



The Jerome Levy Economics Institute of Bard College

Public Policy Brief

Regulating HMOs

An Ethical Framework for
Cost-Effective Medicine

Walter M. Cadette

No. 47, 1998

LEVY INSTITUTE

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ISSN 1063-5297
ISBN 0-941276-59-7

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Preface

Managed care, or specifically HMO medicine, has been a powerful force in slowing the decades-long escalation of health care costs. Health care expenditures as a percentage of GDP have now leveled off at almost 15 percent—good news for employers providing health care benefits and for the government, one-fifth of whose budget goes to Medicare and Medicaid. But the cost controls of HMOs have come at a price for patients. All too common now are stories in the media about people who feel they have been harmed when an HMO denied them a test or a treatment and about physicians who feel their clinical judgment has been compromised on grounds of cost.

Policymakers have been drawn into the struggle to balance the cost of health care against the quality of care. Recently, government has intervened between patients and their HMOs by regulating particular medical practices, for example, by specifying rules regarding length of hospital stay after childbirth. But such micro-management is not the most effective role government can play to protect patients; in fact, it often needlessly reduces efficiency.

In this brief, Senior Scholar Walter M. Cadette examines an important aspect of the balance between cost and quality: the ethical problems built into the structure of the delivery of medical care by HMOs. He suggests that rather than attending to the details of care procedures, government should fashion a regulatory framework to address fundamental issues of equity and quality in the practice of HMO medicine. Such a framework would attempt to eliminate financial incentives for physicians to undertreat; require disclosure to patients of the constraints on care imposed by their HMO and the financial incentives the HMO

employs; strengthen the patients' right to informed consent about treatment, including nonreimbursed care; and restore to physicians autonomy in making medical decisions and setting guidelines for practice within the HMO.

Another area for government policy is accountability, or the patient's right to hold a managed care provider responsible when a decision it makes for cost reasons results in serious harm to the patient. HMOs have been able to avoid liability under the provisions of the 1974 Employee Retirement Income Security Act. As a result of ERISA's preemption of states' power to regulate employer health plan benefits, HMOs gained considerable protection against payment of compensatory damages.

The problems that managed care creates are unlikely to disappear. With advancing medical technology, the aging of the population, and the end of the easy efficiency gains that can be achieved by managed care, the cost of health care is bound to rise. With that rise will come intensified pressure to increase cost controls. Finding a way to protect patients, to ensure the ethical delivery of care, and to encourage cost-conscious medicine is the challenge facing policymakers. Cadette offers some approaches that should be considered. I welcome your comments on this research.

Dimitri B. Papadimitriou, *President*
December 1998

Regulating HMOs

A response to demands for control of health care costs, managed care has had a powerful impact on American medicine. It has imposed cost-consciousness on physicians. It has forced hospitals to cut back on the excess capacity that had grown unchecked over the years. And it has left Americans with fewer health care choices than they once had.

In all, managed care has introduced a degree of market discipline into the practice of medicine that was conspicuously absent in the comparatively open-ended health insurance it has replaced. Market discipline in the field of health care surely remains crude and imperfect, but prospects for controlling once runaway costs are brighter than they have been in a long time.

Managed care has also transformed the American health insurance market (Table 1). Almost 30 percent of Americans who were insured in 1996 were enrolled in health maintenance organization (HMO) plans, compared with 18 percent as recently as 1992 (Employee Benefits Research Institute 1997).¹ The percentage is bound to rise further in coming years as governments, in order to match the savings employers have achieved in work-related insurance plans, goad Medicare and Medicaid beneficiaries (who thus far have remained almost entirely in fee-for-service medicine) into managed care. Another 43 percent of insured Americans were covered by preferred provider organizations (PPOs), up from 23 percent in 1992 (Employee Benefits Research Institute 1997). PPOs require subscribers to use physicians who have agreed to provide health care at discounted rates.

The shift to cost-conscious medicine has had a profound impact on the economy at large. Almost half of the decline in the GDP deflator's rate

Table 1 Health Insurance Coverage by Plan Type and Insurance Type (Percent of Insured Population)

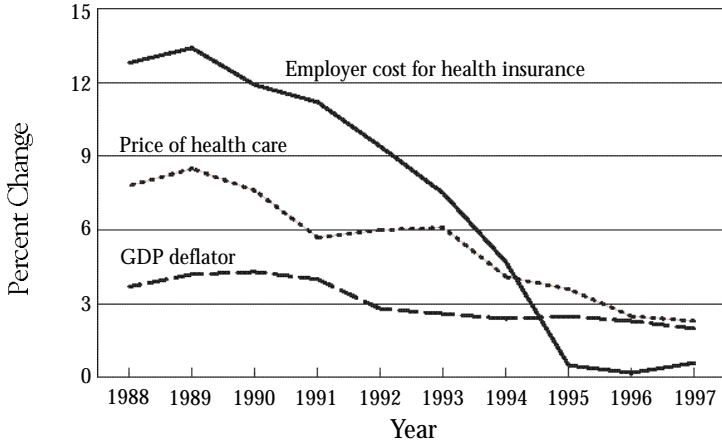
	1992	1994	1996
By plan type			
Fee for service	59	42	29
Health maintenance organization	18	21	28
Preferred provider organization	23	37	43
By insurance type			
Private insurance			
Fee for service	52	33	20
Health maintenance organization	20	22	29
Preferred provider organization	28	45	51
Medicare and Medicaid			
Fee for service	97	92	86
Health maintenance organization	4	8	14
Preferred provider organization	n.a.	n.a.	n.a.

Source: Employee Benefits Research Institute, *EBRI Databook on Employee Benefits*, 4th ed. (Washington, D.C.: Employee Benefits Research Institute, 1997).

of increase during the 1990s (from 4.2 percent in 1989 to 2.0 percent in 1997) can be ascribed to the deceleration in the price of health care.² With health care now almost 15 percent of GDP, and thus rivaling manufacturing in size, a decline in inflation of that magnitude would have been hard, if not impossible, to achieve without a major break in the price of health care (Figure 1). The rate of increase in employer health insurance costs has come down even more dramatically as HMO and PPO plans have taken an 80 percent market share of employment-based health benefits. Cost-conscious medicine has also paved the way for the emerging federal budgetary surplus—no surprise considering that Medicare and Medicaid account for as much as one-fifth of the budget.

It will be hard to contain the claim health care exerts on GDP in coming years. The aging of the baby boom itself promises to add several percentage points to the claim; advances in technology will continue to push costs up; and the efficiency gains managed care has brought about by eliminating much of the high-cost medical practice of the past will not be easily repeated. For now, though, health care's share of GDP seems to have stabilized after decades of relentless rise (Figure 2).³

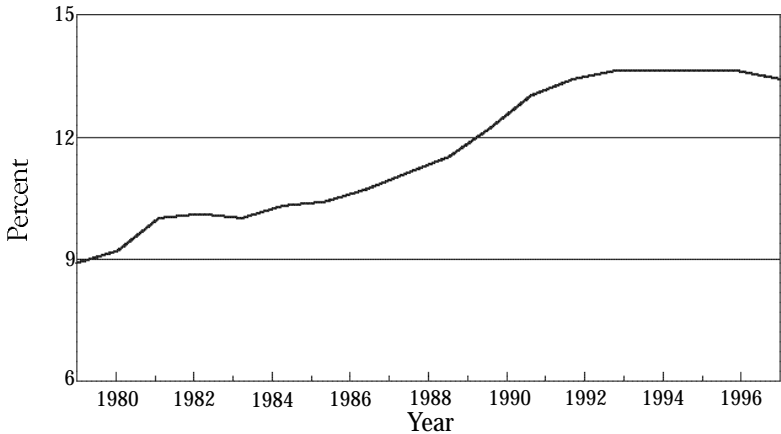
Figure 1 Change in the Price of Health Care



Source: Based on data from *The Annual Report of the Council of Economic Advisers* (Washington, D.C.: Government Printing Office, 1998), Tables B-3, B-16, B-17; unpublished data from the Bureau of Labor Statistics.

Virtually all U.S. health care is managed in some way. Even the least restrictive fee-for-service plan now requires subscribers to submit to utilization review procedures to be reimbursed for all but minor expenses. As used here, however, the term managed care refers only to health care that is (1) prepaid and (2) provided by physicians who are governed by clinical

Figure 2 National Health Care Expenditures as a Share of GDP



Source: Data through 1996 from Katharine Levit et al., "National Health Expenditures, 1996," *Health Care Financing Review* 19, no. 1 (1997): 161; data for 1997 from Katharine Levit et al., "National Health Expenditures in 1997: More Slow Growth," *Health Affairs* 17, no. 6 (1998): 99.

practice guidelines—neither of which applies in a PPO or fee-for-service plan, even though both of these insurance types have taken on many managed care features. The term is thus used here interchangeably with HMO medicine. The HMO links the financing and the delivery of health care; it is both provider and insurer, in contrast to the old fee-for-service model in which these functions were separate and distinct.

Successful as managed care has been in curbing health care costs, it has been much less so in winning public support. Public disquietude has grown as anecdotes of denials of needed care have multiplied in the media: a child with an appendix about to rupture sent to a distant emergency room because that is where the HMO's discount was the largest; a new mother who developed complications after being sent home prematurely to eliminate the cost of another day's hospital stay; a patient with a tumor that later metastasized after tests for early detection were ruled out as too expensive.

Care givers also have become increasingly skeptical, judging by the statement of two thousand Massachusetts doctors and nurses published in the *Journal of the American Medical Association* (December 3, 1997): "Physicians and nurses are being prodded by threats and bribes to abdicate allegiance to patients, and to shun the sickest, who may be unprofitable. Some of us risk being fired or 'delisted' for giving, or even discussing, expensive services, and many are offered bonuses for minimizing care." The nation has fashioned, one physician concludes, a health care system that costs a trillion dollars a year but cannot "afford the luxury of a conscience or a heart" (Glasser 1998).

On one side of the debate about the merits of managed care are those who argue that cost control has come at an unacceptably high price (Table 2). Economies, they claim, will have far-reaching adverse consequences on health outcomes long into the future, as is even now all too evident for vulnerable groups: the chronically ill, the elderly, and the poor (Ware, Bayliss, Rogers, Kosinski, and Tarlov 1996). There is something perverse, they maintain, in a payments system that makes well-intentioned physicians look on patients as a drain on their income (Rodwin 1993).

Advocates for managed care cite the benefits of its emphasis on preventive medicine and on eliminating marginally beneficial (and sometimes even

Table 2 Practice Problems in HMOs as Reported in Physician Surveys (Percent of Physicians Reporting Serious Problems)

Problem	In States with High HMO Presence	In States with Low HMO Presence
Limitations:		
on ordering diagnostic tests and procedures best for patients	41	27
on referring patients to appropriate specialists	42	26
on referring patients to specialists of physician's own choice	57	33
on deciding on how soon patients should be referred to specialists	44	37
on prescribing drugs best for patients	38	28
on deciding if patients are admitted to the hospital	35	36
on deciding on hospital length-of-stay for patients	44	49
Financial incentives to do less than is best for patients	39	31
Pressure to see more patients than physician thinks is appropriate	37	28

Source: Adapted from Harvard/Harris/Pew Future of the Primary Care Workforce Project, 1995, as reprinted in *Health Affairs* 16, no. 5.

harmful) care. They contend that outcomes data for most Americans, who are not in the vulnerable groups, fail to indict managed care as inferior to the more expensive, often wasteful, fee-for-service medicine of the past. As they see it, cost control involves only an extra day in the hospital, a visit to a specialist, an expensive drug—when the stakes are low and confidence in the diagnosis is high (Hall 1997). The economies managed care has brought about, they maintain, do not raise life and death issues.

This paper joins the debate. It examines the features of HMOs and their associated ethical problems, and it points to a framework of needed patient protection. The problems flow from the very design of HMO medicine. Prepayment means that every dollar of revenue is potentially a dollar of “profit” if it is not spent on direct patient care—a temptation, if not also an incentive, not only to economize on care but to skimp on it.

Clinical practice guidelines may yield significant savings, but they threaten physician autonomy and, more important, physician capacity to act as patient advocate. Physicians traditionally have played a fiduciary role—a responsibility flowing out of the disparity between the knowledge of the physician and that of the typical patient. But that responsibility, if not threatened by managed care, has been greatly changed by it. Physicians have become agents of the health plans that employ them as well as fiduciaries of their patients, a highly conflicted role at best.

The public policy concern is the trade-off between quality and cost in HMO medicine and the ethical issues the trade-off raises. This paper focuses on the change in the role of physician from agent of the patient to agent of the health plan as well. To what extent do compensation arrangements that reward physicians for doing less for patients and penalize them for doing more undermine the physicians' fiduciary role? How are physicians to act in their patients' best interests without compromising their own? Behind these questions lie broader ones: Who should decide what care is not worth the cost, and what criteria should be used for those decisions (Hall 1997)?

Textbook economics and standard contract law tell us that patients, as consumers of health care, answer these broader questions when they choose an insurance plan. That sounds fair enough in the abstract, but it is flawed in reality. Contract law assumes freedom of choice and sufficient information. In a regime of employment-based health insurance, however, many consumers have little or no choice. They are, moreover, at an enormous disadvantage not only with regard to information relevant to care decisions but also with regard to the terms of the insurance contract and their possible consequences.

An increasingly complex health care marketplace suggests a new role for government: to fashion a regulatory framework and to promote health care plans that ensure the protection of patients and the ethical delivery of health care. Fundamental issues need attention: financial incentives physicians work under, restrictions on their communications with patients about care options that are not reimbursed under a health plan, disclosure of information about health care contracts, accountability for decisions to withhold care, and return of care decisions to the province of the physician.

Sources of the Ethical Problems

The Rationing of Care

Fee-for-service medicine, in concert with widespread health insurance that levied little direct cost on patients, was inherently inflationary. Indemnity insurance inevitably gave rise to agency problems, as neither the physician who ordered care nor the patient who received it internalized the cost (Latham 1996). Insurers were reluctant to challenge decisions made by physicians, and so were employers. As a result, physicians effectively controlled both the demand and the supply sides of the market. They acted as fiduciaries on behalf of patients with little constraint on their professional autonomy—or, for the most part, on their fees.

Medical care was rationed, to be sure. Those without insurance (mainly the working poor) had to rely on the informal safety net provided by charity care at private hospitals or on public hospitals. For them, care was often “too little, too late.” And, for all, “commodity” rationing—applicable, for example, in the emergency room and on the battlefield—prevailed. All the same, most insured Americans, including the elderly with the advent of Medicare in the 1960s, had unencumbered access to virtually all the medical care money could buy and at little direct cost.

This model worked reasonably well in the United States for several decades after World War II. But it began to break down in the early 1980s as advances in technology spurred health care costs at a previously unheard-of rate. Costly interventions and diagnostic tools—hip replacements, organ transplants, CT scans, MRIs—became commonplace. It was then that “all the medical care money could buy” became prohibitively expensive.

In the managed care model that emerged in reaction to the surge in costs, physicians have a dual role. They are still cast in the role of a fiduciary for the patient but they also share responsibility for the financial well-being of the organization that employs them. They are required to practice medicine according to formal guidelines or protocols set with cost-effectiveness in mind. The shift is from an ethic of “use it if it might help” to one of “don’t use it unless it clearly will” (Morreim 1991). To be sure, the guidelines may be modified by concurrent review when a case is unusually severe. Still, the distinguishing feature of HMO medicine is control by

insurance companies of health care choices that had traditionally been made strictly within the patient-physician relationship (Rodwin 1995).

The rationing of medical care has thus become “fiscal” as well as “commodity” in character. The physician becomes a guardian of the organization’s, and ultimately society’s, resources as well as fiduciary for the patient. HMOs, in effect, ration medical care in much the same way as do governments in industrial countries whose health care expenditures are set by a fixed budget (Jack A. Meyer, personal communication 1998). The process may be payer by payer rather than centralized and it may be largely a private sector rather than a public sector activity,⁴ but the decision making is essentially the same. And so is the broader goal: to limit health care’s absorption of resources, which otherwise could expand virtually without limit.

Enforcing Cost Controls

Financial incentives, including both penalties and bonuses, enforce the physician’s guardian role. Selective contracting with physicians, hospitals, and other providers has made it possible for managed care organizations to drive costs down or keep them from rising as they otherwise might. Major savings have been achieved by cutting back on hospital use and caring for patients in less costly settings; there is a vast difference between HMO subscribers’ hospitalization rates and those of the population at large, even allowing for the relatively young and healthy populations HMOs tend to serve (Table 3). Savings also derive from discounts for HMOs on fee-for-service payment, mainly for services by specialists.

Table 3 Hospital Usage—HMO Experience Compared with National Average

	1992		1995	
	HMO Subscribers	All Americans	HMO Subscribers	All Americans
Hospital days per 1,000				
People under age 65	306	456	258	434
People age 65 and over	1,737	2,772	1,295	2,677
Average length of stay (days)				
People under age 65	4.3	5.0	3.9	4.9
People age 65 and over	6.3	7.8	6.1	7.8
All ages	4.5	6.2	4.3	6.0

Source: Ernst & Young LLP, Health Care Data Reference Card, February 1998.

Table 4 HMO Payments to Primary Care Physicians (Percent)

	1989	1994
Fee for service	38	24
Salary	25	26
Capitation	37	50

Source: A. Hillman, W. Welch, and M. Pauly, "Contractual Arrangements between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools," *Medical Care*, February 1992, 136–143; M. Gold et al., *Arrangements between Managed Care Plans and Physicians: Results from a 1994 Survey of Managed Care Plans* (Washington, D.C.: Mathematica Policy Research, 1994).

Here, health plans control costs through their market power to contract selectively and to set fees through their practice-guideline techniques.

In the 1940s and 1950s labor unions and a few employers, such as Kaiser, set up prepaid medical plans in which physicians were salaried and the health plan, like Kaiser Permanente, was nonprofit. HMOs have moved away from this staff model to a network model in which the physicians remain independent contractors or work in a group practice and the plans have increasingly become investor-owned. The trend also has been to "capitation," the payment to the physician or group of a set amount for every enrolled patient (Table 4). The payments are set so that the network physician (usually a primary care physician rather than a specialist) can meet the expected medical needs of the enrollees, using the norms of the health plan for cost-effective medicine. The physicians can be at financial risk, however, for unusually sick enrollees or for a practice pattern viewed as more costly than the norm. Similarly, lower-than-expected expenses on patient care add to physicians' income. Incentives to keep expenses low include bonuses, distributions from provider risk pools (created from capitation payment "withholds") if medical expenses come in below budget, and distributions from "subcapitation" pools (set up to cover specialist and other outside services) if expenses for those services come in below budget.

Perhaps an even more powerful incentive to physicians to adhere to the health plan's guidelines is the risk of being dropped from its network, or "delisted." In local and regional areas where only a few HMOs dominate, it is the HMOs, and not the physicians, that now effectively control

Table 5 HMO Presence in Large Metropolitan Areas, July 1995

	Market share (%)	Number of HMOs
Sacramento, Calif.	61	12
Rochester, N.Y.	57	2
Oakland, Calif.	52	12
Buffalo, N.Y.	50	3
Portland-Vancouver, Ore.-Wash.	46	9
Miami, Fla.	44	18
San Francisco, Calif.	42	15
Boston, Mass.	42	14
Minneapolis-St. Paul, Minn.	42	8
San Jose, Calif.	42	12
Los Angeles-Long Beach, Calif.	39	22
Anaheim-Santa Ana, Calif.	38	15
Salt Lake City-Ogden, Utah	38	8
Riverside-San Bernardino, Calif.	35	13
Louisville, Ky.-Ind.	35	7
Jacksonville, Fla.	34	9
San Diego, Calif.	33	12
Dayton-Springfield, Ohio	30	8
Milwaukee-Waukesha, Wis.	30	8
Philadelphia, Penn.-N.J.	29	12
Denver, Colo.	29	10
Washington, D.C.-Md.-V.-W.Va.	27	17
Baltimore, Md.	27	16
Phoenix-Mesa, Ariz.	26	10
Orlando, Fla.	25	11
Providence-Warwick, R.I.-Mass.	25	8

Source: Employee Benefits Research Institute, *EBRI Databook on Employee Benefits*, 4th ed. (Washington, D.C.: Employee Benefits Research Institute, 1997).

both the supply and the demand sides of the market. Significantly, fewer than 10 HMOs care for at least 25 percent of the insured population in 9 American cities of more than 1 million people (Table 5). Rochester and Buffalo, at the extreme, have HMO market penetration rates of 50 percent or more, with only 2 HMOs in Rochester and 3 in Buffalo. Nationwide, large organizations have come to dominate the market. Of almost 600 HMOs in this country, fewer than 50 are responsible for the health care of almost 90 percent of the enrollees (Fletcher and Engelhard 1995).

According to the American Medical Association, 92 percent of physicians in 1997 were in a practice that had contracts with one or more managed care companies (*New York Times*, March 25, 1998, D1). An

estimated one-third of these had at least one capitated contract as of 1996, as compared with one-fourth in 1994 (Miller 1996). And, if physicians in provider risk pools are included in the count, as many as half of all physicians were at some financial risk in 1994, based on a poll taken by the Physician Payment Review Commission (Latham 1996).

New Decision Makers

Another distinguishing feature of the HMO model is that a whole set of players, besides the once highly autonomous physician, become important in medical decision making. Under the rubric of cost-effective care, the writers of the protocols all but determine what physicians may do. Those who interpret the protocols also play a role, deciding, for example, whether a patient may see a specialist or take a diagnostic test.

Stepped-down professionalization is also the rule. The primary care physician frequently replaces the ordinarily more expensive specialist. The nurse or the technician performs tasks that a primary care physician commonly did in the past. Case managers, who are often nurses, typically interpret the protocols, for example, determining when a chronically ill patient will be discharged from the hospital by ruling on whether the health plan will reimburse an additional day of stay.

Employers, who in the past were almost totally uninvolved in medical decisions, have assumed complex new responsibilities under managed care (Moskowitz and Nassef 1997). Once passive bill payers, they now make decisions about the specific types of care health plans will reimburse and the appeals process when care is denied. How are such appeals to be heard? Are they to be reviewed only on their medical merits or should they be looked at against the broader interest of the firm, for example, in the case of a denial by health plan officials of a bone-marrow transplant for the spouse of an especially valuable employee? Even just a few years ago, issues of this kind would have been considered the inviolable business of patients and their physicians.

Keeping Savings within the Care Group

The underlying principle of managed care is that allocating medical care must have a social as well as an individual context, as it does elsewhere in the industrial world where costs are constrained by fixed budgets.

U.S.-style managed care, however, is hardly a “closed” system, responsible for bringing a given pool of resources to a collection of patients, as the British national and the Canadian provincial health systems are often described as being. If one patient in those systems is denied a procedure, say, elective surgery, because the costs seem large relative to the expected benefits, the resources not spent are used elsewhere in the group. The aim is a larger fairness—something that makes it easier to deny care to British and Canadian patients than to their American cousins (Menzel 1990). If nothing else, the patient denied care in a closed system has the consolation that someone else in need in the group will gain from his or her loss.

An American HMO is “closed” in the sense that premiums are exceedingly difficult to raise, but it is hardly closed in the social sense of distribution of resources within a group, especially with the trend to investor-owned HMOs. The opportunity cost of a medical procedure is not kept internal to the system. Any saving in costs stands to benefit not just other health plan subscribers in the form of lower premiums or other health care services, but also stockholders and top management in the form of compensation (sometimes well into seven-figure brackets). Strikingly, the founder of U.S. Healthcare received over \$900 million in cash and stock when the company was sold to Aetna in 1996 (*Wall Street Journal*, April 2, 1996, 2). In this key respect, today’s HMOs are unlike the prepaid medical plans of the 1940s and 1950s. Those nonprofit plans were closed systems, designed for the benefit only of those in the care group.

Incentive to Undertreat

What made fee-for-service medicine inherently inflationary was its incentives to “overtreat” patients: to minimize, if not ignore, costs in the calculation of benefits. The ethic of “use it if it might help,” while it gave some patients a chance for beneficial procedures they might otherwise not have had, coincided with, indeed promoted, physicians’ economic interests. It also stimulated advances in medical technology, which, while they benefited some patients medically, benefited physicians financially.

The ethic of “don’t use it unless it clearly will help” and the incentives in managed care pose the opposite danger of “undertreatment.” Every

decision to forgo an expensive diagnostic test—because it promises little, even if some, benefit—goes directly to the financial interests of the organization itself and its contract physicians. Yet, every such decision poses some, even if little, health risk to the patient. HMO medicine thus sets up an inevitable conflict between the financial health of the organization and its physicians and the physicians' traditional fiduciary role.

In theory, such conflict will be resolved by HMOs' quality control mechanisms and appeals process. But, in practice, decentralized network HMOs are difficult for centralized quality control mechanisms to monitor (Povar and Moreno 1988), and it takes a willingness on the part of physicians to make a case for care outside the protocol or on the part of patients to appeal a denial of possibly beneficial care.

For physicians, the penalty of being dropped from a network for repeatedly going outside plan guidelines has become ever more severe as HMO market share and size have increased. Rarely are patients in a position to challenge care decisions made by a health plan, especially if they do so without their physician's support.

Sharing Financial Risk with Physicians

Capitation is a way for the insurer to shift some of the financial risk to the physician. Because it relieves the insurer of the need for case-by-case or day-to-day medical decision making as a means of cost control (Miller 1996), it restores, albeit within a fixed budget, some of the clinical autonomy physicians had lost. Capitation, however, adds to their double agent dilemma. It makes them not just double, but triple agents, facing daily conflicts between the needs of their patients, their responsibility to the health plan that employs them, and their own need to make a living.

Capitation was designed to force physicians into the cost-conscious practice of medicine by putting their economic interests at stake. But that is why it is ethically dubious. It pits the economic needs of physicians directly against the medical needs of patients. It compromises their ability to offer disinterested advice (Rodwin 1993). Worst of all, unless capitation is adjusted for the medical needs of patients—a virtual impossibility except for crude adjustments such as for age—or covers

groups of patients large enough so that the costs of caring for them are easily subsumed in a large aggregate, it acts as an incentive to avoid enrolling and caring for the sickest patients.

Capitation is especially problematic when the cost of diagnostic tests, specialists' fees, or hospital stays in excess of the norms of the health plan must be carved out of the set amounts paid to primary care physicians. "Gatekeeping" may be a role natural to modern medicine, with its many specialties and subspecialties, but it becomes a hopelessly conflicted role for HMO physicians when undertreatment can be rewarded.

Traditionally, medical ethics requires physicians to provide all necessary care to their patients, irrespective of cost. Now, however, a growing number of physicians are being compensated under arrangements that conflict with rather than foster that professional ideal (Latham 1996). The ideal, to be sure, is ingrained. But, with ever larger financial incentives coming into play, even deeply held values can easily get compromised.

Undermining Informed Consent

When care that could prove to be beneficial is denied, HMO subscribers may want to purchase it on their own. Physicians have an obligation to help patients understand the costs and the benefits of the nonreimbursed care, that is, to continue to act as agents of patients even if not also as agent of the HMO that denied the care. What if, however, patients could not possibly afford to pay for the denied care on their own? Of what value is it to educate them about a possibly beneficial course of testing or treatment that is beyond their financial reach?

When a medical option will not be reimbursed, the risk is that HMO physicians will downplay its merits. The danger is especially large when patients lack financial resources, but it is not confined to them. Even those who might be able to afford nonreimbursed care may opt to appeal a denial of care, putting the physician in the middle of an often painful process.

To discourage appeals, health plans often use various direct and indirect means to encourage physicians to downplay the potential medical usefulness of nonreimbursed care. Many states have outlawed HMO "gag

rules,” which inhibit physicians from educating patients about medical care choices a health plan is not willing to reimburse. The federal government banned gag rules in last year’s Balanced Budget Act, although only on behalf of Medicare and Medicaid patients.

Compliance with these regulations, or more to the point with their intent, is difficult to enforce, however. Rarely, if ever, do health plans require their physicians to sign contracts containing clauses that would plainly bar physicians from telling patients about nonreimbursed treatment options (General Accounting Office 1997). Routinely, however, plans require physicians to abide by clauses that can easily be interpreted as limiting such communication. The limitations may appear under the guise of a requirement that a physician not undermine the confidence of the subscriber in the health plan—the standard nondisparagement clause. Or they may be phrased as noncompete or confidentiality clauses. The effect is the same: to inhibit physicians from giving full information to patients about medical options outside the plan. A health plan’s ability to terminate a physician’s contract—at will and without cause—can have a chilling effect on physician-patient communications.

However subtle or disguised, gag rules undermine informed consent, the patients’ right to be told about treatment options which has been integral to the practice of medicine in the United States for decades. Gag rules deny to patients the autonomy that informed consent endows and they turn back the clock to a “doctor-knows-best” era when patients had little access to information about their conditions and little control over what physicians did on their behalf.

Gag rules also promote “gaming.” Blocked from pursuing the care that physicians believe is indicated and even from honest communication with their patients about alternatives outside the health plan, physicians may be tempted to exaggerate to health plan management the adverse consequences of not following what they prescribe or shade the truth in other ways in an effort to get the care they believe their patients need. That may be all to the good in individual cases, but the merit of a medical care system that can so easily give rise to a culture of dishonesty to ensure that patients’ needs are met is questionable.

Accountability for Care Decisions

HMOs can be sued for malpractice when their contract or staff physicians make a serious medical mistake and their physicians remain personally liable for malpractice. The HMO physicians may well be more exposed to lawsuits than those in independent practice because of their reduced freedom to pursue what the HMO regards as marginally beneficial procedures.

It is difficult, however, to hold health plans legally accountable for care decisions that ultimately cause serious harm if the plans are acting on behalf of self-insured employers—a powerful protection since most Americans covered by private health insurance are covered under self-insured employer plans. Under such plans, an injured person can recover the dollar value of the benefit that was denied, but usually nothing more. The courts have tended to find no cause for action against self-insured plans, as they have interpreted a particular modality of care or a denial of care that caused serious harm as a benefit determination under the 1974 Employee Retirement Income Security Act (ERISA).

Drafters of the law had not intended to free health plans from liability for institutional negligence; concern about such negligence was not even on the horizon in the early 1970s when fee-for-service was the dominant model. The object of the law was to allow large employers to reap the full benefit of cost-conscious medical care, using their sophistication as purchasers and their clout in the marketplace (Zelman 1996). To that end, employers could become exempt from state taxation of insurance, which was growing rapidly at the time, and from state regulation of benefits. Such regulation, which was often confusing and conflicting, was seen at the time as a major impediment to the growth of national health insurance companies and national compensation policies for their employer customers (C. Eugene Steuerle, personal communication 1998).

While not intended to do so, the ERISA preemption of states' authority to regulate health plan contracts afforded health plans a remarkable degree of protection against compensatory damages. An HMO is liable when one of its physicians makes a serious medical mistake (e.g., a surgeon leaves a sponge in the stomach of a patient after an operation), but

it does not have to fear a lawsuit when a patient suffers comparably serious harm because of a decision based on a contract definition of benefits (e.g., after a utilization review nurse rules that an inexpensive diagnostic test is called for rather than an expensive, though generally more reliable, one).

The courts that have found health plans not liable for errant care decisions, in effect, have been unwilling to view the plans as sharing the moral agent role with physicians. And yet, the plans adopt the protocols, rule on whether patient care is in line with those protocols, and act as quality control managers. They cannot reasonably claim, as they could in the old fee-for-service model, that they are but the paymasters of employers, responsible only for ensuring that contract terms are met.

Nor can they claim that they are simply pursuing a care regime about which there can be no question. To the contrary, the protocols governing decisions to provide care in one way rather than another or to deny care are not the product of a consensus within the medical profession. They are but guidelines devised primarily by for-profit companies themselves and unilaterally imposed on physicians (Reinhardt 1996). In application, the guidelines may well miss important elements in clinical situations, for example, the special needs of the elderly, the severity of an illness, and the complexities of interacting diseases. They also become dated very quickly.

Choice and Understanding in Insurance Contracts

Many analysts stress that key decisions about health care are made when people purchase health insurance (Havighurst 1995). The choice of a lean health plan, the argument is, is also a choice to spend on other things. The relevant question is not whether someone who comes down with a dread disease would want to “pull out all the stops”; rather, it is whether other persons, when they are healthy, would want to share in the costs of such efforts “to provide for the unlikely event of personally being in the same situation” (Hall 1997). The conflict is not between a patient and society, but between two equally rational preferences of an individual, only in different circumstances. Willingness to pay drops to zero when the risks become infinitesimally small (Menzel 1990).

Emphasis on choice at the level of insurance, however, glosses over the practical limits of the choices many people have. Employees ultimately pay for their own health insurance by forgoing other compensation, but it is their employers who are the purchasers of health care for them (a by-product of the tax exclusion enjoyed by employment-based health insurance⁵) and it is their employers who as the purchasers design the benefit packages and thus the kind of care the employees will receive.

Even when employees can choose between a traditional indemnity plan and an HMO, few are in a position to know the full implications of that choice. In choosing the HMO, they consent to medicine that, relative to what they knew in the past, is constrained in the use of resources and that affords their physicians less scope to advance their interests. They consent to care limited to what health plan officials, rather than their physicians, view as worth the cost, forgoing care that falls outside that boundary. The consequences of that consent are almost impossible for them to know. Even if insurance policies could be written to describe the care to be provided in every circumstance, they would not be understood, judging by the jargon and the caveats that characterize the policies. Indeed, understanding does not seem to be the aim at all.

Given this lack of choice in the design of benefits and this lack of information, it is fair to ask: Can people be held to contracts entered into without freedom or understanding? Surely society's answer is no when it comes to the care of the newborn; resource limits get pushed out very far, precisely because newborns have no free choice (Menzel 1990). Emphasizing choice at the level of insurance may be perfectly reasonable if what is at issue is a contract between parties with similar information, which is the underlying premise of business ethics. When the relationship must depend on trust—because parity of information is impossible to attain—business ethics cannot govern.

When adjudicating health insurance contract disputes, U.S. courts generally have rejected the traditional presumption of parity of information built into contract law. They have, instead, interpreted those contracts according to what the beneficiary might reasonably have expected, or should be entitled to expect, rather than the actual terms of the contract. The theory has been that justice hinges on enforcing contracts people can both choose and understand (Morreim 1995).

Hall (1997) has argued that HMO subscribers consent to care constraints and incomplete information when they make the insurance decision. The theory is that, except for major invasive treatments, people cede informed consent to their HMO director and their primary care physician as part of a broader bargain to buy cost-conscious health care. They agree in advance to a bundle of unspecified refusals of marginally beneficial care (and, in addition, to being told about the care that is not covered)—just as they agree to being subjected to a regime of blood pressure and temperature checks and similar small routines when hospitalized.

Some people may well be prepared to strike the bargain Hall proposes. Others, however, will regard it as Faustian. Much like a gag rule, ceding informed consent to an HMO or a physician, even if only for care considered routine, would mean a reversion to the paternalism of the past. It would vest a trust in protocols that may be warranted in most circumstances but not in all. And it would require confidence in the HMO's ability to suspend short-term "bottom line" thinking in care decisions.

A Framework for Patient Protection

As public concern with managed care has grown, the response of policy-makers at state and federal levels has been to second-guess the protocols and often override them by regulation or statute. Not surprisingly, their intervention has been on matters that have captured headline attention: 24-hour hospital stays after routine childbirth, outpatient mastectomies, and other such practices that strike much of the public as bizarre.

Regulatory interventions of that kind may be useful if they remind health plan officials (and ultimately the employers who shape the benefit packages) of the dangers of carrying the economical practice of medicine to extremes. But they put government in a micromanagement role it cannot hope to perform well. And they may well encourage the kind of "cook-book" medicine that critics of managed care accuse it of providing. These interventions are, moreover, regulation around the edges of the problem. Government, instead, should fashion a regulatory framework that would deal with more fundamental issues—most important among them, financial incentives, disclosure, professionalization, and the impact of ERISA on patient welfare.

Separating Financial Incentive and Patient Care

Capitation may be an effective way of forcing physicians to practice cost-conscious medicine. The challenge for regulators is to retain the power of the economic incentive to achieve reasonable cost reductions but to separate it from the welfare of individual patients. This could be done by limiting the extent to which physicians' income is at risk; by spreading the risk across large numbers of health plan participants and physicians; and by calculating the incentive payments over a long period of time. The object would be to weaken the close connection between individual clinical decisions and physicians' incomes.

Limiting the income subject to risk is the approach the Health Care Financing Administration has taken in ruling that stop-loss insurance is required if the percentage of income at risk for an individual physician or for a group exceeds 25 percent. This type of ruling, however, provides little protection to patients when it affects the income of physicians in solo or small group practices. It spreads the income risk over too few patients to be much of a defense against undertreatment. In particular, as Latham (1996) has pointed out, it would be of little value to potentially high-cost patients who seek medical care at the end of the contract period when significant amounts of money in the form of incentive payments—even if far short of 25 percent of income—are riding on the kind of care they are given. Unexpected expenses from only a few patients need not be all that large to upset a budget that is on track as the end of the contract period nears. What matters most from the patient's point of view is how much money is at stake in his or her own treatment—a consideration that regulation built around a 25 percent figure fails to recognize adequately in many cases.

Limiting the income subject to risk makes more sense if applied across a large physician group—large enough in any case to undermine the incentive to undertreat. The theory is that one physician's unexpectedly high costs in a given contract period will tend to balance out another's unusually low costs—making it possible for all to earn the incentive payments without having to compromise clinical judgments.

It would also make sense for regulators to oblige health plans to calculate incentives infrequently. That, too, would separate the incentive from the care decision. High-cost patients would pose a smaller threat to physician income if their expenses were averaged in the cost data for a whole year, say, rather than for only a month or a quarter. Unusually large expenses for a given patient would be far less threatening to an annual budget than to a monthly or quarterly one.

Need for Transparency

Most current regulation governing physician conflict of interest was written when fee-for-service medicine was the dominant model. It thus characteristically prohibits arrangements (such as tie-ins to physician-owned laboratories and other outside facilities) under which physicians benefit from providing unnecessary care (Martin and Bjerknes 1996). But it is the withholding of care that is the problem arising from today's dominant model. Regulation needs to be keyed to today's reality, not yesterday's.

Health plans ought to be required to disclose—in plain language—the financial incentives under which their contract or salaried physicians work. HMOs have resisted disclosure on grounds that it would undermine the trust of patients in their physicians. Disclosure, to be sure, would not further trust, but any resulting distrust would come not from transparency but from the incentives themselves. The fear that disclosure will undermine trust says a lot about the incentives and the decisions taken because of them. Physicians should not work under financial arrangements they would be unwilling to disclose to patients (Hall 1997).

Health plans should also be obliged to disclose just how they practice cost-conscious medicine. Granted, it is impossible to describe how they would respond to every contingency, but it is not impossible to provide reasonably complete information on such things as the utilization review process, the criteria used for denial of care, and the recourse patients have when denied. Honest discussion of the plan's methods for meeting the medical needs of their subscribers at relatively low cost would be of greater benefit to subscribers than the hype that now characterizes the marketing of many HMOs.

Moreover, every means of striking implicit as well as explicit gag rules from physician contracts ought to be pursued (Martin and Bjercknes 1996). Federal legislation to that end (H.R. 2976, the Patient Right to Know Act), which was introduced in 1996 by Representatives Greg Ganske (R-Ind.) and Edward J. Markey (D-Mass.), received wide bipartisan support. The draft legislation, which would bar a health plan from restricting communication between patient and physician, was defeated, however, on grounds that it would raise health care costs—an acknowledgment that gag rules, in fact, restrain costs.

Treatment denials and the options open to denied patients should be truthfully disclosed, as the Ganske-Markey bill would have required. And they should be disclosed even if disclosure would have the effect of making denials difficult to enforce—the reason why gag rules help contain health care costs. Patients may have agreed to cost-conscious health care when they made the insurance decision, but, because their knowledge of what that might mean in practice is necessarily limited, they did not agree in advance to remaining ignorant of their options outside the plan. The taxpayers who finance Medicare and Medicaid, whose patients are protected by federal law against gag rules, deserve similar protection as patients.

Role for Purchasing Cooperatives

Regulatory disclosure requirements may not provide adequate consumer protection, however. One promising possibility would be to resurrect the idea of “purchasing cooperatives” (a concept akin to the “health alliances” of the Clinton health plan), designed at a minimum to make available to consumers objective comparative information on health plans and their style of practice, thus mimicking the benefits office of any well-run U.S. corporation of size. The goal would be to push the managed care marketplace in the direction of competition on the basis of quality and price rather than marketing.

Regularly published data on such things as the rate of legitimate complaints from subscribers, the percentage of subscribers who disenrolled, and physician turnover would be of value not only to consumers but also to small employers unable to staff a benefits office. The model could be the Pacific Business Group on Health, a coalition of large employers (located

Table 6 Medical Loss Ratios (Percentage of Premium Revenue Spent on Direct Patient Care)

	1994	1995	1996
All HMOs	80.1	83.1	86.1
For-profit HMOs	79.6	82.2	85.6
Nonprofit HMOs	85.3	86.4	88.5

Source: HCIA, *Guide to Managed Care* (Baltimore: HCIA Inc, 1997).

mainly in Northern California) that collects health plan performance data and disseminates them to participating employers and their employees.

Regularly published comparable data on “medical loss ratios” (the percentage of premium revenue spent on direct patient care) would also help consumers to make a choice (Table 6). These ratios, which have crept up in recent years, especially at for-profit companies because of heightened competition and attendant price pressures, averaged 85.6 percent at for-profit plans in 1996 and 88.5 percent at nonprofit plans (HCIA 1997). While many factors could account for the lower percentage of revenue that investor-owned firms still dedicate to direct patient care, the pressure to produce earnings to support share prices is surely among them.

Purchasing cooperatives would also bring the benefits of pooling to relatively small employers.⁶ And they could be an instrument for prodding the market in the direction of largely uniform plans. Having to choose among a relatively small number of plans would enhance rather than restrict choice, as it would reduce the complexity consumers now face in making a choice. Largely uniform plans whose features become well known would also increase consumer confidence that needed care will not be unfairly denied or otherwise compromised on cost grounds. Standardization, moreover, would also reduce the cost of contract administration and thus channel proportionately more resources to direct patient care.

The role of the cooperatives could be broadened to include an appeals mechanism. The object would be independent appraisal of whether denials of care, for example, were in line with the stated practice of a health plan. Third-party objectivity would help to reduce the volume of

malpractice litigation as well as level the playing field between subscribers and health plans.

Third-party appeals mechanisms would also foster cost-effective medicine. HMOs thrive financially by taking an aggressive stance on whether a particular benefit is covered under a health insurance contract. They can do so because of the gray areas, if not outright uncertainty, medicine must deal with, especially in a high-tech age. But this creates costs that ripple throughout the health care system: in claims disputes, in the financing of unpaid hospital receivables, and in other overhead—all of which would diminish when contract disputes could be settled promptly with third-party rulings.

Reasserting Medical Criteria in Care

Regulators also need to ask some basic questions about what constitutes the practice of medicine. Reduced professionalization does not necessarily raise credentialing issues. But the same cannot be said of utilization review by nonphysicians.

One approach would be for regulators to insist that utilization review be the province of physicians—in effect, to declare it the practice of medicine (Gray 1991). That would restore a measure of autonomy that physicians have lost in the shift to managed care. And it would tip the power balance away from business, and toward medical, criteria in care decisions.

An alternative approach, which has been put forth by the American Medical Association, would be to require a medical staff structure similar to that at hospitals (Council on Ethical and Judicial Affairs 1995). This also would put utilization review back in the hands of physicians, as they would have to sign their names to any patient care decision of any importance.

Reexamination of ERISA

Consideration also ought to be given to amending ERISA to ensure that health plans can be held liable when decisions adopted for cost reasons do serious harm. In combining the financing and delivery of health care, HMOs cannot claim that all they do is implement the benefit decisions of employers. If only because they can deny care, they are active in the

delivery of care and are thus fiduciaries in their own right. Like physicians, the health plans have obligations based on traditional medical ethics in decisions to provide or withhold care or to provide it one way rather than another. As ordinary business enterprises they have obligations based on the square-dealing required by business ethics. Regulation is needed to hold the health plans accountable for both sets of obligations.

Another reason to amend ERISA is that it creates an uneven playing field in its override of state mandates for self-insured plans. It is doubtful that the quality of medical care in this country has been adversely affected by the override. Certainly, however, mandates designed in the lobbying corridors of the statehouse, which have shaped the kind of insurance everyone else has been forced to buy, have added to health care costs. As a result, other, possibly more beneficial, services have not been included in the fixed budgets that health plans have had to work with. Ideally, not only self-insured employers but all health plans would be exempt from state mandates. That would be at little potential cost to health care quality and, quite possibly, of large potential benefit.

Yet another reason for amending ERISA is that it impedes efforts by the states to enact health care reform by blocking the application of reform to self-insured plans. Perhaps most important in an age of managed care, states are hampered in funding care for the indigent through insurance pools because they cannot tax self-insured funds (Farrell 1997).

This is especially important because care for the indigent is much harder to finance than it was in the past. To be sure, HMO medicine has made health insurance more affordable for millions of Americans who would have had to forgo health insurance had the cost trend of the past continued. But the discounting that managed care has forced on private hospitals (along with the higher administrative costs they have had to incur to deal with managed care payers) has squeezed their charity budgets, pushing patients who are unable to pay in ever greater number into underfunded, and often inadequate, public hospitals.

Enacted long before the advent of the trend to managed care, ERISA is overdue for reexamination in the light of then unanticipated institutional change. The express preemption of state law-making authority creates a legislative void. The states may not act, and Washington, relying

on a statute whose relevance is now questionable, has not acted. The void has been filled by the courts, but the resulting judge-made law, without a legislative framework, is piecemeal and inconsistent (Farrell 1997).

The Provider-Sponsored Network: A Modern Variant of the Staff-Model HMO

The market itself is taking steps to shift the power balance back to physicians, creating in the process a modern variant of the staff-model HMO. That is the message of the rise of “provider-sponsored networks” (PSNs), which are effectively HMOs but with roots in medicine rather than insurance.

The core property of PSNs is their capacity to assume responsibility for a continuum of medical care (Zelman 1996). Their assets are concentrated in the actual delivery of care (hence the similarity to the staff-model HMO of old), whereas the assets of the typical network-model HMO are largely in its administrative capacity (Hirshfeld 1996). Significant savings can flow from integration—especially by cutting out the overlapping costs incurred when patients are moved between hospital and nursing home or rehabilitation facility. By reducing redundant procedures and red tape, integration would make for a more humane as well as a more efficient health care system. Today’s HMOs—built as they are on loose networks of physicians and hospitals—are hardly structured to bring about the case-management benefits that, in the end, are the rationale for HMO medicine (Kuttner 1998).

PSNs—whether made up of physicians only or, as is increasingly the case, linked to hospitals and other care givers—have emerged in reaction to the trend to capitation in the network-model HMO. If physicians are to assume significant financial risk for such things as the services of specialists and even the hospitalization of their patients, they may as well take on the full insurance function themselves. That way, they not only regain lost autonomy, they cut out third-party administrative expense.

If the PSN is nonprofit, the system is closed, an added advantage from an ethical perspective. Any savings would be held within the care group—if not in the form of medical care, then in the form of lower premiums. This added advantage is far from assured, however. It depends on

restraint in physician compensation, lest the nonprofit PSN become indistinguishable from the investor-owned HMO with which it competes (C. Eugene Steuerle, personal communication 1998). Whether excess returns are in the form of outsize physician salaries or in the form of profit windfalls makes little difference to patient welfare.

The federal government was instrumental in promoting PSNs in the Balanced Budget Act when it offered Medicare beneficiaries the option to select a PSN among a wider choice of health plans than beneficiaries had available to them in the past. As part of the legislation, PSNs were given the opportunity to meet new federal solvency standards rather than state standards, which vary greatly and thus often blocked the development of PSNs. In most states, only the largest and most sophisticated physician practices, which were typically linked to hospitals, were in a position to be state licensed as a health plan.

As for the commercial market, only an employer that is self-insured—typically a large corporation—may contract directly with a PSN for the health care of its employees. Just as before, the corporation bears the insurance risk. Also, just as before, it can count on fixed costs for health care—in this case, what would be a global capitation payment. But, now, its employees gain from decisions influenced more by strictly clinical considerations. Employers have formed coalitions in several cities (notably Minneapolis and St. Paul) to contract directly for health care. The California Public Employees Retirement System (CalPERS) announced earlier this year that it was exploring the possibility of direct contracting.

Allowing employers generally to contract directly with PSNs would be a step forward. The key question is just how much financial risk PSNs assume in dealing with relatively small employers who are not in a position to bear insurance risk. One option would be to regulate PSNs as insurance companies, but not for services that they perform themselves. The theory is that they do not assume insurance risk for such services—only routine business risk, which does not threaten their capacity to deliver what was promised. Under this option, capital requirements would be risk-based. A PSN would be required to hold capital commensurate with its exposure to insurance risk, which would become quite small as PSNs grow in size and scope.

A relatively small PSN, however, would assume insurance risk even for its own services, as its solvency could be threatened by a handful of high-cost enrollees (Stephen A. Felsted, personal communication 1998). Re-insurance could be required, which would transfer risk back to the insurance market. The federal government should pioneer such insurance if the private marketplace is timid to establish it.

Ultimately, the problem with prepaid medicine is that risk-bearers must have significant control over allocation decisions. They must be in a position to price risk and manage it. But that thrusts insurance carriers into health care roles for which they are not suited. To mute the inherent conflict between business and medical criteria in care decisions, much if not all of the risk of financial failure has to be put on those who properly make care decisions.

Cost-Effectiveness versus Quality Care in the Future

Further spread of managed care is almost certain in a background of ongoing advances in costly medical technology. Despite the misgivings of many physicians and of an apparently growing part of the public at large, the payers see themselves as without good alternatives. Also, the federal government is relying on managed care as part of a long-range plan to rein in outlays for Medicare and Medicaid. Employers can be counted on to continue to keep a lid on benefit costs, even as advances in technology pull in the opposite direction. Indeed, much of the backlash against managed care should properly be directed at employers, who are much more active than ever before in fashioning the set of health benefits their employees receive. In the end, HMOs are instrumentalities of those decisions.

In coming years, managed care's ability to control health care costs will be tested as never before. It will be greatly more difficult to keep health care costs under control now that much of the high-cost, low-benefit medical practice of the past has been eliminated. Managed care can no longer generate rapidly rising earnings and, at the same time, maintain the level of quality it now provides. The real test of managed care as an instrument for both cost-effectiveness and the ethical delivery of quality in medical care thus still lies ahead. While the slump last year in Oxford

Health's stock price reflected company-specific problems, the challenge managed care now faces also must have figured in the outcome.

Renewed rise in HMO premiums for many employers is also troubling. The pressure for earnings imposed by the marketplace is unrelenting. But, with the "low-hanging fruit" already picked, it is no longer easy to satisfy investors without sacrificing the quality of health care or without raising its price. The danger that patient care will be compromised is thus now especially high. The pressure for earnings has been there all along, interacting with financial incentives that can be perverse. Both of these, on their own, may be innocuous enough—even benign—but not in combination. The combination promises to pose even greater threat to patient care now that the easy efficiency gains in health care have been made.

In this background, it is especially important that consumers have an opportunity to exercise choice in their health insurance; that they understand the consequences of cost-conscious choices, in particular; and that they are fully apprised of the financial incentives under which their physicians work. It is also especially important that health plans be held accountable and that consumers have an opportunity to prevail in disputes with health plans when the merits of their cases can be shown.

Notes

1. This includes so-called point-of-service plans, which give enrollees greater choice of physician than traditional HMOs in exchange for higher out-of-pocket costs.
2. Author's calculation based on Table B-3, *The Annual Report of the Council of Economic Advisers*, February 1998.
3. As noted later, the price of health insurance has quickened this past year. Insurers have responded to a squeeze on margins, although pricing power remains limited because of the pressure employers continue to exert to keep their employment costs down. In any case, the macroeconomic impact of recent price increases has been quite small. The Office of the Actuary at the Health Care Financing Administration has estimated that 1998 health expenditures as a percent of GDP have crept up only 0.2 of a percentage point from the 1997 figure of 13.5 percent (Smith et al. 1998). The figure has been basically unchanged since 1992.
4. It is not entirely a private sector activity because of the buying power of Medicare and Medicaid and the regulatory authority of the states and the federal government.

5. The tax exclusion is prominent among the reasons why U.S. health care costs are extraordinarily high—and thus a major reason for the shift to managed care. Because of the exclusion, employees typically have more health insurance than they otherwise would. The insurance protects against the financial consequences of a major unforeseen illness, a reasonable use of insurance to spread risk. But it also pays for routine and predictable expenses that otherwise would be paid out of after-tax income, an unreasonable use of insurance made reasonable only by the exclusion. The arena over which moral hazard has held sway has thus been very broad. The exclusion pushed health insurance in the direction of increasingly comprehensive benefits and then, as moral hazard would have confidently predicted, overuse of those benefits as if “free.” Fee-for-service medicine was able to charge more than it otherwise could have, since the payments ultimately came out of before-tax, not after-tax, income (Cadette 1997).
6. Small employers have begun to join forces as purchasers of health insurance in California and a handful of other states. Their impact on the market thus far has been quite small.

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Acknowledgments

I am grateful to many friends and colleagues for their help in writing this paper. Steve Felsted and Mark Sibben (Holy Cross Health System), Jack Taylor (formerly of The Park Ridge Center), Gene Steuerle (The Urban Institute), Bette Crigger (The Hastings Center), Susan Regan (Visiting Nurse Service of New York), and Jack Meyer (New Directions for Policy) made insightful comments on the draft. Ken O'Donnell (Employee Benefits Research Institute) and Jean Chenoweth (HCIA) were most helpful in responding to requests for data. As always, the editorial and library staffs at the Levy Institute gave generously of their time and talent.

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