively work with accreditation and administrative groups, such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), HCFA, the Foundation for Accountability (FACCT) and the National Association of Insurance Commissioners (NAIC).<sup>11</sup>

### CONCLUSION

There is great variation, on both the federal and state levels, regarding consumer protections in health

<sup>8</sup> MEPS is the third in a series of national surveys conducted by the Agency for Health Care Policy and Research to provide nationally representative estimates of health care utilization, expenditures, sources of payment and insurance coverage for the U.S. non-institutionalized population.

<sup>9</sup> Community Catalyst's work focuses on assisting state and community-based consumer groups to participate directly in health system change.

<sup>10</sup> In mid-1997, the American Association of Health Plans launched a major redirection of its public relations activities by announcing its "Putting Patients First" campaign. A major component of the campaign is to establish guidelines for member plans that call for an end to gag rules in managed care contracts.

<sup>11</sup> NAIC currently has five model laws to help consumers in the market-driven health insurance environment: The Quality Assessment and Improvement Model Act; the Health Care Professional Credentialing Verification Model Act; the Managed Care Plan Network Adequacy Model Act; the Utilization Review Model Act, and the Health Care Carrier Grievance Procedure Model Act.

care. Whether individuals are covered by self-insured plans, Medicare, Medicaid, or fully-insured plans has a distinct impact on how they are "protected" vis-à-vis their basic health care. As some industry leaders are calling for "legally enforceable national standards," the Kaiser/Harvard study found that 52 percent of Americans feel that government should protect consumers of managed care; 40 percent assert that regulatory intervention is not worth the increased costs that may result. In response to a question asking by whom they would like to see managed care plans regulated, the public was divided over whether the government -- federal (19 percent) or state (18 percent) -- or an independent organization (34 percent) should regulate the industry (id).

A 1996 Advisory Board<sup>12</sup> report entitled "Resurgence of Choice" predicted that the next decade (1998 - 2008) will see an exponential increase in consumers' wielding their power in the health care market and labeled the period "The Consumer Era." The report indicates that the period of 1900 to 1988 was the era of fee-for-service medicine, when physicians held primary authority in health care. The decade from 1988 to 1998 follows, during which time insurers assumed broad authority over health care decisions, physicians' power weakened and the role of consumer choice diminished. In the Consumer Era (which begins this year), there will be a resurgence of consumer choice in health care and both physicians and insurers will act in service to consumers.

In her 1997 book, Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry, Regina Herzlinger echoes the same prediction. She views the American patient not as passive, or ignorant -- a "victim" in dire need of consumer protection laws -- but as a savvy user of Web sites and chat rooms who will be able to negotiate the rapids and undertows of the new health care system to their best advantage.

In sharp contrast, a 1997 Kaiser-Harvard study found that, when asked to describe their knowledge of health care, few Americans "are familiar with some of the key terms used in debates over health policy," including the terms "fee-for-service" and "managed care." Once again, the "facts" about health care are difficult to ascertain.

It behooves public policymakers to continue to press for reliable research studies to ascertain the effects the changing health care system is having on access to health care and its quality and costs. Such information can inform the policymaking process and

clarify decision points regarding the imposition of regulatory measures as the health care "work in progress" continues.

## POLICY IMPLICATIONS

In 1997, a survey conducted by the Kaiser Family Foundation and Harvard School of Public Health found that few Americans "are familiar with some of the key terms used in debates over health policy." Do state and local policymakers have a responsibility to design public education and ombudsman-like programs to educate and to assist consumers -- who are expected be accountable for our own health care -- in negotiating the new health care environment?

The enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is believed to be significant for the precedent it sets for a new state-federal partnership for regulating health insurance (*State Initiatives in Health Care Reform*, January 1998). Although the law may not have great force or impact on the industry, it has created a new presence and role for the federal government in the health benefits marketplace. However, it is anticipated that some state regulators may be reluctant to accept federal involvement in their health insurance markets. What are the implications of these new partnerships in other areas of health insurance reform?

A recent *Modern Healthcare* editorial called on insurers and providers to align their interests and craft a market-based solution "that balances patient needs with clinical limitations and economic realities" (April 1998). It proffered the belief that only an industry-wide effort -- led by hospitals (many of which already operate commercial managed-care plans and are preparing to enter the Medicare risk-contracting business through provider-sponsored organizations), health systems and medical groups -- can persuade advocates of consumer protection regulatory measures that a voluntary, private-sector approach to regulation is viable. Do New Jersey's lawmakers and health industry leaders see this approach as one worth investigating in our state's policymaking arena?

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<sup>12</sup> The Advisory Board Company is based in Washington, D.C. and is a strategic research firm and for-profit think tank which researches and publishes studies, briefings and custom projects on topics from health care to global corporate practice.

APPENDIX

Table 1									
PROMINENT REGULATIONS OF HEALTH PLANS BY STATE									
STATE	Any Willing Provider	Gag Rules	Direct Access	Freedom of Choice	Emergency Care Coverage	Length-of-Stay Mandates	Financial Incentives	Due Process	Privacy Laws
Alabama			Ob.	Rx		Mat.			Yes
Alaska						Mat.			
Arizona		Yes			Yes				Yes
Arkansas	Broad	Yes	Ob., Derm.	Rx, Eye	Yes	Mas., Mat			
California		Yes	Ob.		Yes	Mat.		Yes	
Colorado		Yes	Ob.		Yes				
Connecticut	Rx	Yes	Ob.	Rx	Yes	Mas., Mat	Yes		
Delaware	Rx	Yes	Ob.	Rx					
Florida	Rx	Yes	Ob.,Derm		Yes	Mas., Mat			Yes
Georgia		Yes	Ob.,Derm.	Rx, POS	Yes	Mat.		Yes	
Hawaii									Yes
Idaho	Broad, Rx	Yes	Ob.	POS				Yes	
Illinois	Noninst.		Ob.	POS		Mas., Mat.			Yes
Indiana	Broad, PPO	Yes	Ob.			Mat.		Yes	Yes
Iowa				POS		Mat.			
Kansas	Rx	Yes			Yes	Mat.			Yes
Kentucky	Broad		Chiro.	Chiro.		Mat.			
Louisiana	Broad, Rx	Yes	Ob.		Yes				
Maine		Yes	Ob., Chiro			Mas., Mat.			
Maryland		Yes	Ob.	POS	Yes	Mat.	Yes	Yes	
Massachusetts	Rx	Yes			Yes	Mat.			
Michigan		Yes							
Minnesota	Allied	Yes	Ob.	POS	Yes*			Yes	
Mississippi	Rx		Ob.	Rx					
Missouri		Yes	Open Ref.			Mat.		Yes	
Montana		Yes	Ob.	POS		Mas., Mat.			
Nebraska		Yes	Ob.		Yes			Yes	
Nevada		Yes		Allied					
New Hampshire	Rx	Yes				Mat.	Yes		
New Jersey	Rx	Yes	Ob.	Rx		Mat.	Yes		
New Mexico		Yes*	Ob.			Mas., Mat.			
New York		Yes	Ob.	PO	Yes	Mas., Mat.		Yes	
North Carolina	Rx	Yes*	Broad	Rx	Yes	Mat.			
North Dakota	Rx	Yes		Rx		Mat.			
Ohio						Mat.			
Oklahoma	Rx	Yes		Broad, POS		Mas., Mat.			
Oregon		Yes	Ob.	POS	Yes			Yes	
Pennsylvania		Yes			Yes	Mat., Mas.			
Rhode Island		Yes	Ob.	Rx		Mas.			
South Carolina	Rx, Allied					Mat.			
South Dakota	Rx			Rx		Mat.			
Tennessee	Narrow	Yes				Mat.			Yes
Texas	Regul.	Yes*	Ob.	Rx, POS	Yes*	Mas., Mat.		Yes	Yes
Utah	Broad	Yes	Ob.	Broad					
Vermont		Yes							
Virginia	Rx, Allied	Yes	Ob.	Rx	Yes	Mat.			
Washington	Broad, Allied	Yes	Ob.	Opt Out		Mat.			
West Virginia			Ob.			Mat.			
Wisconsin	Rx	Yes		Rx		Mas.			
Wyoming	Broad	Yes							

Source: EBRI *Issue Brief*, April 1998; State Legislative Health Care and Insurance Issues: 1996 Survey of Plans, *Major Health Care Policies: 50 State Profiles, 1996; State Health Notes; and Spencer's Research Reports on Employee Benefits.*  
 Notes: Broad=broad array of physicians; Chiro=chiropractor; Derm.=dermatologist; Eye=eye care; Mas.=mastectomy; Mat.=maternity; Noninst.=noninstitutional providers; Open Ref=open referral; Ob.=obstetricians/gynecologists; POS=point-of-service option; PPO=preferred provider organizations; Regul.=regulation; Rx=pharmacies; \*=enforced by regulation.

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