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HIGHLIGHTS

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Regulating HMOs

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In little more than a decade, managed care has transformed the financing and the delivery of American health care. It has imposed cost-consciousness on physicians and hospitals, and it has forced hospitals to cut back on excess capacity. It has all but replaced fee-for-service medicine in the employment-based health insurance market. It has slowed the decades-long rise in health care's share of GDP, and its projected saving for Medicare and Medicaid is a key premise behind the budgetary surpluses penciled in for the decade to come.

At the same time, it has limited the health care choices insured Americans once had, and public disquietude with HMOs has increased as anecdotes of denials of care have multiplied. Some disquietude is also being felt in Congress and state governments, judging by discussions of a patients' bill of rights and the imposition of rules regarding clinical practice, for example, minimum hospital stays after childbirth.

Regulatory interventions of this kind may be useful if they remind HMOs (and ultimately the employers who shape the benefits packages) of the danger of carrying the economical practice of medicine to extremes. But they put government in a micromanagement role it cannot hope to perform well. Government, instead, should focus on building a regulatory framework to protect patients that would deal with fundamental issues, principally, the financial incentives under which HMO physicians work, restrictions on physicians' communication with patients about care options not covered by their health plan, accountability for decisions to withhold care, and the return of care decisions to the province of physicians.

Sources of Ethical Problems

The ethical problems of HMO medicine flow from its very design. A major source of concern is the guidelines that govern the clinical decisions of HMO physicians. The guidelines may yield significant savings, but they threaten physician autonomy and physician capacity to act as patient advocate.

In the HMO system of prepayment, every dollar of revenue is also a potential dollar of profit if it is not spent on direct patient care—an incentive, or at best a temptation, not just to economize on care but to skimp on it. Every decision, for example, to forgo an expensive diagnostic test because it promises little, even if some, benefit to the patient goes to the financial interest of the HMO and its physicians. Yet, every such decision poses some, even if little, health risk to the patient.

The trend has been to capitation, the payment of a set amount for every enrolled patient. The payments are calculated to allow health plan physicians (usually primary care physicians rather than specialists) to meet the expected medical needs of enrollees, using the norms of the health plan for cost-effective medicine. Physicians can be at financial risk, however, for unusually sick patients or for practice patterns viewed as more costly than

the norm. Similarly, unexpectedly low patient care expenses add to physicians' income. An even more powerful incentive for physicians to adhere to the health plan's guidelines is the risk of being dropped from its network. In local and regional areas where only a few HMOs dominate, they, no longer the physicians, effectively control both the supply and the demand sides of the market.

HMO medicine thus sets up an inevitable conflict between the financial interests of the organization and its physicians and the physicians' traditional fiduciary role. Physicians have become agents of the health plans that employ them as well as fiduciaries of their patients.

Disclosure requirements may not make enough information available to patients to protect them, however. One promising possibility is the idea of "purchasing cooperatives," designed at a minimum to supply people (as consumers of health care) with objective comparative information on health plans and their style of practice.

Policies to Mute the Conflict between Medical and Business Criteria in Care Decisions

The challenge for regulators is to retain the power of the economic incentive to encourage cost-conscious practice, but to separate it from the welfare of individual patients. This could be done by limiting the extent to which physicians' total income is at risk, by spreading the risk across large numbers of health plan participants and physicians, and by calculating the incentive payments over long periods of time. The objective would be to weaken what otherwise might be a close connection between physicians' incomes and the decisions they make regarding the treatment of any one individual.

Health plans ought to be required to disclose—in plain language—the financial incentives under which their contract or salaried physicians work. Health plans object that disclosure might engender distrust, and, to be sure, disclosure in itself would not further trust. The lack of trust lies not with failure to disclose the financial incentives, but with the incentives themselves. Physicians should not work under financial arrangements they would be unwilling to disclose to patients (Hall 1997).

Every means of striking gag clauses from physician contracts ought to be pursued (Martin and Bjerknes 1996). Rarely do health plans explicitly bar physicians from telling patients about nonreimbursed treatment options (General Accounting Office 1997), but routinely they require physicians to abide by clauses (nondisparagement clauses, for example) that can easily be interpreted as limiting such communication. However subtle or disguised, such clauses undermine informed consent, the patient's right to be told about treatment options that has been integral to the practice of medicine in this country for decades.

Health plans should be obliged to disclose just how they practice cost-conscious medicine. Granted, it is impossible for them 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 a procedure is denied. Such disclosure should be required even if it would have the effect of making denials difficult to enforce—the reason gag rules help contain health care costs. Patients may have agreed to cost-conscious health care when they enrolled in a plan or chose one plan over another, but, according to principles established in contract law, because their knowledge of what that decision might mean in practice is necessarily limited, it cannot be argued that they also agreed in advance to remaining ignorant of the options outside the plan.

Disclosure requirements may not make enough information available to patients to protect them, however. One promising possibility is the idea of "purchasing cooperatives," designed at a minimum to supply people (as consumers of health care) with 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 percentage of premium revenue spent on direct patient care, the rate of legitimate complaints from subscribers, the percentage of subscribers who disenrolled, and physician turnover might also prod the market in the direction of largely uniform plans, reducing both the complexity consumers face and the cost of contract administration.

The role of the cooperatives could be broadened to include an appeals mechanism. Independent appraisal of,

for example, whether denials of care were in line with the stated practice of a health plan, would level the playing field between subscribers and health plans and also help reduce the volume of malpractice litigation. A third-party appeals mechanism 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 uncertainties in medical practice, especially in a high-tech age. But this aggressiveness creates other costs that ripple throughout the health care system: in claims disputes, the financing of unpaid hospital receivables, and other overhead—all of which would diminish if contract disputes could be settled promptly with third-party rulings.

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

Regulators also need to ask some basic questions about what constitutes the practice of medicine. Reduced professionalization does not necessarily reduce the quality of care or raise issues of the level of training that should be required to perform certain tasks, 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 to be the practice of medicine (Gray 1991). That would restore to physicians a measure of the autonomy they have lost in the shift to managed care, and it would tip the balance in care decisions away from business criteria and toward medical criteria. Another approach, which has been put forth by the American Medical Association, would be to require managed care organizations to establish a medical staff structure similar to that at hospitals (Council on Ethical and Judicial Affairs 1995). Such a structure, in which physicians must sign any patient care decision of any importance, would put utilization review back in their hands.

The 1974 Employee Retirement Income Security Act (ERISA) ought to be amended to ensure that health plans can be held liable when decisions adapted for cost reasons do serious harm. Under ERISA, it is difficult to hold health plans legally accountable if they are acting on behalf of self-insured employers—a powerful protection since most Americans with employment-based health insurance are covered under self-insured employer plans. An injured person can recover the dollar value of the benefit that was denied, but often nothing more. The courts have tended to find no cause for action against self-insured plans, as they have interpreted a denial of care or a particular modality of care that has caused serious harm as a benefits determination under ERISA.

Drafters of the law had not intended that it exempt HMOs or others from institutional negligence—a concern not even on the horizon in the early 1970s when fee for service was the dominant model. The object was to allow large employers to reap the full benefit of cost-conscious medical care. However, the exclusion of self-insured plans from state regulation of benefits has afforded health plans a remarkable degree of protection against payment of compensatory damages. 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. In combining the financing and delivery of health care, HMOs cannot claim that all they do is implement the benefits 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 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 business ethics to deal squarely with their customers. Regulation is needed to hold the health plans accountable for both sets of obligations.

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. (HMOs have moved away from the staff model, in which physicians are salaried, to a network model, in which the physicians remain independent contractors or work in a group practice.) That shift is the message of the rise of "provider-sponsored networks (PSNs)," which are effectively HMOs but with roots in medicine rather than in insurance.

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 more lost autonomy, they cut out third-party administrative expense.

The pressure for earnings imposed by the marketplace is unrelenting. With the "low-hanging fruit" of efficiency gains already picked, it is no longer easy to satisfy investors without sacrificing the quality of health care or without raising its price for employers and for enrollees.

If the PSN is nonprofit, any savings are kept strictly within the care group-put toward treatment for enrollees who require more-than-expected care and toward 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. Whether excess returns are in the form of outsize physician salaries or in the form of windfall profits makes little substantive difference to patient welfare.

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

Cost-Effectiveness versus Quality Care in the Future

Managed care's ability to control health care costs will be tested as never before in coming years. The aging of the baby boom and advances in medical technology and knowledge will continue to push costs up, and managed care has already captured most of the savings it can through eliminating high-cost medical practices of the past. It can no longer generate rapidly rising earnings and at the same time maintain the quality of care it now provides. The real test of managed care as an instrument for both cost-effectiveness and quality in medical care thus still lies ahead.

The pressure for earnings imposed by the marketplace is unrelenting. With the "low-hanging fruit" of efficiency gains already picked, it is no longer easy to satisfy investors without sacrificing the quality of health care or without raising its price for employers and for enrollees. This pressure for earnings combined with the system's built-in financial incentives for physicians to undertreat poses a mounting danger that patient welfare will be compromised.

In this background, it is especially important that people have an opportunity to exercise choice in their health insurance, that they understand the consequences of cost-conscious choices, 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 patients have an opportunity to prevail in disputes with health plans when the merits of their case can be shown.

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