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Consumers, Gag Rules, and Health Plans: Strategies for a Patient-Focused Market

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Summary: The "gag rule" controversy has become a symbol of new tensions and changing relationships among patients, physicians, and health plans. This paper offers a consumer-focused analysis of these fundamental issues from the point of view of a patient with a chronic illness. It starts with a case study of a specific individual and then considers the systemic incentives and other factors that lead to conflicts among patients, physicians, and health plans.

This consumer focus invites the reader to consider managed care with the following question in mind: "What would you want for yourself if you were the patient?" The paper suggests that many private-sector initiatives, as well as government actions, could contribute to a better health care market. Among the reform strategies discussed are (a) professional responsibility and private-sector standards, (b) consumer assistance, and (c) government regulation. All of us, including persons with chronic illness, need a consumer-focused health system. So, too, do physicians and health plans that want to provide excellent care for all of their patients.

Pro-consumer regulation of the managed care industry is now a front-burner political issue. With bipartisan support, the last Congress put statutes on the books assuring new mothers of at least a 48-hour hospital stay and requiring greater parity for mental health benefits. In 1996, 40 states enacted legislation to strengthen consumer protections vis-à-vis the managed care industry. These laws dealt with 14 major areas of access, quality of care, due process, consumer information and confidentiality, and other issues.¹ President Clinton has recently named a national commission to ensure quality of care and develop a patient bill of rights. Pro-consumer legal protections will be considered for Medicare's 37 million elderly and disabled enrollees and in other national legislation.

Clearly, the managed care industry faces a crisis of public confidence. While the industry has exemplary leadership plans and considerable potential for improving the health system, it also has power over patients' lives, market-driven incentives, inadequate quality measures, and a potential for mismanagement

of care. And some health plans have engaged in egregious practices. The people have a right to be concerned about the accountability of health plans on which their lives may depend.

To gain a better understanding of consumer protection issues, we have been considering the "gag rule" controversy as a symbol of the new tensions in the evolving healthcare system. Participants in these discussions usually employ one (or more) of the following definitions of a gag rule: (a) contractual provisions between health plans and health care providers that limit the information, advice, or counsel that a provider may give to a patient; (b) anti-criticism provisions in contracts that prohibit a health provider from making any communication that may adversely affect confidence in the health plan; and/or (c) any health plan practice that inhibits open communication between physicians and patients.

Political agendas and consumers' concerns both suggest a high priority be given to considering incentives that alter physician/patient communications. First, they are already on the government policy agenda. Just before last year's elections, Congress came close to passing legislation to prohibit gag rules; the managed care industry fought off the bills as overly broad. Subsequently, new Medicare and Medicaid policies have been announced to ban contractual gag rules by health plans in serving these populations. Second, gag-rule-type controversies arise from the push of managed care plans to change physicians' practices and to limit patients' use of services that plans consider inappropriate. Health plans and their medical directors need to be able to influence physicians and hold them accountable if they are to produce cost savings and improve quality of care. However, whether health plans should be allowed to restrict the information and advice that a physician gives his or her patient is an extremely important matter to physicians and to patients. The gag rule controversy illustrates the need for social consensus on rights of patients, responsibilities of health professionals, and the accountabilities of health plans for balancing cost containment and the best

interests of individual patients. If consensus could be reached, the managed care industry would be on a more solid foundation for demonstrating its potential for health system improvement.

Our approach to this issue is “consumer-focused” analysis. We started by trying to understand consumers’ problems in today’s rapidly changing health system that lead to gag rule controversies. We then put on our policy analysis hats and convened a meeting of health plan medical directors, physicians, consumer representatives, scholars in law and sociology, and other experts to try to understand why these problems are occurring. A major purpose of this meeting was to assess these issues from different viewpoints and to explore the extent to which they arise from systemic problems in the changing relationships of the health care market. The areas explored included consumer rights, information and assistance, professional ethics and protections, the science base for managing care, insurance market regulation, legal system reforms, and market incentives. Finally, we considered what actions could address political and social concerns about the changing relationships and incentives between plans and physicians, clean up the industry, reward the good performers, and work better for individual consumers. We are grateful to a number of consumers, physicians, health plan medical directors, and others who participated in this endeavor. We absolve them from responsibilities for the views expressed in this article, particularly several who believed the views expressed were excessively focused on the needs for reform of the managed care industry.

A CASE STUDY

To introduce this consumer-focused approach, we invite the reader to consider the following idealized case study designed to raise critical issues that arise even when a clinically good plan and physician and an informed consumer are involved. We have chosen to deal with a patient with a high-cost chronic illness; this type of consumer has high

potential for benefits from managed care but is also likely to be a money-losing enrollee for a health plan. Performing to contain costs and assure quality of care for such consumers may be the greatest challenge as well as the greatest benefit of managed care plans. The reader is invited to consider this case study with the following question in mind: “What would you want for yourself if you were the patient?” This is a time-honored starting point for philosophical and ethical inquiries; it is also realistic. In today’s marketplace, most readers of this paper, or a reader’s family member, could find himself or herself in a similar situation.

Charlie has shopped carefully for health care and a health plan because he has a high-cost chronic illness. By asking around among other physicians and people with his condition, he has found a well-qualified physician whom he trusts and has been seeing for some time and who sees many with his condition. He has also chosen a health plan—from among several choices available to him—that includes this physician on its panel.

Charlie is experiencing a new level of discomfort and disability and has read in *Readers Digest* about a procedure (not experimental) for people like him. He decides to see his physician to see if anything can be done. Moreover, it is open season for health plans, and he decides to ask the physician if he has any advice on the various health plans. He has heard from others with his condition of various kinds of difficulty getting services they or their physicians feel they need.

Dr. Smith examines Charlie and decides he is, in fact, a good candidate for the procedure based on the available journal articles. Before talking to the patient, however, he checks with his clerk/nurse who handles Charlie’s particular health plan and is advised to call the plan first. Dr. Smith is a participating provider with the plan and has a good many patients from it. While there are no specific gag rules in his contract, his payment from the plan reflects the extent of his use of high-cost services.

The plan’s medical director explains the plan’s guidelines on the procedure, which is

costly and about which there is still ambiguity in the clinical literature. He declines to cover it until a number of other steps are tried. Dr. Smith points out the patient's level of discomfort and disability and argues that he does not believe the other steps will help and that Charlie, after all, is an ideal candidate. The medical director is not persuaded based on his understanding of the evidence.

The doctor returns to the patient in the examining room. What does or should he say from the viewpoint of the patient, the plan, and his professional and business concerns?

Option A: "Rather than rush into this new procedure, let's try some other things first, and later we can perhaps reconsider."

Option B: Option A plus, "You know, on most issues like this I am inclined to go along with your health plan. I am a business partner of the plan, and I have a lot of regard for their medical judgement overall."

Option C: "I personally think you should have the procedure, but I have checked with the health plan and the medical director there won't approve it at this point. I pushed it, but he insists we first try some other things and if they don't work we can go back to them. You could pay for it yourself, or I could do it or refer you to someone who specializes in it. Or you might want to argue the issue with your plan. What do you want to do?"

Option D: Option C plus, "You might also consider changing health plans. Many of my patients with your condition find that the XYZ plan is more in agreement with my way of practice in dealing with your condition. And you are going to need a number of things over the next few years that your present plan drags its feet on."

Option E: The physician does not first check with the plan and tells Charlie "I think you should have the procedure."

FACTORS LEADING TO CONFLICT

We will return to a consideration of what answer you would want for this question if you were Charlie, and how to achieve it, after

first exploring the major factors that lead to this conflict among Charlie (the consumer), his physician, and the health plan's medical director. An understanding of such factors is important to considering the case for specific responses.

Consumer Concerns

Charlie may well enter this case study with misgivings about "managed" care. He did not ask to have his care managed by anyone except himself and his physician. Not only does Charlie now have to obtain care through a managed care plan—contracted by his employer—but he is likely to have had few choices among plans. Moreover, even for careful shoppers like Charlie, it is often difficult or impossible, prior to enrolling, to get information from health plans about their internal review guidelines, limits on what services or drugs will really be paid for, or objective evidence on their quality of care. Even good health plans usually do not want to advertise their quality for high-cost conditions because they may attract sicker patients. Lower-quality plans do not want people to find out their restrictions for fear of tarnishing their image.

Given the incentives in the system, Charlie and other consumers with high-cost chronic illnesses know they have reasons to worry. Employers have contracted with health plans to control costs. In turn, health plans also now have contracts and business partnerships with providers and expect them to help contain costs. Employers, health plans, and providers—as they work out their new roles and relationships—are negotiating unprecedented power over our health care. In the process, patients are losing control (and choice), as well as trust. Adding to patients' concerns are media "horror stories" and critical reports about managed care policies and practices that are discussed among patients with chronic illness and among physicians. Unfortunately, reports of excellent medical care do not make headlines. Anxieties can run high.

In this case study, the health plan may well leave Charlie feeling angry and upset by refusing to approve something his doctor feels

will help to alleviate his suffering. Charlie does not know whether the health plan has sound medical reasons for this decision or whether it is just trying to save money. He might be even more annoyed or perplexed if he knew that health plans often use their guidelines as “speed bumps” or “stop and think” advice and that the plan may wind up paying for this procedure in 30% to 40% of cases if a patient and physician go ahead. Charlie may also not know that the nonpayment decision will be made by an employee of a health plan that has a large financial self-interest in denying such payments and is likely paying substantial salaries to its executives and returns to its stockholders from the amount it “saves” by such economies.

If Charlie decides he wants to go ahead with the procedure, his plan may (or may not) have an appeal or grievance process, and he may (or may not) be told about it. The plan is likely to take the position that Charlie bears the burden of proof, and it will probably act as judge (as well as defendant) of his complaint. Charlie’s employer may (or may not) be willing to take up the matter. If Charlie wants to take the health plan to court to get the procedure paid for, his lawyer is likely to tell him that this will be a very expensive and time-consuming process and that the health plan has worded its contract in such a manner that it is uncertain whether he can prevail. Under the federal ERISA statute, Charlie typically has very limited rights of legal action against his employer if it is failing to look after his interests. Many health plans also claim that the federal ERISA statute protects them, as an employer’s agent, from an employee lawsuit.² State insurance laws typically fall short of adequate consumer protections in the new managed care environment—hence the spate of state pro-consumer legislative activity. And Charlie may worry about how he will be treated in the future if the plan views him as a troublemaker.

Given the incentives in today’s new marketplace, Charlie and other patients need open communications with their health care providers and the best (unbiased) professional ad-

vice of those providers if they are to protect their own interests vis-à-vis managed care plans. But these conditions are in jeopardy as physicians work as business partners with plans. A recent Institute of Medicine study warned that

the committee is concerned about the increasing restrictions on physicians (and the potential conflicts of interest) of physicians when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee is particularly concerned about reported contractual restrictions (such as anticriticism clauses) on physicians acting in their professional role as a source of advice to their patients.³

There is recent research showing patient underservice, at least among some managed care plans, compared to fee-for-service insurance.⁴

Charlie’s adversarial relationship with his health plan puts him in a difficult position, and he hopes he can rely on his physician. But he cannot be sure any more that his physician is completely on his side, or just which of the above options his physician will choose today—or in the future.

Physician Obligations

Our interviews and discussions found that physicians, like Charlie’s doctor, feel conflicts between professional obligations to their patients and their new business relationships with managed care plans. Participation in managed care plans is now an essential business decision for most physicians. Many, especially those in oversupplied specialties, now feel that they have a weak bargaining position and are vulnerable in these relationships. And, with forecasts for up to 160,000 physicians out of work if the staffing patterns of managed care plans become new national norms, they expect competitive pressures to accommodate health plans’ cost-cutting agendas to intensify. As one board-certified cardiologist put it: “There aren’t many superstars in my specialty. To managed care companies, most of us are just a commodity.”

As with Charlie's plan, health plans do not usually have to rely on heavy-handed demands to change clinical practices. They can rely partly on a physician's desires to obtain patients the health plan can bring for being part of its network and on other financial incentives. They also use various guidelines, protocols, profiling, counseling, and approval procedures that both seek to change physician behavior and involve hassles for physicians if they attempt to practice medicine outside the plan's desired parameters. To challenge these standard operating procedures can lead a physician to become known as a less desirable part of a plan's network.

Still, physician leaders also say that their colleagues are strongly divided about recent trends, with some opposing managed care and others seeing it as a way to a better health system. Indeed, most physicians we talked with felt health plans were justified in some of their attempts to change "practice styles." They know that health cost control is now a nationwide movement and that there is an inadequate scientific basis for resolving many of the differences between more expensive and less expensive clinical practices, particularly in specialty care and hospital use. Most recognize that, after decades of fee-for-service reimbursement and legions of practice consultants showing hospitals, physicians, and other providers how to maximize their revenues, there are many economies that can be made. But these physicians seem genuinely troubled, because they do not know where to draw the line, and worried that some of their colleagues are more accommodating and influenced by financial incentives than they are.

Complicating the dilemmas for Charlie's physician and his colleagues is that their traditional professional responsibilities have been to counsel patients on what will benefit them as individuals and to serve as their advocates. Physicians often view health plan efforts to economize as cutbacks in medically appropriate services that are likely to be of benefit to some patients. A health plan's economic/clinical tradeoffs can lead to clinical policies that are quite different from how a physician

would advise an independent patient. A Washington, D.C., internist recounted to us his conversation with a plan medical director who refused to pay for a diagnostic procedure that predictably reduces lifetime cancer mortality on grounds that enrollees did not stay with the plan long enough for it to bring cost savings.

Charlie's physician does, of course, have the possibility of refusing to do business with his health plan. But, in the classic triad of ways to respond to troubling situations—loyalty, voice, or exit—physicians' willingness to leave is mitigated by the interests of their patients, as well as economic interests.⁵ If a physician refuses to deal with a plan, he or she is, in effect, telling his or her patients that they will have to find another physician, ending what may be a personal relationship of many years. Physicians also tell us they and their colleagues, in today's oversupplied market, do not want to get reputations as troublemakers among health plans and that this inhibits even "collective voice" from professional groups.

Physicians report that their patients look at them differently under managed care, even when they are giving the same advice they gave under fee for service. As one physician described the change in her practice, "When I used to tell patients that their low back pain could be treated without surgery, they were pleased. Now, if I give them the same advice, they think that I'm trying to save money for the managed care plan." Nevertheless, despite concerns about managed care, most patients still retain a high degree of trust in their physicians.

Health Plan Approaches

In our case study, Charlie's health plan did not use a specific gag rule. We understand that few written contracts between health plans and physicians now contain explicit provisions that require physicians to limit communications with patients. Recent research by our colleagues, Sara Rosenbaum and her legal associates, on over 700 managed care contracts identified few explicit gag rule provisions. More common are so-called anticriticism clauses such as "physician shall make no communication that undermines or

could undermine the confidence of enrollees, their employers or the public" in a particular health plan. Such language can be interpreted by health plans to mean that their physicians should not tell a patient that he or she disagrees with the pattern of medical care that a health plan says it will pay for and should not advise them to join another plan if asked. But the most powerful incentive for the physician is the possibility that his or her contract could be cancelled. Health plans, if they want to influence what a physician says, need not be so unsophisticated as to have written rules; they have functionally equivalent ways of telling physicians how they want them to practice medicine, for example, phone conversations, and other influences on physicians' behavior. The usual managed care plan-physician contracts are "contracts at will," which means that a health plan may simply terminate physician contracts without cause if they frequently challenge plan guidelines. In whatever form, a "gag rule" symbolizes undue encroachment of health plans into physician-patient relationships, and the desire of health plans to restrict what physicians say to their patients, for the economic interest of the health plan.

Managed care trade associations launched an effort to defeat anti-gag-rule legislation in the last Congress. They argued that, if Congress were to inhibit the health plan's capacity to discipline its physicians for inappropriate communications to patients, health plans would lose the ability to control costs and assure quality of care. They also characterized anti-gag rule legislation as a strategy fostered by medical associations to protect providers' incomes. The managed care industry also argued, because most of its members do not now use specific written gag rules, there was no cause for action.

But health plans have incentives to restrict clinical care in ways that compromise patient welfare, and there is reason to believe some do. The CEO of one large health plan, for example, said that he wanted to initiate a 48-hour stay for normal deliveries but could not do so because his competitors had 24-hour practice guidelines

and his plan would get a disproportionate share of money-losing maternity cases. The head of another national managed care plan told us he could offer a first-rate cancer treatment program but would not take this step unless his was the third or fourth plan in the market to do so; being known as a market leader in cancer treatment would be a bad business decision.

If patients and physicians are worried about the current state of affairs—and, even more, about the foreseeable future—so are some health plan leaders. They worry that their plans will be judged mostly on price, rather than quality, and that health plans that underserve high-expense patients may win out in the marketplace.

ACCOUNTABILITY OF HEALTH PLANS

We have presented an illustrative case study, and filled in the background about how such situations arise from the changing economic relationships between plans, physicians, and patients/subscribers. In today's marketplace, Charlie is right to be worried about what is happening to him—and what may happen to him in the future. The individual consumer can find that he or she has few choices and little information, is enrolled in a health plan whose policies and practices may prove inimical to his or her health, and has inadequate procedural and legal protections. And patients can no longer be sure that physicians will be completely on their side.

We think Charlie's case is representative of a well-read physician, a health plan reasonably attentive to clinical concerns, and a sophisticated patient/subscriber. But we also agree with most of the experts who discussed the case study that there are wide variations among health plans, providers, and consumers. There are practices in leadership health plans and in states that have led the way in industry regulation that seem to prevent and deal fairly with many problems when they occur. But most patients, like Charlie, are not in these plans or in these states. In many areas, health care is becoming a "Wild West" marketplace, driven by economic incentives, with few consumer protections.⁶

Given all of these circumstances, we believe that Charlie, his physician, and (possibly) his health plan's medical director cannot do much better on their own than they are now doing. Like most patients, physicians, and health plans, they are caught up in a new system, with new roles and tensions, that has many participants worrying that health plans and providers will ration care to patients, without their knowledge or agreement.

Perhaps the concerns about specific gag rules that limit physician counseling and advice to patients will prove the most readily solved part of this problem. We found unanimous opposition to such gag rules among patients, physicians, and medical directors of leading managed care plans. In terms of the case study example, option C had the broadest support—indicating a consensus belief that a physician has a professional obligation to give a patient his or her best advice, regardless of a health plan's views on payment. A similar consensus was also stated in the recent Institute of Medicine study of the Medicare market: "Physicians must maintain their freedom to talk to their patients with full honesty about the clinical aspects of their care and treatment options."⁷ This possible consensus agreement was also reflected in a recent directive by HCFA for Medicare HMOs that a doctor caring for a Medicare patient "may not be limited in counseling or advising the beneficiary" about treatment options that may be appropriate for the patient's condition or disease.

This is a start toward consensus, but is this what we would want for ourselves? Some physicians and patients felt they would prefer Option D to be how the future health system works—that the new professional role of the physician should also include candid advice about joining (or leaving) a health plan. A Washington, D.C., internist who is not allied with any managed care plan supported Option E; he felt that a physician was already on the slippery slope toward compromising professional ethics if he checked with a health plan about payment issues before giving his advice to a patient.

Could private leadership and public policy bring about a new health plan market that builds on a foundation of well-informed patients and freedom of communication between physicians and patients and is accountable for patient well-being? Since many underlying factors are contributing to Charlie's situation, how far need reform efforts go in dealing with these more fundamental issues to assure such change, rather than symbolic action? Our discussions identified three broad strategies that could lessen the negative effects of gag rules and their equivalents, and help to bring about such a patient-focused market: professionalism, better consumer information, and government market regulation. To elicit discussions and invite responses, specific proposals are mentioned below, with an assessment of how they could affect Charlie's situation.

STRATEGIES FOR A PATIENT-FOCUSED MARKET

Professional Responsibility

Professional responsibility of individual physicians should be the primary guarantor of health care quality and well-informed patients. Professional ethics need to come from within the health system; they cannot be imposed by government regulation. Health care professionals need to do what is best for patients. With an appropriate role for professionalism, there will be a basis for assuring that patients at least know what medical care they need, even if a health plan does not pay for it, and can make an informed choice regardless of the perversities of the new managed care market. If health care providers fail their patients, however, it is difficult to see where the "bottom" is in terms of potential erosion for health care quality.

For discussion, we suggest the following voluntary actions for the private sector to consider.

Physician responsibilities. Health plans that want to be known for quality of care could express their commitment to professionalism and to open communication between their physicians and patients as part of their

provider contracting. This code of ethics should include support for the professional rights (and obligations) of physicians to provide patients with their best advice and counsel, without regard to whether or not a service is covered by their health plan, and include assurance that there will be no penalty for physicians offering their best counsel to patients. It should also include physician participation in development of medical protocols and guidelines, impartial adjudication of appeals, elimination of anti-criticism clauses, and "whistle-blower" protections for medical personnel who bring to light fraudulent, illegal, or anti-patient practices.

Consumer bill of rights. Assurances to patients could be included in every patient contract to endorse the rights of consumers to have unrestricted advice and counsel from their physicians. Included in this bill of rights should be standards in most of the other areas of consumer complaints in which states have been imposing pro-consumer regulation. To monitor compliance, the physicians' rights and consumer bill of rights might both be included in National Committee for Quality Assurance (NCQA) accreditation reviews.

Recently, the American Association of Health Plans (the managed care industry's trade association) initiated a major redirection of its public relations—a "Patient's First" campaign. The initiative establishes guidelines for member plans that call for the end to "gag rules" in managed care contracts. If health plans abide by the voluntary guidelines, patients (by the end of 1997) will also receive, upon request, information from their plan on subjects such as how physicians are paid, utilization review procedures, the basis for specific disapprovals, which prescription drugs are covered, and how plans decide when a procedure is experimental.⁸ These are steps in the right direction, recognizing that the industry has substantive, as well as public relations, problems in its treatment of consumers. The extent to which voluntary standards will be influential with the elements of the managed care industry that most need to change their policies and practices is open to question.

If these initial voluntary efforts were extended to apply to all the major issues of consumer and physician complaint, with monitoring by an outside party, Charlie might have greater confidence that his health plan wanted him to have full information about treatment options. Charlie's physician might also have greater confidence that the plan respected his right to advise Charlie. Both would know that some outside agency was checking up, in the accreditation process, to be sure that these were, in fact, the health plan's operating policies. Plans that did not adopt and live by these standards would be known to physicians and patients through their failures to receive accreditation and through the related deficiency reports.

This would be a good start, but not all reasons for concern would be addressed. In particular, enrollees in plans that did not subscribe to these high standards or were not accredited (still the large majority of plans) would not be protected. Some further steps to strengthen external accountability, such as those outlined below, would be needed.

Purchasers' standards. The nation's employers now drive the health plan market by their purchasing decisions. Leading business groups, such as the Chamber of Commerce, the National Association of Manufacturers, the Business Roundtable, the National Federation of Independent Businesses, and the leading business health coalitions (the Washington Business Group on Health, the Midwest Business Group on Health, and the Pacific Business Group on Health) could have a major impact on ending anti-consumer practices in the managed care industry. If these member companies—working with employees, the AFL-CIO, and patient groups—developed a common set of pro-consumer purchasing standards that they required health plans to meet in order to get business, the standards would likely have much more impact than the industry trade association's voluntary guidelines.

Such initiatives would give Charlie additional protections by altering the employer's contract with the managed care plan and, most

importantly, by increasing the employer's potential clout to drop a misbehaving health plan and report its practices to other employers.

Collective voice. The physicians we have met with can usually cite specific managed care plans and practices that they believe are inimical to patients. But, as individuals, they feel relatively powerless to buck the plan or obtain corrective action. One example cited was a Washington, D.C., managed care plan that had recently sent a letter to its physicians saying that it had lost money in the previous quarter and announcing new restrictions on use of specialists, that is, it was asserting rights to determine clinical practices to meet its financial goals rather than to provide what was medically best for patients. Mental health providers have also said to us that plans have imposed some patient care changes that are not in their patients' best interests, but that individual providers are intimidated from speaking up by the fear of losing business. In some instances, "collective voice" by professional associations—through private meetings, public protests and media attention—may be necessary to protect professional standards and patients. With this type of professional recourse, Charlie's physician could feel that he had peer support from his colleagues if any health plan adopted practices that were clear violations of good medical care practices.

Finally, the following initiative could help health plans and medical professionals resolve issues about appropriate clinical practices.

Bell Labs. All parties in today's health care market recognize that the scientific basis for resolving differences such as those between Charlie's physician and the health plan's medical director is much weaker than it should be. Indeed, the management techniques for some health plans do not extend much beyond a set of guidelines for economical low-cost care, for example, those developed by Milliman & Robertson, and various forms of bureaucratic harassment, for example, requiring a time-consuming health plan approval for each specialist visit for a chronically ill patient. One way to improve this situation might be to have a (private-sector) center for support of

clinical assessments research, with a governing board of clinicians, patients, purchasers, and health plan medical directors, charged to identify the major clinical issues about appropriate treatments, including newer procedures and technologies, and to oversee the necessary research. With proper organization, including clinical trials and automated medical records from statistically sampled providers and patients, many patient care issues might be resolved within a few years. The funding overseen by the center could go to various "Bell Labs" applied research organizations around the country—for example, at leading HMOs and delivery systems and academic health centers—to investigate outcomes of therapies, evaluate new technologies, compare alternative treatments, and test new models for the delivery of patient care. This effort should be funded from a small assessment on private health plan premiums, Medicare and Medicaid.⁹ With such an initiative, Charlie, his physician, and the medical director could reasonably expect that, by the time of a *Readers Digest* article, much better information would become available.

Consumer Assistance

A second set of initiatives could be focused on consumer assistance. In today's medical marketplace, there are financial incentives for underservice. Consumers need better information about health plans, providers, and healthcare options to protect their own interests—and to carry out their (assigned) role in the new health care market—the role of good shoppers holding the health care system accountable for meeting their needs.

Clinical information. It would be ideal for patients to be able to obtain, in user friendly form, as much objective information as is available about their health problems and treatment options. Trained medical personnel should be available to assist patients in finding answers to their questions. Copies of patient-oriented medical material, as well as relevant medical journal articles, should also be available. It makes little sense for each health plan to develop such information services on its own for its patients or medical

staff. Although best organized and operated in the private sector, such services might also be partly funded, like the Bell Labs initiative, from a small assessment on health plan premiums. With this service, Charlie could be confident of being able to obtain the best available information to supplement his physician and the health plan.

Health plan information. For the health plan market to work properly, Charlie and his employer both have to be able to evaluate health plans using accurate and useful comparative information. This can occur only if government requires standardized health plan “report cards,” such as those proposed by NCQA and the Foundation for Accountability, and sees that this information is widely available. Consumers should also have full disclosure of clinical policies and protocols so that the consumer has a better idea of what he or she is getting and how a plan operates, as well as information on consumer grievances. Here again, there is a case for partial public financing, through health plan assessments, for the collection, audit, and dissemination of such information. It is particularly important that such information include a health plan’s performance for patients with chronic illness.

Government

The two strategies described above—professionalism and consumer information—deal with some important protections against patient underservice and lack of consumer information. They would help consumers. But health plans would still have enormous financial incentives to underserve and underinvest in serving high-expense chronically ill people like Charlie. There are many tactics that health plans employ to avoid such costs, of which gag rules are only one.¹⁰ For discussion, we suggest the following four additional government actions to assure social accountability for use of health plans’ power.

Tough regulation. Managed care is going to have to be a much more regulated industry. The managed care industry is taking on the functions of the old insurance industry, indeed many insurers are transitioning into managed

care. Health insurance, like other insurance, has had to be a government-regulated industry because of its incentives to deny claims and use creative nonpayment practices and because of the attractiveness of the large amounts of money involved to less scrupulous operators. Managed care companies, if they are of such a mind, have a host of new “management” tools they can use to prevent claims from even being submitted in the first place; these include gag rules, financial incentives to physicians, protocols, intimidation of physicians, administrative procedures, selection of physicians, limitations on referrals to specialists, and prescription drug formularies. While all of these can be legitimate management tools, they can also be misused. Unfortunately, it is realistic to expect egregious managed care behavior from some companies. Last year, a Florida HMO, for example, was discovered to be turning off its phone lines for approval of emergency care on weekends—and then denying payment for these services on grounds that the patients had not obtained approval.¹¹ This is the kind of behavior that should produce decisive regulatory action.

Medicare reform legislation would be an excellent vehicle for establishing national standards. The regulatory structure could use states as the front-line enforcers, but it seems expedient to have a national accountability organization, like the Securities and Exchange Commission, which can oversee the health plan marketplace, including the report cards. It should have investigatory and enforcement authorities, including the SEC’s ability to ban individuals for life from the managed care sector for flagrant abuses. Should we not be at least as concerned about protecting consumers in the health care system as we are about safeguarding investors in securities markets? Charlie, physicians, patient groups, and good health plans should be able to call in the police when they see egregious activities.

Nevertheless, there are many questions about how well government can regulate managed care plans, beyond basic standards and policing, or how much it would need to if market competition were working better. In a well-functioning market, the financial penalties

imposed on substandard plans by voluntary employer and consumer choice of other plans are likely to vastly exceed whatever sanctions are available to government regulators.

Consumer choices. Charlie's concerns about being sure he is getting good advice could also be allayed by requiring all health plans to provide a "point of service" option so that individuals could go to any physician for medical consultation and advice. This option would protect consumers from having to rely just on the physicians who happen to have been selected by a health plan and who might thus be expected to be unduly influenceable by this plan. Patients, particularly those in need of sophisticated services, would always be able to obtain the best clinical advice and care, even if it were not offered (or fully reimbursed) by their health plan. The health plan market is already moving in this direction. We also favor assuring all individuals a broad choice among plans, through direct employer offer, employer purchasing cooperatives, the new Medicare choice system, or other means.

Legal reforms. In our case study, if Charlie appealed the plan's decision, the ultimate adjudicator of whether or not Charlie's procedure would be paid by the health plan would be the legal system. Courts of general jurisdiction and citizen juries would be asked to resolve the meaning of ambiguous insurance contract terms such as "medically necessary and appropriate" and to determine whether a therapy was "experimental" or had become accepted medical practice. Indeed, managed care contracting is fraught with such legal ambiguities that it is impossible for parties to the contract, such as Charlie, his employer, and health plan, to tell exactly what will be paid for. The problems of good drafting, informed agreement among all parties, and adjudication grow worse as more health plans, with complex sets of business arrangements, enter the market and as health plans establish new protocols and patterns of care that intentionally differ from community practice norms. Health plan advertising frequently promises greater benefits than traditional indemnity insurance; however, fewer services

are actually provided. In this arena, it may be useful to have national legal efforts to standardize insurance contract language and coverage options, for the parties at interest and legal adjudication. Perhaps there should also be a specialized court system, analogous to the United States Tax Court, which would provide initial judicial review for many of the contract disputes. This would make possible more consistent and professionally competent adjudication of many coverage and related issues. Such courts might also provide initial determinations concerning malpractice cases. With such reforms, Charlie and his lawyer, as well as his physician and health plan, might have both a much clearer understanding of whether the insurance company's contract required payment for the procedure and some hope of speedy and professionally competent legal resolution, if necessary, of payment questions.

Market incentives. From the consumer's perspective, the suggestions outlined for discussion above would be advances in today's marketplace. They would help increase the consumer's confidence level in plans and providers and better equip them to make meaningful choices. Nevertheless, today's market environment has powerful financial incentives lined up against the individual consumer who has predictably high-cost chronic conditions—and against the physicians and health plans who want to give excellent care to all their patients. In the view of the authors, these incentives are so powerful that the person with chronic conditions, and their health plans and physicians, face a grim future in the market without fundamental changes that pay health plans more fairly for these individuals.

CONCLUSION

Over the past decades, proponents of managed care have emphasized that health plans must operate within a structure of "managed competition," be accountable for their performance, and have appropriate incentives if they are to realize their full potential for improving the health system.¹² Today, these are no longer only theorists' concerns. Consumers, including

chronically ill consumers, as well as health plans and physicians that want to provide excellent care for all of their patients need fundamental health system reforms.

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ENDNOTES

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3. Institute of Medicine, *Improving the Medicare Market: Adding Choice and Protections*, (Washington, D.C.: National Academy Press, 1996), 100.
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