GETTING BEYOND THE MANAGED CARE BACKLASH

by Tom Miller and Gregory Conko

ANXIETY AND CONFUSION about the quality and limitations of managed health care are giving rise to new federal proposals for regulating the medical marketplace. Although the migration to managed care during the 1990s helped to restrain the rate of growth in health care costs, consumers increasingly resent the limits on covered treatments and fear rationing of medical services. Cost and quality seem to be on a collision course.

Several proposed regulatory "remedies" that emerged in the 105th Congress are back on Capitol Hill this year. The proposals would, for example, force health care providers to provide certain services or to collect and dispense specified information about their services. The proposals are intended to appeal to voters who are covered by employer-sponsored plans but face tighter restrictions on the options available to them under those plans. The proposals are also aimed at health care provider groups that are resisting restrictions on professional discretion and coverage within health care networks.

Tempting as these proposals may be, their adoption would simply create new problems by piling new regulations on an already overly regulated industry. The managed care backlash calls for a market-oriented remedy.

WHAT IS MANAGED CARE?

Traditional indemnity, or "fee-for-service," insurance reimburses doctors for each treatment covered by a patient's insurance plan. Fee-for-service insurance therefore offers an incentive to prescribe unnecessary or marginally beneficial treatments.

Managed care is the generic term for techniques and structures used by purchasers to hold health care providers accountable for cost as well as quality. Unlike fee-for-service insurance, managed care plans rely less on patient cost-sharing, through deductibles and co-payments, and more on provider incentives. There are four principal techniques for managing costs: capitation, gatekeeping, provider networks, and utilization management.

- Capitation. The provider receives a predetermined monthly or quarterly fee for every assigned enrollee. Physicians keep any money paid in excess of actual treatment costs, but they must cover expenses above the capped fees.
- Gatekeeping. The physician acts as the patient's personal doctor and also authorizes and controls the patient's access to other health care services covered by the plan.
- Provider networks. Some managed care plans create provider networks through careful selection and retention, dismissing those who do not meet their standards. A plan with a large enrollment can use its bargaining power to drive down the fees charged by those providers who sign up for the plan, to gain participation by those providers the plan wants to sign up, or to do both.
- Utilization management. UM is a technique for supervising the practice patterns of physicians to ensure that patients receive appropriate treatments in adequate quantities, as indicated by clinical studies. UM can encompass complete case management—pretreatment review, concurrent review, and retrospective claims review—using protocols to determine which treatments are most effective for a variety of conditions. Where the effectiveness of alternative treatments is not clearly determined, the least expensive one is usually indicated.

TYPES OF MANAGED CARE

Managed care models are differentiated by the controls they use. The best-known model is the Health Maintenance Organization (HMO). An HMO is a prepaid health plan that combines insurance coverage and health care facilities. The premium paid by (or for) enrollees gives them the benefit of being covered for nearly all types of health care services, with little or no cost sharing. The enrollee must usually choose a primary care physician (PCP), who acts as gatekeeper for the enrollee's access to other services covered by the plan.

Managed care plans come in several varieties: staff model, group model, network model, independent practice association, preferred provider organization, point-of-service, and open-ended.

- Staff model. A staff model HMO is tightly integrat-

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ed; it owns the facilities where treatment is administered and employs its primary care physicians, who are usually salaried. Staff physicians serve only the HMO's members, who must seek treatment in the HMO's facilities if the services are to be covered.

- Group model. A group model HMO differs from the staff model in that it contracts with independent, multispecialty group practices instead of hiring its own physicians.
- Network model and independent practice association (IPA). An enrollee in one of these HMOs is treated in the offices of private practitioners or associations of physicians retained under contract by the HMO. The doctors usually contract with several HMOs and may see non-HMO patients as well.
- Preferred provider organization (PPO). A PPO is a commercial firm that contracts with health plans to arrange a network of physicians and hospitals to plan enrollees. The PPO negotiates with providers for discounted fees.
- Point-of-service (POS) and open-ended. An enrollee in one these HMOs is expected to seek treatment from a primary care physician in the network, but the enrollee may "opt out" and see a non-HMO physician for a higher deductible or co-payment.

THE ROAD TO MANAGED CARE

The HMO and managed care are not new concepts. As far back as the 1930s, traditional staff/group-model HMOs such as Kaiser Permanente and Group Health Cooperative of Puget Sound have restricted patients to "one-stop-shopping clinics" and salaried physicians. But the autonomous-doctor model of traditional fee-for-service medicine continued to dominate health insurance markets through the 1970s.

In the fee-for-service regime, doctors generally drew on their sometimes out-of-date training and treated patients in the manner they thought best. Patients or their health insurers who paid all "usual and customary" claims rarely questioned the doctors' practices. Many studies, however, demonstrate that the fee-for-service regime "failed to protect patients from ineffective, inappropriate, and even dangerous care. . . . [M]ore than half of all medical treatment—and perhaps as much as 85 percent—has never been validated by a clinical trial" notes journalist Michael Millenson in a 1997 study, Beyond the Managed Care Backlash.

When it became clear that its costs would be higher than expected, Medicare began experimenting with a "health maintenance strategy" and allowing beneficiaries to choose between fee-for-service Medicare and HMOs. To encourage the growth of this still fledgling industry, Congress passed the Health Maintenance Organization Act of 1973, which established procedures for HMOs to become eligible to participate in the Medicare program and gain a federal "seal of approval." Other claims review standards were later developed to determine whether certain treatments should be reimbursed by the government and how much to pay for them. And in the late 1970s the National Blue Cross and Blue Shield Association (BC/BS) added utilization management strategies to its fee-for-service health plans.

It was not until the 1980s, as employers faced mounting insurance premiums, that the shift from unmanaged indemnity insurance to managed care accelerated. In 1987, 41 percent of employees in traditional fee-for-service plans were subject to some form of utilization management. That share had risen to 95 percent by 1990, according to the Employee Benefit Research Institute.

The American Medical Association reports that more than 90 percent of physicians are in practices that have at least one contract with a managed care organization. As of 1996, approximately 63 percent of Americans were enrolled in a managed care plan of some type. A June 1997 KPMG Peat Marwick survey of mid-size to large employers, Health Benefits in 1997, found that only 18 percent of their covered workers received care in conventional, fee-for-service plans and that only 2 percent of those plans had no precertification requirement.

MANAGED CARE AND COST CONTROL

Although health care costs can be hard to estimate, a number of studies have found that managed care plans significantly reduce both the use and price of health care services. The cost savings depend, in each instance, on the nature of the plan. A February 1995 Congressional Budget Office (CBO) study (The Effects of Managed Care and Managed Competition), taking fee-for-service plans incorporating UM practices as a benchmark, found a 34 percent reduction of inpatient days for group and staff model HMOs and a 7 percent reduction for IPAs. On the other hand, a 1991 study by Bryan Dowd and others, which compares IPAs and staff model HMOs with indemnity plans, found about the same utilization of physician services in HMOs and fee-for-service plans.

Even in managed indemnity arrangements, most of the cost savings have come from reduced inpatient utilization. Although outpatient visits and services have risen with the decline of inpatient treatment, outpatient services are usually less costly.

In a 1994 review paper, Robert Miller and Harold Luft found that, on average, HMOs could reduce the use of services that had less-costly alternatives by as much as 22 percent. In their 1997 update of the paper, Miller and Luft suggested that HMOs reduce the use of more costly tests and procedures, "often with little visible effect on quality of care." They concluded, further, that greater market penetration by HMOs has spillover effects: reduced indemnity insurance premiums and hospital resource use in the market as a whole.

A 1994 Congressional Budget Office (CBO) review of published literature (Effects of Managed Care: An Update) estimated the following cost reductions per member, taking unmanaged indemnity plans as the benchmark: 11.6 percent for group and staff model HMOs, 4 percent for indemnity plans with mature UM programs, 3.2 percent for IPAs and network model HMOs, and 2 percent for PPOs and POS plans. CBO's own empirical study, conducted in 1995, estimated that the use of services, on average,

is 7.8 percent lower for HMOs than for indemnity plans.

An October 1996 study by KPMG Peat Marwick (Health Benefits in 1996) found reductions in the rate of growth of premiums of managed care plans but not in the premiums of indemnity plans. However, a 1996 study by Paul Ginsburg and Jeremy Pickreign found that the premiums of fee-for-service plans were declining at about the same rate as the premiums of managed care plans, presumably because of the increasing use of managed care techniques by traditional insurance plans.

Some skeptics of managed care point to other factors behind the recent slowdown in the rate of growth for health care costs, and question whether managed care can sustain long-term reductions in the rate of cost growth. Further, PPOs, POS plans, and IPAs—the most rapidly growing sectors of the managed care industry—offer their enrollees the greatest latitude in choosing services and are the least capable of controlling costs.

COST-CUTTING AND QUALITY CONCERNS

Although lower premiums have attracted customers to managed care, many critics argue that the overemphasis on cost leads to skimping on marginally beneficial care and eventually reduces the overall quality of care. There has been extensive media coverage of anecdotal tales of patients suffering, and even dying, because treatment options were delayed or denied.

In theory, managed care protocols seek to ensure against the administration of inappropriate treatments. The empirical evidence suggests that the typical managed care plan is neither better nor worse than fee-for-service insurance at delivering "quality" care. In their comprehensive review of the managed care literature, Miller and Luft examined more than 90 empirical studies that compared the costs, enrollee satisfaction, and quality of HMOs and fee-for-service plans. They found broad variations in cost and quality, but concluded that, "fears that HMOs uniformly lead to worse quality of care are not supported by the evidence...." However, "hopes that HMOs would improve overall quality also are not supported." With respect to overall HMO performance, Miller and Luft found equal numbers of statistically significant positive and negative results for HMOs and non-HMO health plans. Generally, though, they found broad variations in the results for different health plans and different enrollee populations.

Managed care's greater emphasis on preventive treatment can benefit patients. HMOs, for example, perform more prenatal examinations, administer more inoculations, and conduct more cancer-screening tests for elderly enrollees than do indemnity plans. A 1994 study by Gerald Riley and others at the Health Care Financing Administration and the National Cancer Institute found that Medicare HMO enrollees who developed breast cancer, cervical cancer, colon cancer, and melanomas had their cancers diagnosed significantly earlier than Medicare fee-for-service patients.

Managed care physicians who are paid salaries or on a capitated basis have an incentive to prevent diseases and promote health. To the extent they believe that preventive care can ward off some illnesses and that early diagnosis can hold down treatment costs, they will perform more of those services.

Managed care protocols and practice guidelines also provide crucial information for busy doctors who are unable to keep up with the latest clinical research. Although those procedures are often criticized as "cookbook" medicine, doctors practicing under "the old guild structure of professional self-policing demonstrably failed to protect patients from ineffective, inappropriate, and even dangerous care," according to Millenson.

Case management can be very helpful in coordinating the care of patients with multiple conditions and ensuring that treatments for the various conditions—especially prescribed drugs—do not conflict.

Finally, managed care plans tend to offer more comprehensive benefits than traditional indemnity plans. In 1996, for instance, 94 percent of HMOs covered pharmacy services, typically with copayments of $10 or less. Many HMOs provide relatively generous prenatal and maternity benefits. Most HMOs and PPOs also cover childhood immunizations with minimal cost sharing.

However, certain groups of patients may not fare as well under managed care. A 1994 study by Dolores Clement and others found that Medicare HMO patients with chronic conditions were less likely than fee-for-service enrollees to see specialists, to have follow-up exams recommended, or to have their progress monitored. Although HMO enrollees with joint pain experienced complete elimination of symptoms at about the same rate as fee-for-service patients, they generally reported less symptomatic improvement. The authors could not determine whether reductions in ambulatory care services provided by HMOs were due to the more reasonable use of those services or to limits on beneficial care.

In 1995, CBO found that group and staff model HMOs and IPAs sometimes restrict access to specialists, with adverse effects for patients, especially those with conditions for which treatment norms are not well defined. And a 1993 study by Thomas Rice and others supports the conclusion that the restrictive practices of managed care pose special risks for persons in poor health, especially in low-income families. A 1996 study by John Ware and others of chronically ill patients found that declines in physical health among the elderly and poor were more than twice as likely in HMOs than in fee-for-service plans.

On balance, there is no clear evidence that points to better outcomes under managed care arrangements and worse outcomes under fee-for-service insurance, or vice versa. Interestingly, the poor and elderly populations that are most likely to encounter weaknesses in managed health care quality usually receive their insurance coverage through the highly regulated Medicare and Medicaid programs, which already provide beneficiaries extensive legal rights.

SEEKING POLITICAL REMEDIES

Pending Legislation. Despite evidence of the advantages of managed care, patients and provider groups have demanded changes. Two major approaches to comprehensive managed care reform came up in the 105th Congress: the "Patient Access to Responsible Care Act" (PARCA), advanced by Rep. Charles Norwood (R-Ga.) in the House, and the "Health Care Quality,

Education, Security, and Trust Act" (QUEST) in the Senate. Further, President Clinton was quick to support interim recommendations made in November 1997 by his Advisory Commission on Consumer Protection and Quality in the Health Care Industry for a wide-ranging "Consumer Bill of Rights and Responsibilities." In February 1998, the President ordered federal agencies to provide similar guarantees to beneficiaries of federal health programs, such as Medicare and Medicaid.

In the 106th Congress Rep. Norwood has reintroduced a variant of his legislation (H.R. 216). Further, there are Republican-sponsored bills in both the House and Senate: the "Patient Protection Act" (H.R. 448) and the "Patients' Bill of Rights Plus Act" (S. 300). House and Senate Democrats also have introduced their "Patients' Bill of Rights" (H.R. 358, S. 6).

H.R.448 and S.300 are quite similar to legislation offered by congressional Republicans last year that offered modified versions of PARCA-like and QUEST-like managed care reforms, but balked at expanding legal liability for employer-sponsored health plans under state law and limiting those plans' ability to determine whether insurance coverage for certain procedures and treatments is "medically necessary." S.300 would apply its "core" protections only to self-insured employer health plans, but extend its provisions for appeals processes to all employer-sponsored plans.

Information Disclosure, Data, and Quality Improvement. The President's advisory commission recommended the establishment of public- and private-sector advisory panels that would recommend ways to improve health care data collection and reporting and to track health care quality. Among other things, the Norwood bill (H.R. 216) would require providers to supply information about the benefits their health plans cover and exclude; the plans' utilization review procedures; the number, mix, and distribution of participating providers; and (by category and type of provider) both the ratio of enrollees to providers and the expenditures and utilization per enrollee. H.R. 216 would also mandate that health plans demonstrate measurable quality improvements. The Patient Protection Act and the Patients' Bill of Rights Plus Act would require disclosure of similar kinds of information.

Will government standards for data reporting help consumers judge which plans are best for them? Significant technical problems stand in the way of gathering and reporting useful and reliable data. To begin with, medical experts have been unable to produce truly valuable and reliable performance measures. Aside from that, not only do health plans vary widely in their details but the accuracy of information within databases is doubtful. A pervasive concern, regardless of the reporting scheme, is the confidentiality of information about individuals.

Even as political momentum builds for government mandates, health plans have sought, obtained, and distributed more information about health quality indicators and plan performance. Consumer satisfaction surveys, health plan "report cards," and private accreditation are the primary means by which to gauge the value of a plan.

Consumer surveys have produced mixed results. In their 1997 literature review, Miller and Luft found that HMO enrollees tended to be less satisfied than fee-for-service enrollees with the nonfinancial aspects of their plans, but more satisfied with the financial aspects.

By the early 1990s, a few states began requiring health plans to collect and report performance data in an easy to understand summary. But self-reported data on health plan quality may not always be reliable. Further, even when the information is verified, individual medical records and plan databases are not always sufficiently accurate or complete for report card purposes.

In addition, there is still disagreement over how to satisfy state standardization mandates. Moreover, some statewide systems have had difficulty conforming to national standards even when the data elements are unambiguous in definition and straightforward in coding.

Third-party health plan accrediting organizations have begun to fill the void of reliable information. Groups such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations perform quality audits of managed care plans based on internal data from plan records. Most of the rating criteria, however, are inputs—treatments or preventive measures—not outcomes, because inputs are easier to numerate and less difficult to misinterpret than outcomes.

The Foundation for Accountability (FACCT) was established in November 1995 specifically to measure and report health care quality outcomes in a manner that consumers and purchasers find easy to use. However, a report on the first performance measures in the *New England Journal of Medicine* (September 26, 1996) concluded that the project "seems no more focused on outcomes than do those of the NCQA—a reflection, perhaps, of the difficulty of the task."

Because they operate outside government mandates, the private groups can refine and adjust their evaluative techniques to meet the needs of their customers, the purchasers of health care plans. Increasingly, employers seek not just lower costs but engage in "value-based" purchasing that focuses on quality, cost, and the tradeoff between the two. The growing availability of accreditation and rating information has enabled employers to make decisions based on better information. Unfortunately, value-based purchasing is still mainly a large-firm phenomenon, and the emphasis on "quality data" remains quite limited in scope.

Government mandates for standardized information reporting conflict with the needs of purchasers, consumers, and their agents for more varied and customized information. Moreover, the various mandates now being considered could easily evolve into baseline statutory requirements for higher quality, more costly health care, accompanied by unnecessary administrative procedures. Ironically, because the most restrictive types of HMO-style health plans are already in a better position to gather information and collect data, such mandates would give them a competitive advantage over other health insurance arrangements.

Mandated Emergency and Specialty Care Coverage. All the major reform bills would require health plans to cover treatments administered in a hospital emergency room whenever a "prudent layperson" could reasonably expect the

absence of medical attention to place a person's health in serious jeopardy. The House Republican measure, however, adds a "prudent emergency medical professional" standard for the authorization of emergency services beyond screening exams.

The "prudent layperson" standard for emergency services may be politically popular but is likely to be ineffective at best. Drawing a line between urgent and nonurgent care is difficult even for professionals, who often face the problem of screening patients who come in for conditions that are routine or not life-threatening. The emergency care mandates would make it harder for managed care plans to control the moral hazard of patients who simply seek unwarranted, expensive care. The confusion would be compounded as juries in different communities interpret "reasonable" differently.

All of the reform plans before Congress would prohibit payment differentials for hospitals in a plan's network and those not in the network. This mandate would undermine the plan's efforts to maintain quality and negotiate price discounts.

Most of the bills before Congress would require plans to give consumers with medical conditions requiring frequent specialty care direct, in-network access to qualified specialists of their choice. Some states already have enacted such "direct access" laws.

Mandatory coverage of emergency care and specialty services could have an especially adverse effect on cost control for POS and PPO health plans, which have relatively weak utilization review mechanisms. Requiring plans to offer more providers and expand the range of covered services will raise costs, with the result that some consumers will not be able to afford coverage and others will choose not to pay for it.

Plan Choice and POS Option. The President's advisory commission urged that group purchasers provide members with a choice of health plans. Where group purchasers are not able to offer a choice, the commission recommends that they provide for "adequate input from employees in the development of the criteria and selection of the health plan to be offered." The Norwood bill would require plans that provide coverage of services through provider networks to offer enrollees the option of POS coverage, entitling them to see out-of-network doctors. Any additional premiums may not exceed what is "fair and reasonable" as determined by the applicable state regulatory body.

Although a POS mandate affords greater choice it can also lead to higher costs and premiums. A group health plan sponsor may be forced to split group members among two different plans. The POS mandate would also prevent a plan from guaranteeing doctors a captive customer base, diluting the plan's bargaining power in negotiations with providers. Moreover, the POS mandate would limit a plan's ability to control quality through compliance with clinical treatment protocols.

Finally, forcing an HMO to provide an open-ended product, which is much like indemnity care, would require it to make a host of costly organizational changes, to hire new processing personnel, and to develop methods for reimbursing non-network providers. The HMO would have to learn how to underwrite the indemnity portion of open-ended coverage and comply with various indemnity-specific state insurance regulations and capital requirements. The mandate could require the HMO to restructure financial incentives in existing provider contracts to reflect the HMO's reduced bargaining power and the fact that network providers no longer provide all covered care.

A 1994 study by Douglas Wholey and Jon Christianson suggests further that HMO enrollment growth, particularly group enrollment growth, might be reduced if all HMOs were required to offer an open-ended product. Enrollments would probably fall most among members of those plans whose sponsors selected HMOs primarily for cost savings. The upshot could be a reduction in the total insured population.

On the other hand, a December 1997 analysis by the Barents Group (Health Care Choices) of a KPMG Peat Marwick survey found that 56 percent of covered employees are offered a choice among health plans. Another 36 percent of covered employees are offered only one plan, but it is one that now allows enrollees to receive care from non-network providers (POS, PPO, or fee-for-service). The Barents Group therefore concludes—perhaps optimistically—that 92 percent of employees already have a choice between network and non-network providers. But more than half of all workers who are offered only an HMO plan work in firms with fewer than 200 employees, the very firms most likely to terminate all health insurance coverage if plan premiums rise too high.

Even in the absence of political mandates, more HMOs have been offering POS options (and increasing their costs). HMOs have been losing market share to PPOs in any event.

Utilization Management and Appeals. The President's commission concluded that more timely appeals processes could help to reduce the incidence of Americans harmed by "inappropriate" denials of health benefits. But the commission assumed an especially costly standard of care—any "service whose benefit is greater than its risk."

Under the Norwood bill, utilization review procedures would have to be developed "with the involvement of participating health professionals and providers." An internal review of the initial denial of coverage would have to be conducted by a physician who did not make the initial denial. Any external review to reconsider initial review decisions must involve one or more "independent medical experts" with recognized expertise in the applicable health care field. The Norwood bill also would set deadlines for reviews and require that patients be given written explanations of denials of coverage.

The Patients Bill of Rights Plus Act provides somewhat different time requirements for internal and external reviews. The Senate Republican measure also requires appropriate medical expertise and independence for physicians making internal reviews of coverage denials based on a lack of medical necessity or appropriateness, or on an experimental treatment. S.300 provides for further external review of such coverage denials in certain cases after internal appeals are completed (the amount involved exceeds a "significant financial threshold, or there is significant risk to the enrollee's life or health"). Coverage determinations by an external reviewer are binding upon the health plan or insurer.

The House Republican-backed Patient Protection Act requires appeals procedures similar to S.300. Health plans failing to comply with external appeals determinations could be fined up to $250,000 (as much as $1,000 per day for bad faith violations.)

A requirement that licensed providers make routine decisions about relatively uncomplicated and inexpensive treatment options can add needlessly to the cost of a health plan and divert professionals from the actual treatment of patients, simply to employ them as utilization managers. New requirements that health plans provide for additional methods of complaint resolution may be unnecessary and costly: health plans are now subject to legal requirements to provide adequate due process for enrollees, and most private-sector accrediting organizations require plans to maintain fair procedures for responding to consumer grievances.

Moreover, although health plans tend to make available summary descriptions of utilization management procedures, they are intent on preserving the secrecy of the proprietary details. To the extent that those details become available, providers can tailor their diagnoses to ensure coverage for their recommended treatments. The Norwood bill, however, would require public disclosure of the details of utilization management procedures.

FIXING LIABILITY FOR DAMAGES

The ERISA Preemption. Under the Employee Retirement Income Security Act of 1974, employer-sponsored pension and welfare benefit plans, including group health insurance plans, are exempt from some or all state regulation. Self-insured plans in which plan sponsors themselves pay claims are entirely exempt from state regulation, but fully insured plans in which the employer purchases coverage from a commercial insurer are subject to some laws indirectly through state regulation of their commercial insurers.

If an employee suffers serious health problems because of denial of coverage under an employer-sponsored health plan, the employee must seek redress in federal court. ERISA limits money damages from self-insured and insured plans to the cost of an improperly denied service. ERISA exempts all employer-sponsored health plans from punitive or compensatory damages in civil suits, brought under state law, that charge improper denial or processing of an employee's health coverage.

Although courts are carving out more exceptions to broad ERISA protection from state-based legal claims, they generally find that ERISA protects insurers and other third parties from tort liability and other state claims when they are performing services on behalf of an employer health plan. ERISA also prevents states from applying consumer protection laws, mandated benefit requirements, premium taxes, and other state-based insurance requirements to self-insured employer health plans.

With about 125 million Americans covered by health plans subject to ERISA, its preemption of state malpractice laws and state insurance regulation has been a major reason for the growth of managed care plans. During the last two decades, employers have increasingly turned to self-insurance in an effort to escape the indirect cost of state health insurance regulation, and about 40 percent of employer-sponsored ERISA plans are now self-insured.

The President's advisory commission was unable to agree on any new legal remedies and sidestepped the ERISA issue. But critics argue that ERISA unfairly shields insurers and self-insured employers from legal accountability for decisions that affect the lives of covered beneficiaries. The Norwood bill would revoke the portion of the ERISA pre-emption that prevents state laws from holding employer-based health plan insurers and plan administrators liable for personal injury or wrongful death damages. Employers or other group health plan sponsors would not lose this ERISA protection unless they "exercised discretionary authority to review and make decisions on claims for plan benefits," and a decision made by the sponsor resulted in those kinds of injuries. Insurers and plan administrators for employee health benefits plans who are held liable under the Norwood bill for damages under state law would not have a right of recovery or indemnity against employers or plans sponsors.

Employers and health plans contend that ERISA protections afford them the flexibility they need to hold down health care costs and provide essential benefits. ERISA protections also allow self-insured multistate employers to adopt uniform benefits packages instead of fine-tuning them to deal with a patchwork of state laws and regulations.

Employer groups emphasize that exposing their health plans to liability suits would undermine the ability and willingness of firms of all sizes, but especially smaller ones, to offer health insurance to their employees. Both the Patients' Bill of Rights Plus Act and the Patient Protection Act reject the right to sue employer-sponsored health plans for damages from delayed or denied benefits; the bills' authors rely instead on an expanded review process that limits the scope of potential damages.

More generally, there is the danger that revisiting ERISA's preemption provisions regarding liability would invite reconsideration of other ERISA-based protections against costly state benefit mandates and regulatory cross-subsidies.

A "Vicarious" Liability Argument. Duke law professor Clark Havighurst makes a more sophisticated case for extending "vicarious" liability to managed care organizations. Managed care plans usually require that physicians use certain treatments in certain situations. But a patient's health might suffer because in that patient's particular case the mandated treatment was not the best one available and a doctor, absent the mandate, might have used another treatment. Such might be a case of vicarious liability. Vicarious liability might also attach to a managed care plan because of negligence of providers acting under the auspices of the plan.

Havighurst argues that establishing the liability of managed care plans in such cases, either through court rulings or at the contractual initiative of managed care plans, would create incentives for quality control and place legal responsibility for both cost and quality in the same hands. The results would validate the political legitimacy of managed care insurers as private rationers of health services.

Havinghurst suggests that if exclusive, vicarious liability

were to become the "default" position under the legal system, managed care insurers and administrators might use ERISA protection more creatively as a shield against state restrictions on innovative approaches to medical liability issues. By accepting vicarious liability for the failure of their participating physicians to protect patient welfare within the health plan's own ERISA-protected administrative framework, a managed care plan could spell out and redefine its obligations to plan enrollees in the employee benefit plan itself. It could also contract away some or all of its legal responsibility to hospitals, other corporate providers, or patients' personal physicians.

ERISA protection should be retained against tort liability for improper denials of financing for potentially beneficial services ("unauthorized rationing" of benefits). Such matters are more appropriately dealt with as contractual issues.

THE MANAGED CARE INDUSTRY'S RESPONSE

In 1997, the campaign for expanded federal regulation elicited an initiative by the American Association of Health Plans (AAHP)—the industry organization representing HMOs, PPOs, and similar managed care plans—called "Putting Patients First." The initiative explicitly endorses a patient-centered approach to care, including disclosure to enrollees of information about plan structure, provider networks, covered benefits, and utilization management procedures. Every member company of AAHP must agree, as a condition of membership, to abide by the terms of the initiative.

Some critics of managed care contend that the AAHP initiative lacks the independent oversight and enforcement mechanisms needed for true accountability. A more subtle danger, however, is that industry self-policing will be too effective, that it will further centralize health care decisionmaking and stifle contractual choices about the style, intensity, and quality of health care services.

THE ROAD AHEAD

The danger posed by all of the proposed bills before Congress is that they will loose a new round of statutory guarantees and federal regulatory controls, impose more special-interest benefits, further politicize complex health care decisions, raise costs, restrict choices, and reduce private insurance coverage levels. During last year's congressional debate, PARCA critic former Rep. Harris Fawell (R-Ill.) pointed to its "mind-boggling" list of new government mandates, requirements, and regulations—"at least 336 new minimum federal statutory requirements"—and more than a thousand additional requirements that could be added by states. Given the federal government's past record in addressing health care quality issues, the assignment of such new responsibilities to Washington bureaucrats would be a triumph of hope over experience.

The conventional political response in opposition to greater regulation of managed care rests heavily on the argument that additional regulation will only make a bad situation worse, raise insurance costs, and reduce coverage levels. However, the battle of dueling cost estimates among rival lobbying coalitions largely has been fought to a draw. Moreover, the tactics of stalling for time and relying on preemptive concessions smack of plea bargaining in the face of the allegation that health plans have become too restrictive.

The managed care backlash needs to be challenged on a more fundamental level. There is no single qualitative standard of health care that can be guaranteed or imposed across the board. And even when it comes to health care, money does matter, to physicians and consumers alike.

"Managed care," after all, is not a uniform commodity. Current market trends are pushing most health plan issuers to loosen, not tighten, restrictions on physician choice. Health plans that impose costly administrative burdens which produce little, if any, improvement in the quality of care are losing both market share and profits.

Nevertheless, other aspects of health care policy continue to frustrate more flexible accommodations and tradeoffs in the insurance marketplace. Achieving the goal of value-driven consumer choice requires a more level playing field for health insurance purchasing arrangements. Today, workers who would prefer alternatives to their employers' health plans face substantially higher costs, due in large part to federal tax policy that favors employer group plans and ERISA's selective protection of self-insured employer plans from most forms of state regulation.

Applying various types of tax reform to health care—be it universal tax credits, extending tax deductibility to individuals, a flat tax or consumed income tax, or less restricted Medical Savings Accounts—might trigger greater medical cost inflation. But any of those reforms would give equitable tax relief to consumers who purchase health care without the advantage of the income tax exclusion for employer-provided insurance benefits. Most important, any such tax relief should reach beyond the uninsured and self-employed to include all workers who seek alternatives to their employers' group plans.

Even with more even-handed tax treatment, those who buy insurance coverage outside the workplace will continue to face significantly higher costs. Employer-sponsored group plans (particularly large ones) have substantial economies of scale that make them less costly to underwrite, market, and administer. Risk pools formed outside large firms and solely for the purchase of insurance tend to be less stable, more heterogeneous at entry, and less likely to be replenished with good risks.

The Patient Protection Act (H.R. 448) attempts to address some of those problems by authorizing new "HealthMarts" to provide additional insurance options for small employers and their employees. HealthMarts would offer annual open enrollment opportunities to shop for coverage, ERISA-style protection against state-level mandated benefits, and relief from state fictitious group laws. Unfortunately, the HealthMarts proposal is not properly structured to meet its goals. It applies counterproductive limits on health premium variation and opens vague opportunities for clumsy risk adjustment among participating plans (instead of allowing experience rating of new participants at the time of their entry into a HealthMart). H.R. 448 also fails to open HealthMarts to individual purchasers. It reflexively leaves up to an employer the key all-or-nothing decision whether to place all its workers in a

HealthMart as an exclusive group insurance option. The proposal also frustrates the use of incentives and multiyear commitments to keep consumers in the Healthmart pool. (A similar provision in H.R. 448 for association-sponsored health plans also might expand existing coverage options, but it suffers from some of the same restrictions—prohibiting experience rating of employer members and applying state-based rate regulation to small groups.)

Addressing the managed care backlash through means other than counterproductive legislation also will require private insurers and employer sponsors of health plans to improve the public's acceptance of their moral legitimacy. They must communicate more clearly the operation of their decision-making structures and incentives for cost containment and quality control. Insurers and employers must enlist their customers and employees as allies in a joint effort to retain the benefits of private sector innovation and flexibility against the camouflaged rigidities, distortions, and side effects of political micromanagement.

Current levels of disclosure can be enhanced more effectively through competition for consumers who are empowered to take their business elsewhere, rather than through a one-size-fits-all set of politicized disclosure regulations. The many smaller employers who cannot invest in quality-improvement programs can piggyback on the more sophisticated efforts of larger companies that signal differences among managed care operators and their practices, and which have positive spillover effects on quality throughout the health care system.

At its core, the politics of managed care regulation reflects a feeling of disempowerment on the part of consumers, who feel that they have little control over the decisions about quality and cost that affect their health care. Provider interest group pressures feed on the growing perception among consumers that their current choices are illusory or illegitimate.

The effort to empower consumers to choose and control the types of health plan and benefits packages for which they are willing to pay must begin with greater tax equity and new voluntary pooling options. But asking consumers to be more responsible also means that managed care insurers and self-insured employers will need to accept more accountability. Plan sponsors should provide more relevant disclosure of plan information during enrollment and re-enrollment periods, then be held legally responsible for their representations to plan subscribers. A more ambitious form of accountability would have insurers (and even employers) accept "vicarious" liability for medical malpractice (to the extent that they control and influence medical treatment decisions) in return for the contractual ability to bargain with providers and subscribers for liability transfers, reductions, and waivers.

In such an environment, private health plans could more effectively combine the financing and delivery of health care, particularly if they were to integrate physicians and plan administrators in less contentious and more cooperative relationships. Giving consumers a manageable range of options does not mean relying on centrally prescribed standards to determine rights and obligations in all transactions. Instead, it calls for health plans to adopt more imaginative contractual strategies that use sophisticated economizing techniques to offer different styles of medical care at different prices. Involving physicians more closely in the design and implementation of a plan's clinical policies is essential to the process.

Defenders of decentralized, voluntary health care decision-making also must challenge the moral authority of those who would impose standards that not only try to rule out the risk of bad decisions by free individuals, but effectively threaten to take away affordable health care options for many less affluent Americans.

Currently—within already burdensome regulatory restraints—purchasers of health care plans, patients, and practitioners are balancing and recalibrating the never-ending tension between cost, quality, and accessibility. More rounds of incremental regulation will cripple the effectiveness of any private-sector approach to health care plans and lead to a system that puts patients last.

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