



Public Oversight of Managed Care

By

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Biography

M. Gregg Bloche is Professor of Law at Georgetown University Law Center, Adjunct Professor in the Department of Health Policy and Management at the Johns Hopkins University School of Hygiene and Public Health, and co-director of the Georgetown-Johns Hopkins joint program in law and public health. His recent and current work addresses the role of for-profit institutions in medicine, the conflicting obligations of providers in managed health systems, the problematic goal of systemic rationality in medical resource allocation, and consent-based justifications for restrictions on access to care, release of clinical information, and other practices. He also writes on the connections between health and international human rights.

Dr. Bloche received a Robert Wood Johnson Foundation Investigator Award in Health Policy Research in 1996 for a 3-year project, "Rationality and Consent in the New Medical Marketplace." He is also a co-recipient of grants from the Agency for Health Care Policy Research and the Robert Wood Johnson Foundation for the study of arrangements between physicians and managed health plans. Dr. Bloche's recent work has appeared in the *Journal of the American Medical Association*, *Health Affairs*, the *Annals of Internal Medicine*, the *New England Journal of Medicine*, and other medical and health policy journals, in addition to law reviews and edited volumes. He also occasionally contributes "op-ed" pieces to newspapers. Dr. Bloche serves on the boards of Physicians for Human Rights and other health-and-human-rights organizations and has been a consultant to South Africa's Truth and Reconciliation Commission (on human rights in the health sector), the American Association for the Advancement of Science, the World Health Organization, the National Institutes of Health, the Agency for Health Care Policy Research, and the Institute of Medicine.

At Georgetown, Dr. Bloche has taught courses on health law and policy, the new medical marketplace, tort law, government regulation of risks to health and safety, and international human rights. He is also a participating faculty member at Georgetown's Institute for Health Care Research and Policy and a Fellow at the Kennedy Institute of Ethics. Before joining Georgetown's faculty in 1989, Dr. Bloche completed his residency in psychiatry at the Columbia-Presbyterian Medical Center. He received his M.D. and J.D. degrees from Yale University and his B.A. from Columbia. He was an editor of the *Yale Law Journal* and the recipient of Yale Law School's 1987 Benjamin Scharps Prize. Prior to attending medical and law school, he spent a year as an economics and business writer for the *Dallas Times Herald*.

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Introduction

At its best, the managed care revolution promises a new era of more efficient medical spending, well-targeted to promote the health of populations and to benefit sick patients. Proponents of the revolution promise evidence-based medicine, sensible cost-benefit balancing at the bedside, systematic quality control, consumer choice, and unprecedented commitment to disease and injury prevention. At its worst, the new era threatens to disrupt doctor-patient relationships, reduce access to lifesaving treatments, roll back hard-won protections for patient self-determination, and enrich a new class of avaricious executives at the public's expense. Recent media accounts of tragic deaths after denial of care, health care industry bankruptcies, and financial windfalls for medical care executives have aroused public alarm and spurred calls for regulatory intervention. The collapse last year of both HIP Health Plan of New Jersey and the Virginia company that took over HIP's clinical operations raised wider concern about financial instability in the highly competitive managed care industry and the potential implications of this instability for continuity of care. Economic incentives for physicians to limit patient access to referrals and other costly services have raised both quality-of-care concerns and qualms about corrosion of the Hippocratic ethic of undivided clinical loyalty to patients.

A diverse range of stakeholders now eye the managed care industry warily. Investors who only a few years ago were enthralled by for-profit managed health plans' seemingly unbounded potential are now coming to grips with stunning losses in shareholder value, suffered while other equity market sectors saw extraordinary growth. Physicians resent the industry's bargaining power and intrusion on their professional autonomy. Hospitals have been pressed to give managed health plans high volume discounts, putting the squeeze on their ability to finance new facilities and equipment, recruit and retain staff, provide free care to the indigent, and support research, education, and community programs. Employers who look to the industry to control their health benefit costs are concerned about employee dissatisfaction in a tight labor market, the financial stability of plans with whom they contract, and recent evidence of renewed cost increases. Employees and other consumers of care fear loss of choice from among treatments and providers, denial of access to beneficial services, and the loss of both continuity and trustworthiness in the doctor-patient relationship.

Even within the managed care industry, insistence on a pure laissez faire approach to these threats (whether real or perceived) is rare. Proposed regulatory and other public oversight responses fall into four categories: (1) standard-setting by *private* entities (e.g. managed care trade associations) and voluntary industry compliance, (2) federal and state action to compel disclosures of information and to regulate its presentation to the public, (3) federal and state standard-setting, and (4) federal and state efforts to influence health plans' behavior through market-mimicking economic incentives. This issue brief reviews the principal public policy questions that the managed care industry currently presents, then highlights alternative market-oriented and regulatory approaches. This brief does not take positions as to how these questions should be answered. Rather, its purpose is to identify the most critical underlying issues and to offer a framework for informed discussion about the options facing New Jersey legislators and regulators, health care purchasers and consumers, and payers and providers. This brief is organized into four issue clusters: consolidation and disintegration in the medical marketplace, the impact of wide-open competition between managed health plans, health care quality and accountability, and patient and purchaser empowerment.

Consolidation and Dis-integration in Medical Markets

For more than a decade, proponents of competition between managed health plans as a means of both controlling costs and expanding access have put the integration of medical care financing and service provision at the center of their policy vision.¹ The paradigmatic institutional form has been the staff model Health Maintenance Organization (HMO), a single entity that receives insurance premiums and spends them on the health care providers it employs and the hospitals and other facilities it owns. Other institutional arrangements are consistent with this vision, so long as they empower bearers of health insurance risk to actively manage (and limit) the provision of services through such means as financial incentives to providers to restrain spending and robust, prospective

¹E.g. Enthoven AE & Kronick R. "A consumer-choice health plan for the 1990s". *New Eng. J. Med.* 320:29-37 (1989).

utilization review.² The integration of financing and service delivery, proponents hold, solves the problem of “moral hazard,” the driving force behind out-of-control medical spending,³ by pre-committing health care consumers to living within fixed budgets (determined by annual plan premiums), then empowering managers of health care risk pools to make the necessary allocative decisions.

This appealing model presumes that employers’ and consumers’ economizing preferences will push the health care industry toward vertical integration (of financing and service delivery), followed by robust competition to provide services efficiently, at a variety of cost-quality trade-off levels. Anticipating this new health care order, insurers and providers invested billions of dollars in the 1990s in the development of HMOs and other integrated financing and delivery systems.

To the dismay, indeed shock, of health care investors, the medical marketplace defied these expectations. Consumers resisted tightly-managed HMOs and other plans that greatly restricted choice of providers and treatments. In the low-unemployment labor market of the late 1990s, firms came under increasing pressure to offer desirable health benefits in order to recruit and retain skilled workers. More loosely-organized plans that preserved patient choice (and provider discretion) fared better with prospective subscribers but often failed to accurately anticipate medical claims. In a fiercely competitive market, plans priced their benefits packages aggressively, risking insolvency in the event of small miscalculations of claims and other expenses. The large initial costs of network creation, product development and marketing, and overhead added to the riskiness of their endeavors. Mild marketing disappointments translated into destabilizing financial losses. Plans became insolvent, merged, or were bought out or bailed out. Providers experienced payment delays, and patients faced disruptions in the continuity of their care and their relationships with their doctors.

²Havighurst CC. *Health Care Choices: Private Contracts as Instruments of Health Reform*. Wash., D.C.: American Enterprise Institute Press, 1995.

³“Moral hazard” in medical care is the effect of insurance coverage upon consumers’ demand for health services. Insurance spurs medical demand (and the development of new, more costly technology) by reducing, often to near-zero, the prices patients pay out-of-pocket for medical services.

The market for managed health plans in 1999 is characterized by pervasive financial and organizational instability. The overall trend is toward vertical *disintegration* and horizontal consolidation.⁴ Insurers have fared poorly at creating and managing extensive provider networks, and doctors and hospitals have fared poorly at developing and marketing comprehensive, pre-paid health plans. Big health care purchasers (e.g. large employers) have proven less able than insurance companies at building economically favorable contractual relations with providers. As a consequence, insurers, purchasers, and providers are more inclined now than a few years ago to stick to their “core competencies.”⁵ On the other hand, the principal players in medical markets are now aggressively pursuing horizontal integration strategies. Multistate corporate purchasers are employing their bargaining power to negotiate favorable contracts of national scope with health plans. Health plans, in turn, are entering multiple geographic markets in order to compete for this business and to grow their enrollments more generally. Plans are also developing multiple, diverse network options and benefits packages, tailored to purchasers’ varying preferences and abilities to pay. To marshal countervailing market power and to offer diverse network alternatives, doctors and hospitals are pressing the limits of antitrust law (and lobbying for exemptions) to combine into both comprehensive and specialized health care delivery systems.

A distinctive and troubling feature of the new horizontal consolidation is the fluidity of health plans’ market positions, network structures, and contractual relationships more generally. The shift from organizational integration (with its hierarchical rigidities) to reliance on changing contractual relations benefits plans and providers by giving them more flexibility to quickly enter and exit markets, reformulate networks and benefits packages, and otherwise respond to shifting circumstances. However, it undercuts the case for competition between health plans as a social welfare-enhancing process. In particular, it presents the following challenges, from a public oversight perspective:

- *How should state policymakers respond to actual and threatened disruptions of medical care and of therapeutic relationships due to ongoing financial and organizational instability in the managed care industry?* Policymakers could take an entirely hands-off approach, leaving “punishment” for such disruptions to market forces and/or deferring to standard-setting and self-monitoring by national and state-wide trade associations. Alternatively, regulators could require advance (and annual) warnings to subscribers about contractual possibilities for such disruption (and limits on contractual protection against it), or they could “rate” health plans for fiscal and organizational stability and vigorously disseminate these ratings to subscribers and purchasers. A more robust response might involve tightened minimum standards (administered by the Departments of Insurance and/or Health) for the fiscal soundness of all the institutional components, risk-bearing or otherwise, that operate together, by contract, to constitute each health plan. Insurance companies, plan administrators, networks of doctors and hospitals, and other entities could all be subjected to such standard-setting and enforcement, albeit at considerable expense to both taxpayers and regulated entities. State requirements that contractual commitments between plans and providers be long term (e.g. minimum allowable contract lengths) and that new networks and benefits packages remain intact and available to subscribers for minimum periods of time could also be part of a more robust response to instability. Some or all of these robust responses to instability could be pressed, in the alternative, through tax or other financial incentives.
- *How should state policymakers respond to the actual and threatened effects of industry instability upon health care purchasers’, consumers’, and providers’ interests in their own economic viability?* Large, corporate purchasers of medical coverage, with specialized employee benefits departments and access to sophisticated benefit consultants might reasonably be expected to protect themselves in today’s Darwinian medical marketplace. But smaller employers, the self-employed, and individual purchasers and consumers lack access to such knowledge and sophistication, as do clinicians in sole or small group practice and small community hospitals. Variations on the regulatory stratagems just mentioned merit consideration as potential responses.

⁴Robinson JC. "The future of managed care organization". *Health Affairs* 18(2):7-24 (1999).

⁵Id.

- *What constraints does the federal Employee Retirement Income Security Act (ERISA), which pre-empts state regulation of employee benefit plans, including medical coverage, impose on state regulatory responses to industry instability, and how can imaginative legislative drafting work within these constraints?* In general, ERISA imposes a near-absolute bar to state regulation of decisions by employee benefits managers. ERISA fully immunizes “employee welfare benefit plans” from state regulation, but ERISA’s “insurance savings clause” allows state regulation of myriad risk-bearing entities that contract with employee benefit plans. The exact scope of the “insurance savings clause” and the nature of the risk-bearing that provider networks or other entities must engage in to trigger this clause are hotly-contested legal matters, beyond the scope of this issue brief. But in general, artful drafting of state statutes and regulations, informed by governing federal court opinions about the boundaries of the “insurance savings clause,” can effectively target many of the contracting entities that constitute managed health plans.

Competition Between Managed Health Plans

The vertical dis-integration of the managed care industry and the emergence of myriad, custom-tailored benefits packages and provider network options has large implications for the nature of competition between health plans. The aforementioned model of competition between vertically-integrated plans envisions robust rivalry over the price and quality of comparable clinical services and benefits packages, with, perhaps (more controversially) multiple tiers of quality for purchasers with different abilities or willingness to pay. But vertical dis-integration, market fluidity, and the custom-tailoring of coverage options shift competition to socially less productive spheres. Rather than focusing on efficient management of care, the leaders of horizontally consolidated but vertically dis-integrated health plans will be drawn toward zero-sum competition to obtain bulk purchase discounts from providers by shifting fixed costs to others. Instead of striving to hold down long-run medical costs through health promotion and disease prevention, plan managers in fluid markets with fast-changing enrollment patterns will be tempted to cut clinical corners in the short term, figuring that money saved three, five, or ten years from now through illness prevention is more likely to benefit competitors. Perhaps most perniciously, rather than competing to deliver the best quality of care for a given price, plans that tailor networks and benefits packages for different purchasers will be drawn toward zero-sum rivalry to pick the low-hanging fruit, by designing packages to attract populations with low aggregate medical risk. Over the longer term, intensifying competition for low-hanging fruit may prove a negative sum game, as higher-risk patients and populations are priced out of the medical coverage market by increasing segmentation of coverage based on risk. Indeed, some advocates of competition between managed health plans identify easy comparability of benefits packages as the most important prerequisite for rivalry over quality and efficiency rather than risk selection.

Whether any regulatory intervention can do much to channel competition between health plans away from zero-sum games toward socially productive effort is uncertain. The market incentives involved are so potent, and the actuarial and other management techniques available to plan officials are so powerful, that government efforts to quell zero-sum gaming may be quixotic. From a public oversight perspective, such gaming presents several, related challenges:

- *What, if any, are the public benefits generated by competition between health plans for bulk purchase discounts from doctors and hospitals?* Such discounts may to some degree shift resources in a “progressive” direction (e.g. from high-paid surgeons to middle-class plan subscribers) with minimal short-term impact on quality of services. On the other hand, they may influence quality over the long term by reducing incentives for highly able people to enter some medical fields. This could represent either a social welfare-enhancing shift in the allocation of talent to careers, or a social loss. To the extent that efforts by health plans to win such discounts represents a tug-of-war over who bears providers’ fixed costs, it is a zero-sum endeavor. But to the extent that market pressure to offer such discounts reduces future investment in facilities and technology from irrationally high levels, it enhances social welfare.
- *Do fluid markets and fast-changing enrollment patterns yield any social welfare gains to balance diminished plan incentives to promote health and prevent illness?* Do market pressures resulting from purchasers’ ability to shift quickly between plans produce countervailing benefits -- e.g., perhaps, better or more courteous service or other amenities? Evidence on this question is scant, but answering it is essential to determining whether regulatory interventions might be appropriate.

- *Does the custom-tailoring of provider networks and benefits packages to suit large purchasers yield social welfare gains, in the form of increased consumer satisfaction, to balance the social welfare losses that ensue from competitive risk selection?* Again, evidence is scant, but the question is central for rational policymaking regarding the market's production of myriad, hard-to-compare coverage options.
- *What public interventions, if any, might encourage health plans to invest more in long-term disease prevention and health promotion?* How might subscriber turnover be slowed, and how might plans otherwise be encouraged to commit to the long-term health of their members? Potential steps include industry-set standards (and industrywide self-monitoring) for health promotion programs; required disclosure and reporting of turnover rates and measures of health promotion activity (e.g. percentages of subscribers who receive various screening tests, participation in smoking cessation and stress management programs, availability of physical fitness programs); regulatory standards for health promotion investment and activities by licensed plans, and tax or other financial incentives. So long as state regulation targets free-standing, risk-bearing health plans rather than employee benefits programs, it should, in general, survive ERISA scrutiny.
- *What public interventions, if any, might ameliorate destructive risk-selection competition?* So long as myriad benefits packages continue to proliferate, risk-selection through benefit design will continue unabated. Industry self-regulation (e.g. specification of a basic benefits package or, perhaps, several model packages at different price tiers) and self-monitoring could play a constructive role, though it might encounter antitrust problems. State regulation of the content of benefits packages is precluded (for self-insured plans) by ERISA. A state risk adjustment program (adjusting premiums to cancel out the effects of risk-selection and adverse selection, then requiring health plans with low-risk populations to subsidize plans with high-risk populations) would be technically difficult (perhaps impossible), costly to administer, and virtually impossible to set up under ERISA.

Health Care Quality and Accountability

Efforts by purchasers, consumers, and regulators to assess health care quality confront a basic dilemma: surprisingly little is known, scientifically, about the efficacy of most diagnostic and therapeutic interventions. Most medical decisions are made without firm empirical grounding: doctors make judgments based on revered, senior authorities; local traditions; and that blend of intuition, empathy, and personal experience that has come to be known as the "art" of medicine. Clinical practice protocols employed by health plans for quality control and/or provider reimbursement purposes are thus, for the most part, not scientifically grounded. The paucity of scientific knowledge about clinical outcomes renders systematic cost-quality trade-offs within a health plan impossible to effect in practice.

Other measures of quality are more achievable. Consumer satisfaction, provider credentials, facilities and technology, and even, to some degree, patient trust are possible to evaluate empirically. From a public oversight perspective, an overarching question is how quality in health care provision should be understood and defined. Should quality be treated strictly as a matter of biomedical outcomes, or should subscribers' subjective experiences with their plans and patients' subjective experiences with their doctors and hospitals (e.g. feelings of trust and confidence⁶) "count" in our consideration of quality? How much weight should we give to treating disease versus promoting health when we think about quality. More specific questions include:

- *To what extent should we defer to markets both to generate measures of quality (e.g. "Consumer Reports"-style ratings of health plans by medical outcomes, consumer and patient satisfaction, perceived trustworthiness, health promotion programs, etc.) and to determine, through coverage purchasing decisions, appropriate levels of quality?* Markets have the virtue of generating answers, if only by default, to all of our questions about preferable understandings and levels of quality. Do we want to live with these answers or to employ public policymaking tools to change them?
- *What are the possible roles of information reporting and publication requirements, whether self-imposed by industry-wide organizations or mandated by state regulators, in shaping the market's answers to questions about definitions and levels of quality?* Information dissemination requirements might address

⁶Bloche MG. "Clinical loyalties and the social purposes of medicine". *J. Am. Med. Assn.* . 281(3):268-274. (1999).

myriad quality-related matters, including clinical outcomes, consumer and patient satisfaction, health promotion programs and population-wide health status, and provider credentials and technological and other resources. But they can be, at best, only as useful as the data they put on public view is meaningful. The primitive state of clinical outcomes research, our ignorance about the causal links between providers' credentials and other resources and medical outcomes, and the confounding influences of differences in population-wide health on outcomes data (the "our patients are sicker" argument) are some of the problems that bedevil interpretation of such data.

- *What are the possible roles for quality-related standard setting by either industry-wide bodies or state regulators?* The setting of minimum standards for quality is subject to the problems of definition, interpretation, and grossly inadequate scientific knowledge that have just been discussed. Were government regulators to impose robust and detailed quality-related standards, extensive litigation would probably ensue as substandard performers invoked administrative law doctrines requiring rational decision making to challenge exercises of agency discretion poorly-grounded in empirical data. Monitoring of plan compliance, moreover, would be difficult and costly, and imposition of penalties for noncompliance would be problematic. Substantial financial penalties would likely translate into higher premiums for subscribers, and the ultimate enforcement weapon -- shutting down a health plan -- would disrupt patient care on a wholesale scale.
- *How should state policymakers deal with disputes between patients and health plans over coverage decisions and claims of harm due to denials of coverage?* ERISA bars state medical malpractice actions against health plans for their *coverage decisions*, on the ground that state tort law (which governs malpractice litigation) does not specifically regulate insurance (it applies to *all* persons and organizations) and thus is not protected from ERISA pre-emption by ERISA's "insurance savings clause." But ERISA has been read not to preempt state malpractice actions against plans for their medical *treatment decisions*, on the ground that medical *treatment* is beyond the reach of ERISA's preemption of state law governing employee benefit plans. The line between plans' *coverage* and *treatment* decisions is fuzzy in practice, to say the least, in an era of frequent gatekeeping and other allocative decision making by clinical caretakers, and it is the subject of frequent litigation. State legislators can get around ERISA preemption of tort law by enacting statutes specifically requiring risk-bearing health plans to exercise reasonable care (or to adhere to some other standard) in making coverage decisions: such statutes would be protected by the "insurance savings clause." But employers could protect themselves from the cost of such liability by making coverage decisions themselves (which would withdraw "insurance savings clause" protection, since ERISA bars treating employers as insurers), rather than contracting them out to risk-bearing health plans. To the extent that employers do not do this, state legislators have the ability to enact coverage dispute resolution schemes that entail either traditional court remedies or administrative determination of plans' liability and/or coverage obligations.

Patient and Purchaser Empowerment

In the new world of managed health care, purchasers and consumers make choices at four levels. Purchasers, typically employers, select one or more health plans from which consumers, typically employees, must choose. Consumers then select plans from among the available options (quite limited except in the case of employers that participate in large health care purchasing alliances). Consumers then make choices between providers -- doctors and hospitals -- choices shaped to a greater or lesser extent by plan restrictions and financial incentives (e.g. in-network versus out-of-network reimbursement rates). Finally, as sick patients, consumers, choose to some degree from among treatments, restricted by what their doctors do and do not tell them, by coverage limits, and by participating providers' skills and available technologies. A central feature of this system is that "upstream" choices constrain subsequent, "downstream" options. Managed care enthusiasts embrace this system as the realization of a vision of purchaser and consumer empowerment -- to pre-commit to sensible limits while preserving a measure of "downstream" choice. Consumer activists and some biomedical ethicists complain that this scheme tramples upon traditional notions of patient autonomy and informed consent.

From a public oversight perspective, the adequacy of the available choices (and the information available to the choosers) at all four levels is of serious concern. Constraints on choice generally tighten as one moves downward along the socio-economic scale; Medicaid managed care enrollees face especially severe limits. The sufficiency of choice at the various levels is thus a social justice issue as well as a personal autonomy matter. The ethics of individual and collective pre-commitment to limits, in the face of inevitable scarcity, collide hard against cherished, rights-oriented thinking, enshrined in the law of informed consent and in our constitutional jurisprudence, about self-determination in regard to our bodies. This may well represent the deepest moral dilemma posed by the managed care revolution. Public policymaking concerning the adequacy of the choices available to purchasers and consumers must somehow accommodate the conflicting values and aspirations that frame this dilemma.