

Issues of Quality and Consumer Rights in the Health Care Market

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- This *Issue Brief* describes how the structure of the health care market has changed in the recent years. It outlines the growth in managed care and the changes in the types of managed care plans available. In addition, it discusses the issue of quality in the health care market. It also includes an overview of the legislative topics and issues relating to quality and consumer rights that policymakers are currently considering.
- Growth in national health expenditures, the medical care price index, and employer health care costs has slowed significantly since 1990. This decreased growth has coincided with substantial increases in managed care plan enrollment. The percentage of employees enrolled in managed care plans increased from 48 percent to 85 percent from 1992 to 1997.
- Quality is a multidimensional concept. Although individuals may agree on its components, they may disagree on the relative importance of these components. Therefore, disagreement exists not only on how to measure quality but also on how it is defined. Consequently, policy decisions need to be based on an evaluation of a particular law's effect as opposed to its stated goal or intent. This distinction is important because a law that addresses access or consumer rights does not necessarily address the quality of care a consumer receives. Ultimately, whether an individual believes that a law truly addresses quality will depend in a large part on his or her subjective opinion of what quality entails.
- To date, 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 a negative way. In addition, it is important to note that the current debate on the quality of care provided in the health care market is not new to the present managed care era.
- The regulations and mandates discussed in this report would not guarantee increased quality in the health care market, unless quality is defined as easier access for those with health insurance. However, if quality is defined as the success of the outcomes of health services provided, the effect of these regulations on quality is in need of further research. Yet, the regulations would have some impact on the costs of health benefits and insurance. This impact has been estimated to be relatively small to substantial, depending on the interpretation of the mandates and assumptions derived from that interpretation. Regardless of the magnitude of the estimated increases, some research has shown that these regulations could have serious implications for the likelihood of small businesses offering health benefits.
- While these health plan regulations' effect on quality depends on one's definition of quality, costs would increase regardless of the definition one uses. Consequently, these regulations would come at a price. Thus, legislators must decide between: (a) imposing regulation that would increase access and consumer "rights" for those with insurance but would be of questionable value to the quality of outcomes, and (b) allowing existing market forces to improve quality through experimentation and competitive forces.

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Introduction

In the last decade, substantial changes have occurred in the health care

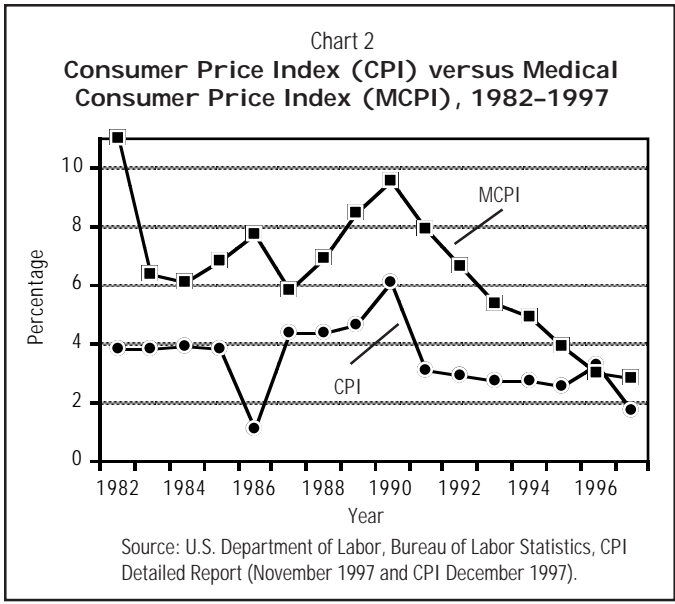
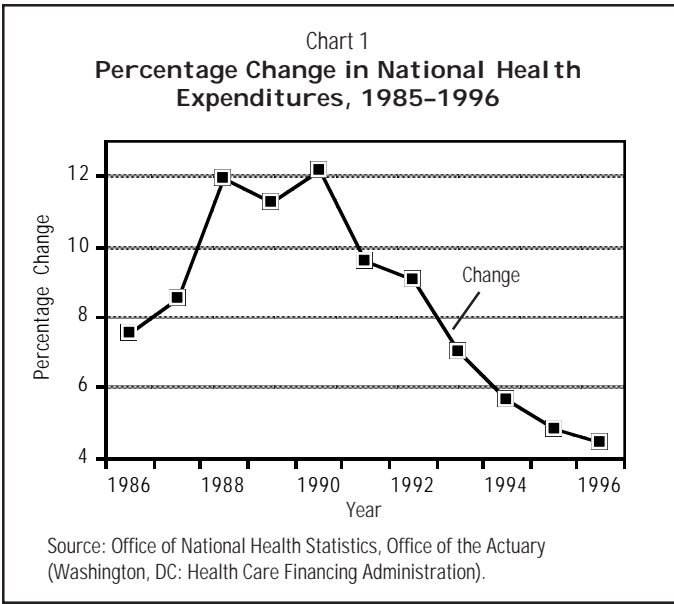
market. Many of these changes were prompted by employers who were no longer able or willing to accept the relatively large annual increases in medical care costs during the late 1980s and early 1990s. The fee-for-service system of reimbursing health care providers was one of the causes attributed to these substantial increases.¹ Under this system, providers were reimbursed retrospectively for the services they performed. Thus, providers did not have economic incentives to control costs or to perform only services for which the benefits outweighed the costs or risks. In addition, the fee-for-service system tended to focus on the treatment of illnesses as opposed to their prevention. As employers searched for methods to reduce annual health care cost increases to a manageable level, they turned to managed care as their vehicle for providing health benefits to their employees. They embraced managed care because under this system providers have financial incentives to control costs, since the payments to providers, including a capitated payment (a fixed fee to cover all services provided), salaries, or bonuses, are structured to reward an efficient level of care. Furthermore, managed care organizations (MCOs) have developed guidelines for the treatment of various illnesses to promote more efficient care. These incentives and guidelines, designed to reduce expenditures for unnecessary utilization, have been primary factors in the success attributed to managed care. This system in turn has led to significantly smaller increases in medical care costs in recent years. Today, managed care plans have become the overwhelmingly

dominant type of health care coverage for the nonelderly population (individuals under age 65) because of their success in controlling costs.

Despite its success in slowing increases in medical care costs, managed care has come under intense scrutiny. Physicians, consumer advocates, and some policymakers believe that part of managed care's success in controlling costs has been achieved by denying necessary medical services. In addition, many consumer advocates contend that employers and health plans are more concerned with reducing costs than with increasing the quality of care provided. Consequently, policymakers have responded by introducing numerous legislative proposals at both the state and federal levels to regulate the operation of managed care plans. However, employers and MCOs argue that managed care has maintained health care quality while eliminating much of the wasteful spending in the health care market. In fact, research thus far shows that managed care plans, as a whole, provide quality of care equal to that provided in fee-for-service plans (Miller and Luft, 1994 and 1997). Furthermore, employers contend that managed care's success in reducing costs has allowed them to continue to provide health benefits for their employees. Yet, due to the perceived lower quality of care that some believe is provided by managed care plans, many employers require these plans to prove that they provide high quality health care. These demands have focused an increased level of attention in the marketplace on the development of quality measures that both employers and consumers will find easy to understand.

This *Issue Brief* describes how the structure of the health care market has changed in recent years. It outlines the growth in managed care and the changes in the types of managed care plans available. In addition, it discusses the issue of quality in the health care market. It also includes an overview of the legislative topics and issues relating to quality and consumer rights in the health care market that policymakers are presently considering. These topics and issues involve ERISA preemption, privacy laws, and regulations of health

¹ The tremendous growth in technological innovations in health care is another important cause attributed to the increases in medical care costs. However, some analysts argue that the fee-for-service system allowed much of the new technology to be adopted.



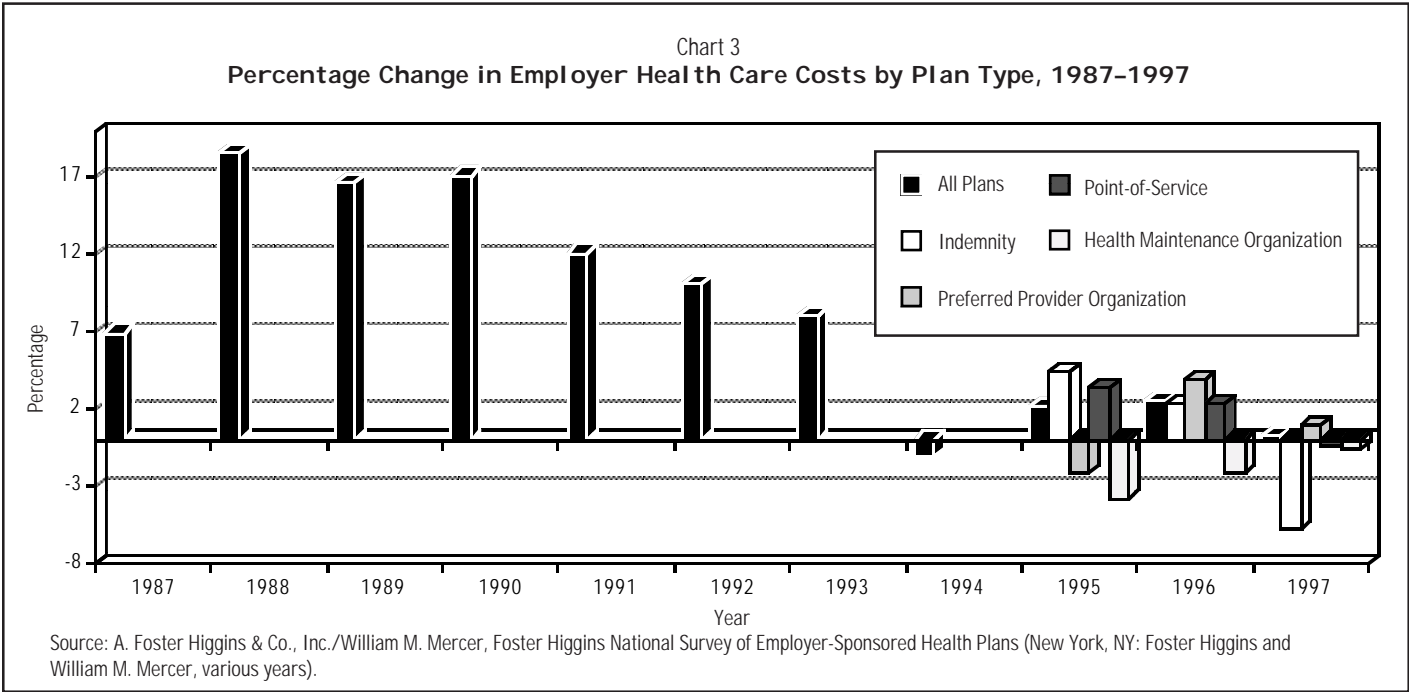
plans, commonly referred to as consumer protection or anti-managed care initiatives by the various groups involved in this debate.

Costs and Market Shares

High annual growth in medical care costs during most of the 1980s moti-

vated extensive changes in the health care market. However, in recent years, these increasing costs have slowed considerably. National health expenditures, a

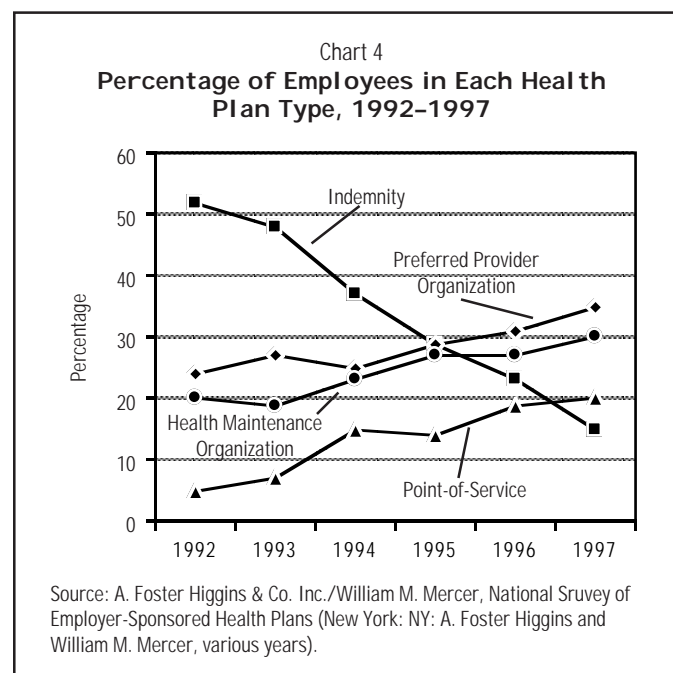
measure of cost and utilization, experienced low double-digit percentage growth in the late 1980s and early 1990s, but the growth has moderated to mid-single digits (chart 1). During the late 1980s and early 1990s, the medical care inflation rate was approximately twice the general inflation rate. This trend has since changed as the medical care inflation rate and the general inflation rate have converged, with the former now standing at low single digit percentage growth (chart 2). Employer health care costs were also increasing substantially during the late 1980s and early 1990s. Yet, by the middle 1990s, increases in costs had fallen to low single-digit percentage growth, with various plan types experiencing



actual cost reductions during some years (chart 3). The expansion of managed care has coincided with the reduced growth in health expenditures, medical care inflation, and employer health care costs. As late as 1992, when national health expenditures increased 9.1 percent, fee-for-service indemnity plans enrolled the majority of employees (52 percent). By 1997, indemnity plans covered only 15 percent of employees, while health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service plans (POSS)—all of which are considered managed care plans—each enrolled at least 20 percent of employees. PPOs, which covered 24 percent of employees in 1992, expanded to 34 percent in 1997. HMOs' market share grew to 30 percent from 20 percent during the same time, while POSS' market share increased from 5 percent to 20 percent (chart 4).²

Now that managed care plans have become so overwhelmingly dominant in the health insurance market, it is vitally important for individuals to understand them. Broadly defined, managed care is any intervention in the provision of health care services or reimbursement of health care providers that is intended to provide health care services in the most efficient setting. However, this definition could include some indemnity plans that employ utilization review. Thus, a more narrow definition of managed care would also entail the use of some explicit financial incentive to encourage patients to see a certain panel of providers. The term *managed care* is often used interchangeably with the term *health maintenance organization*. However, HMOs are just one of the various types of managed care plans. HMOs were the original and typically the most restrictive form of managed care, while PPOs and POSS are the other major forms of managed care.

Traditional HMOs have a closed panel of providers, which is set up as a staff, group, or independent practice association (IPA) model. The physicians work either directly for the HMO (staff) or their services are contracted for by the HMO according to certain criteria (group and IPAs). The physicians are generally given



financial incentives (bonuses, withholds) for meeting cost, quality, and/or patient satisfaction goals and guidelines or protocols to practice in ways a panel of physicians or the physicians of the HMO determine are best. The traditional HMO emphasizes preventive care and providing a more efficient level of care. Originally, HMOs started out as staff model HMOs. However, for-profit IPAs account for most of the current HMO growth. The growth of IPA model HMOs can be attributed to their ease of development and limited need of new HMO-owned facilities. For-profit HMO expansion appears to derive from easier access to the capital market for this type of model relative to the not-for-profit HMO (Gabel 1997).

As managed care plans continued to gain market share and appeared to be able to control costs, employers looked at other types of MCOs that were less restrictive in the choice of providers than HMOs but were still able to control costs. PPOs fit this desire. While PPOs retain the traditional fee-for-service plan feature of reimbursing for the use of any health care provider, they do not restrict patients to in-network providers to be reimbursed.³ At the same time, PPOs provide incentives for patients to seek treatment from providers under contract with the PPO by paying a higher percentage of the patients' bill when they use an in-network provider than

² The percentages may not add up to 100 percent due to rounding.

³ Some PPOs employ a gatekeeper mechanism to obtain referrals. Thus, enrollees would have to receive a referral from a primary care physician before seeing a specialist, but the enrollee would not be required to see a certain panel of specialists to receive reimbursement.

Some policymakers and consumer advocates believe that some of managed care's success in reducing costs has been achieved by denying coverage for medically necessary services or cutting back on the quality of services provided.

they would pay for using an out-of-network provider. PPOs are able to achieve cost savings because they are able to negotiate price discounts with providers in return for the PPO referring more patients to them. Thus, PPO patients may choose their own provider, but pay more to go out of the network.

Greater freedom to choose a provider is one of the major reasons attributed to PPOs' growth. Ease of start-up is another major reason for their expansion. To start a PPO, an organization only needs to contract with selected providers. PPOs do not require expensive investments related to owning and operating facilities, as do some HMOs.

As PPOs gained market share in the managed care market, many HMO managers responded by offering an out-of-network provider option in many of their plans. These plans are called point-of-service plans (POSs). POSs are basically HMOs that allow patients to see out-of-network providers and still receive reimbursement for the care, but at a lower rate than they would receive for an in-network provider. This makes them similar to PPOs.⁴ Thus, as HMOs have increased their use of POSs, the distinction between the various types of MCOs has become blurred.

Managed care plans' apparent success in controlling costs can be attributed to their methods of reducing wasteful spending and their ability to negotiate discounts. To reduce wasteful spending, plans employ utilization review to determine if procedures are medically necessary, develop guidelines for effective and efficient treatments of various illnesses, provide feedback to physicians on their success and efficiency in treating patients as well as their patients' satisfaction, and institute disease management programs that detect and treat costly illnesses. Plans also obtain discounts from

providers in return for increased patient volume. In addition, plans update their provider networks based on the quality, cost, and patient satisfaction of providers through a provider selection process. Thus, managed care plans have forced the health care sector to be

more efficient and competitive.

However, some policymakers and consumer advocates believe that some of managed care's success in reducing costs has been achieved by denying coverage for medically necessary services or cutting back on the quality of services provided. Consequently, attempts have been made at both the federal and state levels to increase regulation of managed care plans. In fact, a record amount of health care legislation has been introduced and passed in the last few years at both the state and federal levels. Some employers have also responded to this concern by developing strategies to determine the value they are receiving from various health plans. These employers helped develop and now use quality measures such as the Health Plan Employer Data and Information Set (HEDIS) to evaluate the quality of plans before offering them to their employees. This insistence on quality has pressured managed care plans to place more emphasis on meeting certain quality criteria that these measures estimate, rather than solely focusing on premiums.

As the focus of the health care market has turned to quality, many analysts warn that managed care has eliminated the wasteful spending that was easy to identify. Therefore, any further success in controlling costs is going to be difficult. Consequently, many analysts now predict an increase in medical care inflation. However, the magnitude of the increase is not expected to be as large as the increases in the late 1980s. In fact, as shown in chart 2, the medical care inflation rate is beginning to increase more rapidly again than the general inflation rate. Thus, any additional regulations or further emphasis on quality without regard to cost

⁴ However, MCOs suggest that changing an HMO from a closed network of physicians to an open network could cause tremendous organizational challenges for an HMO that could affect the product's viability.

could force medical care costs upward to levels at which some employers would decide they are no longer able to offer health benefits.⁵

Quality⁶

The perception that health care costs are under control and/or that MCOs reduce costs by

denying necessary care has led many health care market observers to question the quality these plans provide. However, once the discussion of health care turns to quality, a question arises about the definition and measurement of quality in the health care market. Quality is a multidimensional concept. Thus, even though individuals may agree on its components, they may disagree on the relative importance of these components. Therefore, analysts disagree not only on how to measure quality but also on how it is defined. Consequently, policy decisions need to be based on an evaluation of a particular law's actual effect as opposed to its stated goal or intent. This distinction is important because a law that addresses access to health care or consumer rights does not necessarily address the quality of care a consumer receives. Ultimately, whether a law is truly believed to address quality will depend in a large part on an individual's subjective opinion of what quality entails.

Defining Quality

Some individuals equate access with quality. If they can choose freely among providers, they believe they are

receiving quality health care. However, these consumers may not choose the providers who can treat them most effectively, whereas a managed care plan may provide an incentive for the consumer to use providers who are better qualified to treat them. However, the reverse situation could occur. Other individuals would include in their definition of quality how respectfully their providers deal with them. Here again, an individual's satisfaction may not directly correlate with receiving the most appropriate care for a diagnosis or even a proper diagnosis. Consequently, the outcomes of patients' treatments are widely believed to be the best indicator of the quality of health care services provided. A high quality episode of health treatment would involve being treated according to a method that restores the individual to his previous health status in the shortest amount of time at the lowest level of risk. Even under this definition, there is no clear way to measure quality because different individuals respond to treatments in different ways. Thus, it is difficult to agree on one definition of quality that fits all circumstances, making the measurement of quality extremely complex.

Measuring Quality

Studies that attempt to measure quality can be classified into three categories: structure, process, and outcomes (Donabedian, 1988). Studies of structure examine the characteristics of health care providers or institutions, such as the providers' credentials or the hospitals' teaching status. In process studies, the methods that providers use to make treatment decisions are evaluated, e.g., through the investigation of the use of specific protocols or appropriateness of a treatment. The analysis of outcomes measures the resulting health status of patients or patient satisfaction levels. However, due to these various dimensions of quality, a complete measure of quality must evaluate all of these dimensions if it is to provide a clear picture of the health care provided. Thus, a measure of quality based on structure is not worthwhile if it cannot be shown to lead to superior outcomes,

⁵ Costs are not the only factor in an employer's determination to provide health benefits. The ability to attract and retain employees is also an important factor. Thus, with an increase in the unemployment rate, employers will find it less necessary to offer health benefits. The opposite would be true as well.

⁶ For a more thorough discussion of quality in the health care market, see Custer (1995). This section draws from that report.

while an outcome measure is not complete if the process that was used to achieve the outcome is unknown.

Progress is being made in measuring the quality of care provided in managed care plans. The National Committee for Quality Assurance (NCQA) has continued to refine HEDIS to provide a multidimensional report card of the quality in managed care plans. HEDIS allows health plan purchasers to compare the quality of managed care plans that use this report card. Currently, HEDIS focuses on structure and process measures of quality. However, as advances in outcome measures occur, HEDIS has expanded its reliance on these measures. These advances are difficult because a large number of factors can affect the outcome of a health care treatment, and the need to control for all of these factors exists when comparing plans and providers on outcomes. A significant drawback to HEDIS-type report card measures of quality is that while they lead plans and providers to focus resources on the factors that are measured, they do not measure other important factors. Consequently, any report card of this type must balance comprehensiveness against understandability, so that purchasers get an accurate picture of the quality a certain plan provides in a manner that is easy to understand.

Quality of Managed Care Plans

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 a negative way. As a review by Miller and Luft (1997) of various studies comparing the quality of HMOs versus fee-for-service plans points out, "HMOs produce better, the same, and worse quality of care, depending on the particular organization and particular disease." Thus, HMOs are not low or high providers of quality per se, but range from good to poor and have strengths and weaknesses in the care of particular diseases.⁷ Therefore, 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.

It is important to note that the current debate on the quality of care provided in the health care market is not new to the present managed care era. As Millenson (1997) points out, *The New York Times* ran features on the failings of doctors and hospitals in the United States in 1976, and a 1982 President's Commission report⁸ concluded that as much as 35 percent of some high-tech hospital care was unnecessary. Thus, Millenson concludes "deep public dissatisfaction with unfettered doctor and hospital autonomy led to the explosive growth in managed care in the first place."

Quality and Regulation of Health Plans

Proponents of the various health plan regulations to be discussed in this report argue that these regulations would increase the quality of health care. However, if these regulations are to truly be considered quality of care measures, they should guarantee that health care consumers will receive a higher quality of health care. These regulations might lower obstacles to access to certain types of care that insured individuals may or may not need. The regulations might also increase insured individuals' satisfaction. In addition, health care providers would gain protection from various techniques that some MCOs use to influence the way providers practice medicine. Yet, the regulations would do very little to ensure improvements in the outcomes of health care treatments administered by medical providers. Therefore, policymakers need to understand the effects, if any, these regulations would have on the level of quality in the health care market.

Access, consumer satisfaction, and provider protections are important components of the health care

⁷ *There appears to be some limited evidence that HMOs provide lower quality of care for chronic physical conditions. However, this has not been universally demonstrated (Miller and Luft, 1997).*

⁸ *President's Commission for the Study of Ethical Problems in Medical and Biological and Behavioral Research.*

market, but improvements in these components would not necessarily improve the overall quality of health care. However, they would increase costs, which could have serious consequences for the number of uninsured individuals. Although estimates of the impact of the cost increases on the number of uninsured have not been developed for most of these consumer “rights” proposals, the Congressional Budget Office (CBO) estimated that for a mental health parity amendment in H.R. 3103 (introduced in 1996) a 4 percent increase in health insurance premiums would lead to 800,000 fewer people having health insurance.⁹ In a general analysis of increases in health insurance premiums for employers, The Lewin Group estimates that a 1 percent increase in employer premiums would lead to an additional 400,000 individuals being uninsured. Thus, if regulating health plans has the potential of creating even small cost increases, a significant number of people could potentially lose health insurance coverage. Consequently, access could be reduced for some in order to increase the satisfaction of those who still have insurance. In addition, health plans and their sponsors contend that these regulations would reduce quality, because plans and sponsors would have limited ability to steer patients to higher quality providers and to enforce protocols that have proven to be the most effective methods for treating various diseases.

Regulations and Issues

financing, and delivery of health care. These changes have prompted discussion of the potential need for additional consumer protections or rights within this new structure. Health care consumers have expressed concerns about restrictions on their access to physicians and to other forms of care (e.g., emergency room care, experimental treatments) as well as their ability to

Managed care's new dominance in the health care market has changed the organization,

dispute denied claims or services. In addition, potential limitations on providers, such as so-called “gag rules” and network participation rules, have also come under scrutiny, because they have the potential to undermine the physician/patient relationship.

In response to consumers' real or perceived negative reactions to managed care, state lawmakers have proposed and passed many laws or regulations that claim to provide protections for managed care plan participants and to increase the quality of care. These measures are commonly referred to as anti-managed-care legislation by the managed care industry, because they would limit or forbid certain activities that are thought to be used by managed care plans while forcing the plans to perform new or additional activities. State lawmakers introduced over 1,000 bills relating to health plans by mid-year 1997, of which 20 percent were enacted (Healthcare Trends Report, 1998). Federal lawmakers have also introduced legislation in this area, using either single-issue proposals or comprehensive packages such as the Patient Access to Responsible Care Act (PARCA) (S. 644/H.R. 1415) introduced by Rep. Charlie Norwood (R-GA) and Sen. Alfonse D'Amato (R-NY). The remainder of this section discusses the types of managed care plan regulations that have been proposed or finalized at both the state and federal levels. Table 1 includes a summary by state of the more prominent health plan regulations enacted.

ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) created limitations on states' ability to regulate all employment-based health plans. ERISA preempts all state laws and regulations that “relate to” employee benefit plans, but it “saves” regulation of the “business of

⁹ The CBO has subsequently cautioned that this estimate cannot be generalized to all mandates on health insurance, because people may place different values on other mandates, which would affect the number of employers continuing to offer health insurance and the number of people taking it up.

Table 1
Prominent Regulations on 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.	POS	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		Mat.			
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							

Sources: 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 organization; Regul.=regulation; Rx=pharmacies; * =enforced by regulation.

insurance” to the states. However, the statute prevents states from “deeming” self-funded health benefit plans to be in the “business of insurance” for the purposes of state regulation. Consequently, states only have regulatory

authority over the health insurance or HMO contracts issued in that particular state. They cannot regulate self-funded plans, because an employer that self-funds a health benefit plan pays for its participants’ health care

In an attempt to eliminate the ambiguities between what individuals and health plans consider an emergency, consumer groups are calling for establishing a standard definition of the need for emergency room care.

claims directly out of its own revenues or assets instead of transferring the risk of covering claims to a health insurance company or an HMO. Thus, the regulation of self-funded plans is left strictly to the federal government. Therefore, it is important to note that if any of the health plan regulations discussed in this section are issued by the states, they would not apply to self-funded plans under the current federal regulatory framework. However, any regulations enforced at the federal level would apply to self-funded plans as well as insured plans.¹⁰

Emergency Care Coverage

Disagreements between consumers and health plans arise in some instances about what constitutes an emergency need for care. The most commonly cited anecdotal example is when an individual goes to the emergency room with chest pains thinking that he or she is having a heart attack, while the problem is actually just heartburn. Even though the individual seriously thought this was a life-threatening situation, a plan could consider this not an emergency because of the resulting diagnosis. Consequently, the plan would not cover the cost of the emergency room services, and the individual would then have to pay for the care out-of-pocket. In many cases, health plans argue that this kind of situation arises because they only receive the diagnosis, not the symptoms. Therefore, the plan makes its decision based on the information received. Furthermore, emergency rooms have traditionally provided a high level of care that would more appropriately be provided in a doctor's office. Thus, managed care plans provide patients with incentives to seek care on a preventive basis as opposed to care in an emergency room.

In an attempt to eliminate the ambiguities between what individuals and health plans consider an emergency, consumer groups are calling for establishing a standard definition of the need for emergency room

care. The definition that most lawmakers have proposed or established is the "prudent layperson" definition. Under this definition, the basis for an emergency would be determined by what an average person reasonably thinks constitutes an emergency, given his or her condition. Thus,

consumers acting out of real perceived need for emergency care would not be retroactively billed for the full costs of emergency room services.¹¹ In response to this concern, the American Association of Health Plans (AAHP), a group that represents managed care plans, has issued its own guidelines for health plans. AAHP has adopted a policy that says an emergency occurs when it reasonably appears to constitute an emergency from the presenting symptoms (Physician Payment Review Commission, 1997). The differences between these definitions and the resulting interpretations are unclear. Rep. Ben Cardin (D-MD) and Sen. Barbara Mikulski (D-MD) introduced legislation (Access to Emergency Medical Services Act of 1997, H.R. 815/S. 356) that would designate the "prudent layperson" definition as the standard to determine coverage for emergency care. In addition, this legislation would forbid any prior authorization for emergency room services. PARCA also contains a provision stipulating the "prudent layperson" definition for emergency room care. Medicare already requires the prudent layperson definition for managed care plans.

Direct Access

Some managed care plans require a primary care physician to act as a gatekeeper to determine whether a patient needs to be referred to a specialist. This type of

¹⁰ See Copeland and Pierron (1998) for more details about ERISA and health plans.

¹¹ Again, the perceived need would still have to meet the "prudent layperson" definition.

arrangement allows health plans to encourage the appropriate use of physicians by having a primary care physician treat general illnesses, while reserving specialist use for complex ailments. However, under this system, some patients feel that they are not receiving all the care that they should receive, particularly if they are denied a referral. In response to the negative reaction to this system, several states have proposed and/or enacted laws that require direct access to certain types of specialists within a managed care plan's network. These laws either give primary care status to certain specialties (e.g., obstetrician-gynecologist) or allow the patient direct access to certain specialties. The most common specialties that have been proposed or have been granted direct access by patients are obstetrician-gynecologists, dermatologists, ophthalmologists, psychiatrists, and, in some cases, chiropractors.

Managed care plans have also been responding to concerns regarding direct access even in states without such laws. One survey found that 81 percent of HMOs allow obstetrician-gynecologists to be considered primary care physicians or allow patients to self-refer to them (Physician Payment Review Commission, 1997). Some plans have developed "standing referrals" for patients who require frequent specialty use over a course of treatment. In addition, plans have developed "open access" products that allow patients to visit specialists directly. Health plans consider direct access laws to be protections for specialists, allowing them to have unrestricted access to any potential patient. They argue that these laws will not increase the quality of care but only result in increased costs, because patients who really need care from a specialist are receiving it without direct access laws. However, the President's Advisory Commission recommended that consumers who require frequent specialty care for complex or serious medical conditions should have direct access to network specialists for the treatment of their particular medical condition. Although if authorization is required, a necessary number of direct access visits under an approved treatment plan is recommended.

Any-Willing-Provider Laws and Freedom-of-Choice Laws

States first attempted to allow patients access to any provider through the use of any-willing-provider laws. These laws force managed care plans to allow into their network any qualified provider who is willing to accept the terms and conditions of the managed care plan's contract, whereas freedom-of-choice laws allow individuals to choose the provider, not the provider to choose the plan. Since any-willing-provider laws leave the choice up to the providers rather than the individuals, these laws lost popularity relative to freedom-of-choice laws that provide choice for individual health care consumers.

The any-willing-provider laws that were enacted vary in their extent of application to providers. Some laws mandate that all providers who are willing to accept the plan's conditions be allowed into the network, while others pertain only to pharmacy services. Furthermore, the types of managed care plans that are affected by these laws vary across states. Both HMOs and PPOs are included in certain states while only PPOs are included in other states. In addition, group model and staff model HMOs, but not IPAs, are excluded in some states. Thus, the range of the laws varies widely, which means that the implications of the laws vary widely.

Any-willing-provider law advocates believe that allowing enrollees in managed care plans to choose their providers and the possibility of continuing care with previous providers would result in higher quality of care for these enrollees. Advocates further argue that any-willing-provider laws would not increase costs, since the provider must accept the plan's terms. However, critics of any-willing-provider laws contend that costs would increase because processing claims from many different providers would involve higher administrative costs and plans would not be able to obtain volume discounts if patients are spread over many providers. In addition, critics of these laws suggest that quality of care would suffer because the plan would not be able to monitor or supervise the care administered by the numerous

Managed care plans have criticized freedom-of-choice laws. They argue that these laws increase costs and lower the plans' ability to ensure superior quality of care.

potential providers.

Various studies have examined the costs of any-willing-provider laws. Studies sponsored by the managed care industry conclude that these laws would result in higher costs and premiums for health plans (Lewin-VHI, Inc., 1995; Wyatt Company, 1991; Atkinson & Company, 1994; Rogers, 1994), while a study by the American Medical Association (AMA) questions these findings (Simon, 1994). In addition, Hellinger (1995) points out that each of the industry-sponsored studies has serious limitations. Consequently, the evidence for the claim that any-willing-provider laws damage managed care plans' ability to control costs may actually be exaggerated. None of these studies examined these laws' effects on the quality of care. Further research is needed to fully understand the effects of any-willing-provider laws on costs and quality. However, the research may be unnecessary, since the Supreme Court denied review of the case, *Texas Pharmacy Association v. Prudential Insurance Company*, in which the Fifth Circuit Court of Appeals ruled that an any-willing-provider law was preempted by ERISA, and states have been moving to legislate choice by other means.

Some states have addressed access to any provider through freedom-of-choice laws. These laws generally require plans to cover the costs of out-of-network providers without reducing consumers' coverage if the level of payment from the insurer is acceptable to the provider. Despite some consumers' strong belief that nothing should obstruct their ability to choose the provider that best meets their needs, a survey conducted by the Center for Studying Health System Change estimates that 58 percent of Americans are strongly or somewhat willing to accept limited choice of providers in exchange for lower health care costs. This percentage becomes even higher when the respondents are younger or poorer individuals (Tau and Cunningham, 1997). This may explain why most freedom-of-choice laws have been quite limited. Specifically, many freedom-of-choice laws apply only to pharmacies, while others include only

certain specialists. In addition, freedom-of-choice laws do not affect all forms of managed care plans.

Managed care plans have criticized freedom-of-choice laws. They argue that these laws increase costs and lower the plans' ability to ensure superior quality of care. They contend that these laws increase plans' costs because providers have less incentive to concede to price concessions, as plans are not able to guarantee extra patient volume to offset these concessions. Furthermore, if patients are free to choose among numerous providers, it is nearly impossible for the plan to monitor the quality of each of these providers. Thus, health plans would be unable to determine which providers exhibit superior quality.

Point-of-Service Option Laws

Partly in response to the criticism relating to any-willing-provider and freedom-of-choice laws, states have moved toward point-of-service option laws as a way of allowing patients more freedom of choice. In fact, in 1997 the laws passed addressing freedom of choice were mainly point-of-service option laws. PARCA also contains a point-of-service option provision. These laws typically require managed care plans and employers that only have closed-network provider plans to offer a point-of-service option in which enrollees can use out-of-network providers without being subject to a substantially reduced reimbursement rate. The proposed and passed state point-of-service option laws have placed varying limits on how much reimbursement rates can differ between out-of-network providers and in-network providers for the point-of-service option as well as limits on the premiums of the point-of-service option relative to the closed-panel plan. PARCA does not allow any differences in reimbursement rates for out-of-network providers. PARCA also allows states to limit the differences in premiums between the point-of-service option and the closed-panel option. Health plans and employers are concerned that if the difference between the reim-

bursement rates of out-of-network providers and in-network providers is small, the plan will just become a fee-for-service plan, and all the costs savings of managed care plans would be lost. This outcome would be exacerbated if the premiums between the two types of plans were required to be nearly equivalent.

The need for point-of-service laws or choice in health plans has come under debate. The Barents Group, in a report commissioned by AAHP, determined that 92 percent of workers are offered a health plan without a closed panel of providers (e.g., either a PPO, POS, or an indemnity plan). However, a Kaiser Foundation and the Commonwealth Fund survey found that only 52 percent of workers ages 18–64 have a choice in health plans (Davis, 1997). Yet, a survey of large firms (500 or more employees) that offer health insurance, conducted by William M. Mercer/Foster Higgins, showed that 35 percent of firms offered an indemnity plan, but only 14 percent of employees enrolled in these plans.¹² For all firms (10 or more employees), the difference was lower, with 23 percent of firms offering an indemnity plan and 15 percent of employees enrolled in it.¹³ Thus, individuals who have a choice of plans do not overwhelmingly, or by majority, necessarily opt for less restrictive plans.¹⁴

Patient Appeals and Grievance Procedures

Some policy analysts have criticized grievance and appeals procedures for ERISA plans, particularly for self-funded ERISA plans (Butler and Polzer, 1996). Either some participants in these health plans are unaware of their right to appeal a decision, or the appeals procedure is not as efficient as desired. These potential dilemmas place the few consumers who have a denied claim in a stressful situation, since they have to wait for a decision of an appeal or are unaware that the decision can be challenged.¹⁵ The length of time allowed for plans to respond to an appeal was not as much an issue under the traditional fee-for-service system, where claims decisions were made retroactively. Conversely,

many managed care plan claims decisions are made prospectively. Thus, access to care becomes a question if a claim is denied before treatment is received, which makes adequate appeals procedures even more important in a managed care setting.

This appears to be more of an issue for self-funded ERISA plans than for insured plans (Butler and Polzer, 1996). Some states in recent years have established laws with very specific guidelines for grievance and appeals procedures. Particularly, the laws specify time limits for appeals and require better information on the right of appeal and the required procedures for an appeal. Furthermore, HMOs that are accredited by NCQA must have what many consider strong appeals procedures. In addition, AAHP has advocated that health plans should improve their grievance procedures with particular attention to patients needing medically necessary care. The Health Care Financing Administration (HCFA) has also established specific grievance and appeals procedures for managed care plans. Self-funded plans are not covered by state laws and do not seek accreditation, but the Department of Labor is examining the need to alter the grievance and appeals procedures for ERISA plans for timeliness of appeals, specifically for cases involving an urgent need for care.

Along with more timely review of appealed claims, many consumer groups strongly support estab-

¹² This is not a direct comparison, because the size of an employer offering a plan can vary tremendously. Thus, the actual percentage of employees offered this plan could be higher or lower than 35 percent. This would also be true for all firms.

¹³ Once smaller firms are included, the likelihood that an employee has more than one choice of health plans decreases. Therefore, an indemnity plan offer for small firms is more likely to be the only option, and consequently more individuals would have to enroll in that indemnity plan.

¹⁴ KPMG Peat Marwick even found that, for large employers (200 or more employees), the employee's monthly share of premiums is less for indemnity plans than for managed care plans. However, copayments and deductibles are greater for indemnity plans.

¹⁵ Remler et al. (1997) conducted a survey of physicians and found that the share of patients denied coverage in the first round for eight categories of services was at the most 5.8 percent and as low as 1.8 percent, with 33 percent to 60 percent of those denied in the first round ultimately being denied coverage.

lishing an outside review board for deciding these claims. Instead of, or in addition to, a health plan employee who potentially has some financial stake in a claims decision, an outside review panel would be responsible for making the decision.¹⁶ Thus, the potential for a conflict of interest would be reduced. However, health plans and employers argue that an outside review board is unnecessary for ERISA plans, because the fiduciary standards outlined in ERISA are so strong that the fiduciary would only consider what was in the best interest of the plan's participants. In some cases, both insured and self-funded plans use an outside review board of physicians to determine the more medically complex decisions. Thus, these health plans are very concerned about the use of an outside review panel that does not include physicians. In addition, multi-state employers feel that if new standards are set for appeals procedures that affect self-funded plans, there should be national standards so that the employers would not have to meet varying state regulations.

Length-of-Stay Requirements

One of the most debated topics relating to managed care was the so-called "drive-through" delivery of newborns. Managed care plans were allegedly requiring new mothers and their newborns to be sent home within 24 hours of a normal birth. Patient advocates expressed outrage over this practice. Consequently, numerous states responded by requiring coverage of minimum hospital lengths of stay after the delivery of a newborn. Most states established a standard length of stay of 48 hours after a normal birth, with longer length-of-stay requirements for cesarean deliveries. In addition, federal legislation¹⁷ was passed in 1996 mandating that all health plans cover a minimum of a 48-hour hospital stay after a normal birth and a 96-hour hospital stay after a cesarean birth.

Evidence appears mixed as to whether longer hospital stays actually lead to better outcomes for mothers and newborns. One study showed that the

likelihood of readmission to a hospital in the first month after birth was not statistically significantly different for mothers and newborns discharged within 24 hours of birth than for those discharged after 48 hours (Gazmararian and Koplan, 1997). In contrast, a study by Liu et al. (1997) found that in Washington State, from 1991 to 1994, newborns discharged within 30 hours of birth were 12 percent more likely to be readmitted to a hospital during their first month of life than those discharged between 30 hours and 78 hours after birth. In addition, there is some discussion that the 48-hour length-of-stay standard may give newborn mothers a false sense of security. These mothers might believe that the 48 hours after birth is the critical timeframe for newborns, and therefore delay seeking necessary medical care (U.S. General Accounting Office, 1996). Consequently, without an agreed-upon standard by the medical profession for the length of stay after delivery the 48-hour mandate may provide only minimal benefits and potentially even cause harm while significantly increasing health expenditures. As the U.S. General Accounting Office (1996) concludes, the length of stay is not as important as the quality of the maternity follow-up care.

The use of outpatient surgery for mastectomies as a substitute for hospital admission has also attracted widespread attention. Concern raised by this procedure has resulted in legislation at both the state and federal levels. The bills have come in two forms: legislation that specifies coverage for a 48-hour hospital stay after a mastectomy and legislation that requires a health plan to pay for the length of stay decided on by the physician and the patient.

Managed care plans argue that the need for this type of legislation is exaggerated. The Medstat Group reported in a study commissioned by AAHP that only 8 percent of mastectomies were performed on an outpa-

¹⁶ Many proposed and enacted laws on outside review require the exhaustion of internal appeals.

¹⁷ *Newborns and Mothers Health Protection Act.*

tient basis. In addition, outpatient mastectomies were found to be no more likely to be performed under a managed care plan than under a fee-for-service plan (American Association of Health Plans, 1997). Outpatient mastectomies appear to have been the choice of the physician and the patient, not a health plan's decision. However, Hadley and Mitchell (1997/98) found HMO patients to have shorter lengths of stay after mastectomies than other insured patients, but they were not able to assess the stage of the disease or the impact on outcomes associated with the shorter lengths of stay. This finding raises the issue of whether the benefits of a one-size-fits-all mandate are worth the cost.

Health Plan Liability¹⁸

For all employee benefit plans governed by ERISA,¹⁹ the courts have consistently ruled that both insured (indemnity and managed care) health benefit plans and self-funded health benefit plans are immune from state tort and contract law for benefit determination and administration decisions. In addition, administrators or administrative companies of these plans, such as utilization review companies, and plan sponsors (e.g., employers and unions) are also immune. (Butler and Polzer, 1996; Association of Private Pension and Welfare Plans, 1997).²⁰ Yet, the preemption of malpractice claims by ERISA is not as clear regarding a decision by a health plan or an agent of a health plan outside of the plan's administration or determination of benefits. For example, in *Pacificare of Oklahoma Inc. v. Burrage* (59 F.3d 151 10th Cir. 1995), the court ruled that the

malpractice claim did not encompass a determination of benefits by the plan and was therefore not preempted by ERISA.²¹ However, in an earlier case, *Butler v. Wu* (853 F.Supp. 125, 1994), malpractice claims against an HMO were held to be preempted by ERISA. Judging from these cases, there appears to be a distinction evolving in the courts between a benefit determination and administrative decision (preempted) and a decision²² outside of a benefit determination (increasingly not preempted). The courts have yet to resolve this issue.

Consumer advocates and some policymakers believe that ERISA's preemption of state tort and contract laws and the limited remedies included in the statute constitute the absence of a major deterrent—the potential for punitive and compensatory damages—to health plan negligence or apathy. In addition to ERISA's limited remedies lacking a deterrent effect, these advocates contend that ERISA health plan participants should have available to them all of the remedies existing under state tort and contract laws. Since many of these advocates believe that the denial of coverage represents the denial of care, they believe that plans make medical decisions and thus should be held responsible for those decisions through malpractice liability. They argue that, once health plans are held liable, the quality of care they provide will improve. Furthermore, these advocates think that if a participant is harmed by a health plan's decision, he or she should be able to claim damages beyond the lost benefit, and it is entirely unfair that such an individual is not able to fully recover these additional damages.²³

¹⁸ See *Copeland and Pierron (1998)* for a more thorough discussion of this issue.

¹⁹ ERISA governs all health benefit plans provided by employers except for government plans and plans provided through churches.

²⁰ Health plans not governed by ERISA and issuers of individual health policies are not necessarily immune from state tort and contract law for these types of decisions.

²¹ See also *Dukes v. U.S. Healthcare Inc., Visconti v. U.S. Healthcare, Inc.* (57 F.3d 350 3d Cir. 1995) and *Kearney v. U.S. Healthcare, Inc.* (859 F. Supp. 182, 1994). In addition, the Department of Labor supports the claim that malpractice claims are not preempted if they are not in the category of administration or determination of benefits. See *U.S. Department of Labor (various years)*.

²² This decision in many cases refers to the quality of a medical decision by an employee or agent of the plan.

²³ ERISA critics point to *Corcoran v. United Health Care, Inc.* (965 F.2d 1321, 5th Cir. 1992). In *Corcoran*, a woman sued her health plan's utilization review company for the wrongful death of her fetus, when the utilization review company denied preauthorization for hospitalization to monitor her pregnancy. The court determined that the claims the woman made were preempted by ERISA because the decision was a benefit determination. Consequently, the only legal remedies available to the woman are those specified in ERISA, which do not include remedies for emotional distress or loss of consortium. Therefore, the court concluded that the utilization review company was not liable for any punitive or compensatory damages.

Supporters of the present structure of ERISA counter that, when a health plan makes a benefit determination, it is interpreting a contract between the health plan and the employee on the benefits that are covered under that contract.²⁴ The health plan does not prevent that participant from receiving the care or tell the participant not to get it, but simply states whether the contract covers the benefit. Therefore, malpractice law would not apply. In addition, employers contend that opening up health plans to more remedies would substantially increase costs but not improve quality. With more remedies available, more litigation would result, including frivolous lawsuits. Consequently, plan costs would increase to cover the expenses resulting from litigation without producing a strong likelihood of improvements in quality, as malpractice suits rarely yield consistent results. Thus, fewer employers would be able to provide health benefits. For those who still receive health benefits, employers argue that the quality of care would not improve and might deteriorate, because the courts do not have the expertise to reach the appropriate decisions in specific cases. Furthermore, innovation could be stifled because employers would be reluctant to cover anything other than what is required. Employers also believe that the marketplace with its current freedom to innovate provides the best quality of care at affordable costs, and that employers and health plans are actively enhancing quality under ERISA preemption, which, they suggest, they would not be able to do if their liability is increased.

The legislation proposed so far that would disallow the immunity of ERISA health plans from state tort and contract law for benefit and administrative decisions would also open up plan sponsors to liability for these decisions as well as individuals or companies that provide administrative services to the plans. Many have interpreted PARCA as making all of these parties liable for benefit determinations. Consequently, Rep. Norwood has introduced the Responsibility in Managed Care Act (H.R. 2960), which is intended to specifically exempt employers from liability unless they make benefit

determinations directly, as is the case in self-funded plans.²⁵ In addition, Texas has passed the first law that specifically says that MCOs are liable for their health care treatment decisions. Under this law, if a MCO does not use ordinary care in decisions regarding health care treatments, it is liable for damages resulting from this neglect to use ordinary care. Other states are also considering this type of legislation. However, the Texas law is being challenged as being preempted by ERISA. Some believe that the law may be saved from preemption because it is directed specifically at the insurance industry, while others believe it will not survive a preemption challenge.

Gag Rules

A much publicized issue raised by managed care opponents is the alleged existence of gag rules or clauses within a managed care contract that prevent physicians from informing patients of some potentially necessary information. These managed care detractors point out that anything that alters the communication between physicians and patients will have the effect of lowering the quality of care either by not describing all treatment options or by not informing patients of the health plan's policies or limitations. Gag rules have been defined in various ways: (a) contractual specifications that restrict physicians from completely discussing all treatment options, particularly treatments not covered by the plan, (b) provisions that prohibit physicians from criticizing the plan (anti-disparagement clauses), (c) requirements that physicians not disclose financial arrangements or not describe the process for approving specific treatments for enrollees (business confidentiality clauses), and/or (d) actions by plans that limit free communication

²⁴ This is not unique to ERISA benefit plans. All health plans (public and private) have limits and exclusions. Therefore, interpretation of any plan's benefits must be made for circumstances that are not clear, such as medical necessity.

²⁵ Many employers believe that not even this bill would exempt them from liability.

In response to the publicity surrounding the alleged existence of gag rules, numerous states have passed anti-gag rule laws, and many others are proposing bans on them.

between physicians and patients (Etheredge and Jones, 1997; Physician Payment Review Commission, 1997).

However, this expansive definition is open to interpretation, with many believing that only (a) actually qualifies as a gag rule.

The existence of these types of contractual provisions is questionable. A GAO report (U.S. General Accounting Office, 1997) found little or no evidence that explicit gag clauses are used by health plans.²⁶ Rosenbaum, et al. (1997) reported a similar finding for Medicaid managed care contracts. However, the GAO report did not examine any other written or oral communications between physicians and HMOs that could limit patient treatment discussions. Therefore, the report did not rule out other measures that HMOs could use to implement gag rules, with termination clauses being of most concern to physicians.

In response to the publicity surrounding the alleged existence of gag rules, numerous states have passed anti-gag rule laws, and many others are proposing bans on them. A bill recently introduced in Congress (Patient Right to Know Act of 1997 (H.R. 586)) would also ban gag rules, as would a provision in PARCA. The proposed or enacted legislation has generally taken the form of banning contracts with clauses that limit what providers can disclose about treatment options or health plan policies or that penalize providers for disclosing this type of information. AAHP has issued guidelines that suggest plans be open about their policies. However, managed care plans are concerned that gag rule bans could interfere with quality assurance programs.

Financial Incentives

One of the goals of managed care plans is to promote a more efficient level of care. One way for managed care plans to achieve this goal is to change the financial incentives of the traditional fee-for-service system. Since a physician is paid for each service provided under a fee-for-services system, the financial incentives are to

overprovide care. However, if physicians have a financial stake in their decisions, they will typically be less likely to provide unnecessary care.

Thus, managed care plans have designed their payments to physicians to include financial incentives that promote a more efficient use of services. Managed care plans use capitation, withholds, and bonuses to alter financial incentives. Capitation involves paying physicians a fixed fee to treat all the necessary services for each patient. Therefore, the physician receives the same payment regardless of the level of services provided, so there is no incentive to provide unnecessary care. Managed care plans also make adjustments to physician payments through the use of bonuses and withholds. These adjustments are partly based on the physicians' success in meeting goals involving costs and utilization as well as on patient satisfaction and quality of care.

In a study to determine the prevalence of the various arrangements managed care plans make with physicians, Gold et al. (1995) surveyed 108 managed care plans regarding their arrangements with physicians.²⁷ They found that PPOs typically (90 percent) pay physicians on a discounted fee-for-services basis, while HMOs typically used some risk-sharing arrangement. In addition, Gold et al. determined that managed care plans were almost as likely to make adjustments to payments to primary care physicians on the basis of consumer satisfaction and quality of care as they were to make them on the basis of cost and utilization. Furthermore, HMOs were more than twice as likely as PPOs to make these adjustments.

Patient advocates fear that these types of arrangements provide too much incentive for physicians to reduce the level of care they provide. Consequently,

²⁶ GAO relied on the managed care plans to submit a typical contract, so not all managed care contracts or even a random sample were analyzed.

²⁷ The study was based on managed care plans' responses. The researchers did not attempt to audit the responses. Thus, there is a potential for a bias in the results.

patients' quality of care could be reduced or necessary care could be withheld, leading to adverse outcomes. However, MCOs contend that these incentives produce a more efficient level of care without reducing its quality. In fact, empirical data have not shown that these incentives reduce the quality of care (Miller, 1997). Yet, some states have addressed these concerns by enacting legislation prohibiting the use of financial incentives that influence physician behavior. HCFA has also prohibited the use of physician payments that might limit or reduce necessary services to Medicare and Medicaid HMO enrollees. (Physician Payment Review Commission, 1997).

Due Process for Providers

Due process laws for providers are mainly intended for provider protection but have implications for patients as well. If providers are dropped from a plan, some enrollees will have to change providers, which can present a difficult situation for some. The enrollee may not be able to find a physician who provides the same style of care or understands his or her particular health concerns as well. Thus, patient advocates want to make sure that the provider is removed from the network of providers for reasonable cause. Several states have passed due process laws for providers, some of which cover all providers while others cover only pharmacies. The laws typically require plans to disclose the criteria for inclusion in the provider network and that these criteria apply uniformly and fairly to all providers. In addition, some laws include a provision that, if a provider has been dropped, a grievance procedure must be put in place to address the appropriateness of the decision. However, many MCOs argue that due process laws for providers represent an unnecessary expense, because the marketplace is continuing to force them to provide higher quality care. Therefore, they must retain the high quality providers in their plans to remain competitive. Furthermore, many MCOs object to legislation that interferes with their choice of licensed providers to contract with, because this

makes it costly and difficult to terminate substandard providers from their networks.

Mental Health Parity

Many employers do not offer the same coverage for mental health care as they do for medical and surgical health care.²⁸ In response to this disparity, mental health experts have raised concerns, arguing that mental health is an illness similar to any physical illness and should be treated the same way in the offering of health benefits. Consequently, some lawmakers have pushed for regulations requiring that mental health benefits have the same coverage (deductibles, coinsurance, and maximum coverage) as other health care benefits. These laws have become known as mental health parity laws.

In 1996, the federal government passed the Mental Health Parity Act requiring health plans to set the same annual and lifetime dollar limits on mental health benefits as they do for nonmental health benefits when both are provided by a health plan. The law does not affect plans that do not offer mental health benefits and does not require plans to offer mental health benefits. In addition, the law still allows higher deductibles and copayments for mental health benefits. Furthermore, a group health plan will be exempt from parity requirements if the costs of the plan increase by more than 1 percent (Fronstin, 1997).²⁹ Therefore, mental health care advocates are pushing for complete parity for mental health benefits as opposed to the limited parity that was passed. This would allow patients with mental illnesses to receive the same comprehensive care for

²⁸ The Bureau of Labor Statistics (BLS) found that the percentage of participants whose mental health benefits for inpatient care were the same as those for other illnesses fell from 54 percent in 1980 to 14 percent in 1993 (U.S. Department of Labor, 1994).

²⁹ The interim regulations for the mental health parity act require six months of actual experience under the law before the exemption can apply. The employer must document the 1 percent or higher cost increase and notify participants before changing the plan.

their illnesses as patients with nonmental health illnesses receive.

Very limited evidence exists showing that proper mental health care can reduce care for other types of illnesses. However, in almost all cases mental health parity would increase employers' costs of providing health insurance.³⁰ Consequently, some employers could drop mental health benefits altogether because of the increased expense of complete parity. This result could make the mandate of mental health parity self-defeating. Even though there is evidence that mental illnesses are diseases similar to other more commonly considered physical illnesses (e.g., cancer, diabetes), the significant increase that occurs in utilization when more generous mental health care coverage is available has led to less coverage for mental health illnesses. By changing the law, policymakers may cause a drop in mental health coverage or adversely affect employers and potential employees through higher costs and fewer job opportunities.

Privacy Laws

Privacy of patient health care records has been a growing concern for many lawmakers and consumer advocates. Currently, national standards for health care record privacy do not exist, which leaves the privacy of these records to state privacy laws that offer varying levels of protection. The Clinton administration proposed federal legislation on health care privacy in the fall of 1997. Some observers suggest that the law is too broad, while others believe it is too narrow. In addition, many states are looking at tightening their privacy laws to provide greater protection for health care information.

The strictness of privacy laws varies, ranging from disallowing the use of genetic testing and information for the determination of insurance premiums to not permitting the use of medical information for any reason. The use of genetic testing has received the most attention in the media. Most people tend to agree that the use of a genetic test to determine insurance premiums

should not be allowed. In most cases, insurers are not interested in genetic test information, since the implications of this information are not fully understood and are expensive to obtain. However, many insurers want to continue to examine enrollees' medical histories for basic health information in order to assess the risks associated with the individuals they underwrite. Otherwise, insurers could ultimately be faced with an adverse risk selection problem.³¹ This could cause insurance in the private market to become unaffordable for many individuals. Despite insurers' worries about the potential breakdown of the individual market, some advocates of strict privacy laws argue that insurers should not be allowed to collect health information on individuals and should treat all individuals the same regardless of their risk. They contend that it is unfair for an unhealthy individual to be denied affordable health insurance because of a preexisting condition. They also contend that insurers should be prohibited from taking that information into account when issuing a policy.

Insurers and insurance purchasers would not be the only ones affected by medical privacy laws. These laws could prevent law enforcement agencies from using genetic information and examining hospital records to investigate crimes. In addition, if enacted privacy laws are too general and broad, health care researchers would be unable to investigate patients' medical charts to gather data for epidemiological studies. Health plans are also concerned that these laws could interfere with quality assurance programs. Consequently, health care privacy laws must be carefully constructed to balance desirable uses of medical information against the protection of patients' privacy.

³⁰ See Fronstin (1997) for more details on mental health parity.

³¹ Adverse selection occurs when the party who is buying insurance knows that he or she is likely to need use the insurance, but the insurer does not have access to this information. Thus, an insurer will then be at greater risk for claims than the insurer had predicted. Consequently, the insurer could end up with more claims than premium revenue to pay those claims.

Insurers argue that community rating leads to adverse selection when the purchase of health insurance is optional, as it is in the United States.

Nondiscrimination

Consumer advocates express concern that individuals with disabilities and other chronic medical conditions lack access to affordable health care coverage. They believe that these individuals are discriminated against in the provision of health insurance, particularly in the individual market. This alleged discrimination occurs when health insurers charge higher premiums to individuals who are more likely to need care than to healthy individuals. To prevent this situation, consumer advocates contend that premiums should be community rated to prevent unhealthy individuals from being forced to pay more for health care coverage because of their condition.

However, insurers argue that community rating leads to adverse selection when the purchase of health insurance is optional, as it is in the United States. Under community rating, insurers would have to charge the same premium to all individuals. Thus, insurers would have to charge higher premiums than they currently charge for healthy individuals, because they could no longer differentiate between the healthy and unhealthy. Because premiums would increase for the healthy, some healthy individuals would drop coverage, reducing insurers' ability to spread risk. Therefore, premiums would have to rise more to cover the increased probability of higher claims due to the increased proportion of unhealthy individuals purchasing health insurance. Consequently, affordable insurance would be even harder to find for those who need it. Insurers claim that at least in a limited experience-rated market, they can charge a lower premium to healthy individuals to encourage them to purchase the insurance, so that risk can be spread over more individuals. This then allows the insurers to charge lower prices to the unhealthy than they would be able to charge in a strict community-rating environment.

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's preliminary report includes the issue of

nondiscrimination in premium charges as one of its proposed "rights."

Under this same "right," the Commission also proposed that every patient be treated with respect and not be discriminated against by such means as lengthy delays in seeing a provider or failure to accommodate language barriers. The Commission does stop short of recommending the use of strict community rating. However, PARCA would prohibit health plans from discriminating in any activity against individuals on the basis of health status or anticipated need for health services, which insurers argue would effectively eliminate underwriting or rating differences in selling health insurance. Consequently, insurers contend that PARCA could have far-reaching implications for the individual health insurance market that might actually reduce consumer access. The implication of the Commission's recommendations appears not to be as far-reaching, particularly since many of its criteria are included in the Health Insurance Portability and Accountability Act (HIPAA).

Discussion of Regulations of Health Plans

Consumer advocates and some policymakers believe that more regulation of all health plans and increased liability exposure for ERISA plans would increase the quality of care. In addition, these groups insist that mandating patients' right to receive coverage for the services of any physician would also enhance the quality of care. They maintain this opinion because legislation in these areas would greatly reduce any existing barriers in the physician/patient relationship. However, plan sponsors and health plans contend that these measures would increase costs and thus reduce employers' and unions' ability to provide health benefits as well as individuals' ability to afford employment-based health coverage. Consequently, more individuals would become uninsured. Furthermore, health plans argue that increased mandates reduce individuals' choices among types of plans. Under the proposed mandates, individuals who might not want a certain benefit would be forced to pay for it if they chose

to have any coverage. The same idea would hold true for plan sponsors in their decision to offer health benefits.

The regulations and mandates discussed above are not a guarantor of increased quality in the health care market, unless quality is defined as easier access for those with health insurance. However, if quality is defined as the success of the outcomes resulting from the health services provided, these regulations' effect on quality is in need of further research. Yet, the regulations would have some impact on the costs of health benefits and insurance. This impact has been estimated to be relatively small to substantial, depending on the interpretation of the mandates and assumptions arising from that interpretation.³² Regardless of the magnitude of the estimated increases, these regulations could have serious implications for the likelihood of small businesses offering health benefits. This is supported by Feldman et al. (1997), who estimated that for small establishments (with fewer than 50 employees) in Minnesota, a \$1 increase in monthly premiums would lead to an approximate decrease of 0.017 in the proportion of small establishments offering health insurance. Consequently, if these regulations raise the costs of health insurance significantly, a potentially sizable number of individuals could become uninsured, especially small business employees.

Other Issues

In addition to addressing health plan regulations and mandates, policymakers at

the federal level have been looking at other areas of the health care marketplace. ERISA preemption of all state

laws that "relate to" employee benefit plans has received a great deal of attention, because it prevents states from effecting systemwide change in their health care systems. In addition, the fostering of associations to provide health insurance through association health plans has also been the subject of serious debate at the federal level.

ERISA Preemption³³

State regulators and consumer advocates argue that ERISA's creation of a different regulatory framework for private employment-based health plans, depending on how they are financed, has resulted in uneven regulations and limited protections for self-funded plan participants (Polzer and Butler, 1997). Due to ERISA preemption, self-funded plans do not have to meet states' mandated levels of coverage. In addition, states cannot prohibit employers that self-fund from changing the coverage offered in a way that prevents participants from maintaining continued coverage for a specific illness.³⁴ Furthermore, state regulators are concerned that an employer that self-funds health benefits could be forced to terminate health benefits or go out of business if one of its employees experiences a catastrophic episode, because of the lack of solvency standards specified for self-funded plans under ERISA.

However, plan sponsors (e.g., employers and unions) find that ERISA preemption of state laws that "relate to" employee benefit plans for self-funded health benefit plans is important if employers are to provide cost-effective and innovative health benefits. First, preemption enables multi-state employers to provide uniform coverage for their employees across all states instead of having to meet many different state regulations. Second, it enables employers to design benefits

³² Millman & Robertson conducted an analysis of PARCA, which contains many of these regulations, for Wal-Mart and determined that health insurance premiums would increase between 7 percent and 39 percent. However, they did not examine the health plan liability issue. Muse & Associates also examined PARCA in a study funded by members of the Patient Access to Responsible Care Alliance and determined that health insurance premiums would increase between 0.7 percent and 2.6 percent.

³³ See Copeland and Pierron (1998) for more details about ERISA and health plans.

³⁴ However, federal regulation does limit employers' ability to alter coverage for some conditions (e.g., Americans with Disabilities Act of 1990).

The goal in creating AHPs is to lower small employers' costs of purchasing health insurance by giving them access to more market power and economies of scale.

that can evolve with the changing treatments of various conditions.

Third, employers are more equipped to control costs because they can negotiate directly with providers and have the flexibility to tailor benefits to their employees' needs. Fourth, self-funded plans are not subject to direct excise taxes that many states place on the insurance premiums employers pay (Atkins and Bass, 1995).

An important underlying issue of the ERISA preemption debate is that states and ERISA regulate health plans differently. States establish specific mandates for health plans and have a regulatory structure with "hands on" oversight of plans.³⁵ In contrast, ERISA does not contain specific mandates, but creates a flexible framework under which a fiduciary must act in the best interest of the plan's participants.³⁶ The fiduciary must disclose plan information and maintain an appeals procedure that meets ERISA's basic standards. The Department of Labor, the enforcement agency of ERISA health plan regulation, typically does not investigate individual complaints, but will address problems that affect the entire health plan's membership (Polzer and Butler, 1997).³⁷

Due to the different manner in which states and ERISA regulate plans, the debate usually comes down to two opposing positions. One would eliminate ERISA preemption for self-funded plans so that states can regulate all health plans in their present manner. The other would maintain ERISA preemption for self-funded plans to allow the flexibility in the provision of health benefits that employers who self-fund desire. Some policy analysts and lawmakers propose a middle ground in this debate. This type of middle-ground proposal would include establishing national standards for self-funded plans that would create state-like benefit mandates and oversight. Consequently, multi-state employers would not have to meet varying state mandates, but for those that feel state regulation and oversight is a more desirable regulatory framework, state-like regulation would now be present at the national level.

Association Health Plans

The Expansion of Portability and Health Insurance Coverage Act of 1997 (EPHIC) (S.729 and H.R.1515), introduced by Rep. Harris Fawell (R-IL) in the House and Sen. Tim Hutchinson (R-AR) in the Senate, would create a new class of multiple employer welfare arrangements³⁸ (MEWAs) called association health plans (AHPs). AHPs would allow small businesses and individuals to band together to purchase health insurance through bona fide associations established for reasons other than the provision of insurance. Once an AHP enrolled a sufficient number of participants, the plan would be allowed to self-fund under ERISA and would be protected from state mandates and regulations. Under this bill, state regulation pertaining to MEWAs would be preempted from applying to qualified AHPs, while state regulation for all other MEWAs would be strengthened.

The goal in creating AHPs is to lower small employers' costs of purchasing health insurance by giving them access to more market power and economies of scale. Preemption of state laws for AHPs would provide an incentive for small employers to join them

³⁵ See State Oversight of Integrated Health Systems (1997) for a detailed examination of the oversight strategies used by the states.

³⁶ Even without specific mandates, self-funded ERISA plans, which are preempted from state regulation, appear to provide equivalent coverage to those plans regulated by the states (Acs et al., 1996).

³⁷ Butler and Polzer (1996) reported the complaint/inquiry history of health insurance plans for two states that included some information on self-funded plans. In both states, roughly 25 percent of the complaints/inquiries on group health plans were about self-funded plans. This number is less than the national total (39 percent of participants in ERISA plans) who are in self-funded plans (Copeland and Pierron, 1998). However, the number reported by Butler and Polzer has a downward bias, since some individuals would understand that states have no regulatory authority over self-funded ERISA plans.

³⁸ Currently, fully-insured MEWAs are subject only to the solvency requirements of the state, while the insurers that issue policies to these MEWAs are subject to the full range of state insurance regulation. For self-insured MEWAs, the full range of state insurance regulations apply except for those that conflict with the provisions of ERISA. In addition, these MEWAs are still subject to ERISA reporting, disclosure, and fiduciary standards (Atkins and Bass, 1995).

and purchase health insurance, since it would give them the advantages of self-funding. Small employers would then have flexibility in the health benefits they offer as well as better control over the costs of their health benefits. Proponents claim the bill could increase portability by promoting the use of associations as the basis of health benefits. Thus, if an employee changed jobs between two employers that were part of the same association, he or she would be able to continue under the same plan without any change in providers.

However, EPHIC's critics argue that allowing AHPs that self-fund to be exempt from state regulation could destabilize the market for small group health insurance. Employers would be drawn to these self-funded associations, because the association plan could offer less than the state-mandated benefits and be less costly. Thus, healthy groups would be particularly attracted to these associations, forcing up the rates in the state-regulated market for small group insurance. Yet, if an AHP were to have significant claims forcing them to raise premiums, some employers might drop out, leaving the AHP without sufficient income to pay claims. This outcome could leave the remaining employers without health coverage for their employees, or with substantially higher costs. Since the AHP would be exempt from state mandates and direct state taxation, it would not be part of the states' guaranty pools. Consequently, some participants or employers could be stuck with responsibility for some claims that should have been covered under the AHP. The bill's opponents believe it does not include enough protections to prevent this occurrence. Due to employers' ability to move in and out of associations as costs change, and the potential reduction in the number of group insurance policy providers caused by competition with association health plans, the group health insurance market could become unstable. Thus, fewer individuals might have access to health benefits or insurance than do today. However, proponents counter that instability in the small group market is already being created by many health insurers' practices, such as doubling or tripling premiums when a

group has a dramatic increase in claims and the selection of risk groups that are more favorable for insurers.³⁹ This instability could be alleviated by allowing small employers to band together. Therefore, AHPs would place small employers on the same level as large employers in their purchase of insurance, and allow more access to health insurance for individuals who work in small businesses. Yet, critics argue that there is no need to expend scarce government resources to create a new federal regulatory framework for MEWAs, when the states have regulations and manpower for the enforcement of these regulations already in place.

Conclusion

The health care market has undergone significant change in the last decade.

One of the most significant changes has been the huge shift from fee-for-service to managed care health care coverage. This change was precipitated by the tremendous increases in health care costs during the late 1980s and early 1990s. During the shift to managed care, health cost increases abated. As costs appeared to be under control, many observers began questioning the quality that was being provided under the managed care system. Some have suggested that managed care brought costs under control by denying necessary care. This belief has led to a tremendous push by consumer advocates for the regulation of MCOs to ensure quality.

The regulations that have been introduced could just as easily be categorized as access measures or provider protections as they can be categorized as quality measures. The determination of whether the regulations discussed in this report would actually improve the quality of care provided in the health care market depends on one's definition of quality. If this definition

³⁹ HIPAA places significant restrictions on these practices by insurers.

only addresses access and consumer satisfaction, these regulations might provide some improvement in quality.⁴⁰ However, if the definition refers to the outcome of a health care treatment, these regulations are of questionable value. While these regulations do address consumer rights, it is debatable whether these rights are desirable considering the costs they add to the provision of health care coverage.⁴¹

While these regulations' effect on quality depends on one's definition of quality, costs would increase regardless of the definition one uses. As discussed above, any increases in costs would almost surely increase the number of uninsured. Consequently, these regulations would come at a price. Thus, legislators must decide between: (a) imposing regulation that would increase access and consumer "rights" for those with insurance but would be of questionable value to the quality of outcomes, and (b) allowing existing market forces to improve quality through experimentation and competitive forces. Recent experimentation has led to some competition on quality through the use of such quality indicators as HEDIS, but the level of quality of care provided still remains a hotly debated topic.

⁴⁰ In Miller and Luft's (1994) review of managed care quality studies, they found that HMO enrollees were generally satisfied with their care. However, HMO enrollees appear to be less satisfied with their quality of care relative to fee-for-service plan enrollees. Yet, in terms of satisfaction with financial aspects of the plan, HMO enrollees were more satisfied than fee-for-service plan enrollees. Thus, some patients appear to be willing to trade off some quality satisfaction for lower costs.

⁴¹ A survey by the Kaiser Family Foundation and Harvard University (1998) found overwhelming support (72 percent in favor) for the consumer bill of rights endorsed by President Clinton. However, if the bill of rights were to increase monthly premiums by \$15 to \$20, the support drops tremendously (only 28 percent would favor).

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