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M A Rodwin

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Consumer Protection And Managed Care: The Need For Organized Consumers

Regulatory action alone will not address consumers' complaints about managed care. Organized consumer advocates are needed.

by Marc A. Rodwin

PROLOGUE: As managed care continues to spread, some consumers feel that their voices are not being heard. Insurers and providers have the financial resources and incentives to organize and lobby on their own behalf, but consumers often are not vocal until after they have had a bad experience. When they do speak out, they are likely to point to managed care as the culprit. Indeed, The Washington Post recently heralded a "managed care backlash."

In this paper Marc Rodwin describes the current proposals circulating to give consumers more protection in and information about the managed care marketplace. Believing that all of the regulatory proposals fall short of their goals, Rodwin proposes and explains some more organized forms of consumer advocacy.

Rodwin, an attorney with a doctorate in health policy, is the author of *Medicine, Money, and Morals: Physicians' Conflicts of Interest*. Associate professor at the School of Public and Environmental Affairs, Indiana University, Bloomington, he has received a Robert Wood Johnson Foundation Investigator Award for a project titled "Accountable Health Care, Competing Interests, Goals, and Policy Approaches." His study will show how thinking about accountability has evolved; describe how it became an issue in health policy; and draw lessons for health policy from attempts to promote accountability in other fields.

ABSTRACT: Despite its many advantages, managed care creates new problems for consumers. Activists have proposed four types of remedies: (1) increased information and choice; (2) standards for services and marketing; (3) administrative oversight; and (4) procedural due process for complaints. Each approach offers some benefits, but they are insufficient to cope with consumer problems. What is lacking is effective, organized consumer advocacy.

THE MARKET IS TRANSFORMING our health care system in ways that are more far-reaching than those proposed by the Clinton administration three years ago. These changes may be characterized as “creative destruction,” to use economist Joseph Schumpeter’s term.¹ At their center is the growth of managed care organizations. Market-driven change is likely to continue, aided by congressional proposals to increase options for Medicare beneficiaries to enroll in managed care plans and states’ efforts to shift Medicaid recipients into managed care.²

These trends can offer consumers tangible benefits. Managed care plans can eliminate incentives for overuse of services and reduce financial barriers to care by cutting out-of-pocket costs. They have the potential to coordinate services, deploy modern information systems to monitor quality, and assess the performance of individuals and organizations. Yet some recent surveys indicate subscriber dissatisfaction, and notable scandals have occurred.³

Managed care plans create three main problems for consumers. First, the way in which these organizations are reimbursed creates incentives to skimp on services. Because plans receive a fixed payment per member, any expenditure for providing services reduces net profits. Cutting services has earned profits for shareholders and handsome salaries for top managers of many investor-owned plans.⁴

Second, as is true of most complex organizations, managed care plans are vulnerable to organizational pathologies.⁵ Well-run organizations can orchestrate complex tasks, deliver services efficiently, and institutionalize memory despite changes in personnel. But large organizations also can impede change, become unresponsive, and limit the appropriate use of discretion by professionals. They can diffuse authority and diminish personal responsibility, thereby reducing accountability.

Third, managed care plans restrict consumer choice, which acts as an escape valve if providers perform poorly. Once patients are enrolled, their medical choices are constrained by the organizations rules and procedures. Consumers must use providers from a closed panel, or “network,” or pay more out of pocket. Opting out is not possible in all plans and is not feasible for persons with limited

resources. To see a specialist, consumers typically need approval from a primary care physician, who has incentives to limit referrals. Utilization reviewers also can block use of expensive services.

Consumer groups have proposed four main reforms: (1) increased information and market options for consumers; (2) standards for managed care services and marketing; (3) oversight of managed care plans by federal, state, or private accrediting organizations; and (4) due process rights for consumers who are denied services.⁶ In this paper I review several of these proposals and suggest the reasons why they are insufficient. Although they have merit, they assume a fixed health care system and traditional governmental oversight. Our health care system, however, is changing rapidly. Market changes and attacks on government that limit funding, authority, and public support also challenge that system of oversight.

The proposed reforms are less effective than they could be because there is neither an active consumer role in running managed care plans nor a sufficiently powerful consumer movement. Effective consumer protection requires organized consumer groups that are strong enough to make plans respond to their interests and that are part of the way these plans regulate themselves and maintain quality. Consumers need organized groups to ensure the presence of and to monitor traditional governmental oversight; to help define policies and practices within managed care organizations; to monitor the performance of managed care organizations and private accrediting groups; to marshal political resources; and to form strategic alliances.

Current Consumer Protection Proposals

Over the past three years several groups have sought new means to protect managed care consumers. Their proposals have taken several forms: white papers and reports, model legislation drafted by the National Association of Insurance Commissioners (NAIC), testimony before state and federal legislatures, and bills introduced at the state and federal levels.⁷

■ **Information and consumer choice.** Several proposals would require managed care organizations to disclose information to help consumers choose among plans and to foster competition.⁸ Some would require performance data; others, information on how gatekeepers control access to specialists and on financial incentives for physicians; and still others, information about grievance procedures, utilization review, quality assurance programs, and ownership interests.⁹ Other reforms would require employers to offer their employees an alternative to a closed panel—either a fee-for-service, point-of-service, or preferred provider plan.¹⁰

Issuing report cards and making other information public presuppose that consumers will make better choices with such information. However, consumers often encounter problems in using such data. Report cards convey simplified, partial, and dated measures of quality. Based on only a few typical examples, they do not reflect the range and variety of medical services delivered by an organization's providers.¹¹ Nor do most report cards convey measures of quality or consumer satisfaction for specific services. Rather, they assess plans' overall performance, which, however useful, obscures contrasts among the particular medical services each organization provides—precisely what many consumers want to know.

On the other hand, too much information is as unenlightening as too little. Although many persons are sure to be interested in detailed information when they have a serious medical problem, few are likely to have the time or expertise to make sense of it.¹²

Specifying what information managed care organizations need to make public would help to resolve some of these problems. The major difficulty, however, is not the amount or quality of data, but that consumers lack resources and must deal with their problems as individuals. There is little evidence that managed care organizations now compete on quality, and whatever information consumers get will not be much help so long as they lack meaningful choices. If managed care organizations generally adopt similar risk-sharing incentives to encourage physicians to reduce services, or use similar internal grievance procedures, it is difficult to see how information on these practices will help consumers.

Giving patients the option of using physicians outside the network gives managed care organizations an incentive to keep customers satisfied. It also allows consumers to avoid a managed care plans limitations. However, such options may help only a few persons while preserving the status quo, since managed care plans may experience fewer complaints from enrollees and hence experience less pressure to change their policies. At the same time, plans lack the means to control out-of-plan quality and costs.

■ **Standards for services and marketing.** Market mechanisms are insufficient to ensure that managed care organizations will be accountable to consumers.¹³ Several reforms would set standards.¹⁴ Some bills would oblige organizations to pay for services rendered by emergency medical personnel if the typical patient in such circumstances would have reacted similarly to the symptoms, even if after-the-fact reviews indicate that emergency care was not necessary.¹⁵ Other federal and state legislation would prevent so-called drive-through deliveries, that is, prematurely discharging women from hospitals after they give birth.¹⁶ Still other bills would require

managed care organizations to pay for out-of-network care if the organization does not have equivalent specialists.¹⁷

Several proposals would require managed care plan accreditation—either by private organizations such as the National Committee for Quality Assurance (NCQA) or by the state—based on criteria such as measures of outcome and patient satisfaction.” Others would limit the amount that managed care organizations could allocate to administration and profit rather than to services for consumers.¹⁹ Still others would require adequate financial reserves.²⁰

Several proposals would regulate marketing. Some would prohibit or regulate compensating agents primarily by commissions, and some would require state or federal agency approval of marketing materials.²¹ Others would eliminate door-to-door marketing.²²

Clearly, some managed care organizations may reduce standards to lower premiums and increase their market share, which would put pressure on other firms to follow suit. Adopting federal, state, or industry standards would prevent a downward spiral in quality.

However, detailed standards set by legislatures also can present a problem. For example, even though legislative standards for length of hospital maternity stay probably encourage good medical practice, legislatures are neither qualified nor able, as a rule, to determine the proper course of treatment for various medical problems. The task is too complex, the variables are too numerous, and medical quality standards change too rapidly. Indeed, identifying good quality is difficult even for experts, and the medical profession itself lacks standards for many medical problems.

Higher standards may raise premiums and make insurance unaffordable for the working poor who lack employer coverage or for the self-employed. It is preferable to set broad standards—for quality assurance programs, utilization review, the provision of out-of-network emergency care, finances, reserve requirements, and other key variables—and then provide for accreditation and oversight.

■ **Administrative oversight.** Just as managed care organizations monitor the conduct of providers, so must plans be held accountable for their performance. Several proposals would grant additional powers to state or federal agencies or create independent ombudsman programs, to help aggrieved consumers.²³ Still others would set up procedures under which the medical decisions of managed care plans would be subject to review by outside independent parties.²⁴

At present, however, dwindling authority and resources are weakening our patchwork system of federal and state oversight of managed care. The 104th Congress proposed a budget that would reduce projected Medicare spending by \$270 billion over seven years (this was reduced later to \$226 billion and most recently to

\$168 billion), which would limit administrative oversight.²⁵ It also has proposed reducing federal oversight of Medicare and Medicaid in favor of state regulation. Yet state administrative agencies, already strained, are unlikely to take on new responsibilities.

Ultimately, consumers will have to organize to represent their own interests in Congress before there can be significant increases in oversight. Until then, we can consider measures that are likely to garner some congressional support, such as minimizing the use of substantive standards in favor of processes that promote quality or make managed care plans responsive to consumers. One approach is to require managed care plans to be accredited; another is to require them to adopt quality assurance and independent utilization review programs; a third is to create market incentives for quality by increasing reimbursement for plans that meet standards; and a fourth is to encourage consumers' voice and representation.

■ **Administrative due process.** Consumer groups suggest the need for procedures for managed care subscribers who wish to challenge decisions denying referrals, services, or reimbursement. They would require appeals rights and grievance mechanisms.²⁶ Some proposals advance managed care plans that have internal grievance procedures but do not specify the mechanism.²⁷ Plans would establish their own criteria to judge appeals and would employ the persons who decide cases.²⁸ Other proposals would have appeals decided by a neutral party that is unaffiliated with the organization.²⁹

Grievance procedures are often time-consuming and costly. Many managed care plans set up internal procedures that exhaust complainants and slow or limit access to the courts. Even grievance procedures that use independent reviewers have limitations. To appeal, the consumer must know that he or she has been denied a service or received poor quality of care, believe that the plan has acted improperly, be hopeful that filing a grievance may provide a remedy, have the time and resources to pursue the matter, and think it worth the cost of doing so.³⁰ These conditions are often absent for persons who are ill, poor, or uneducated.

Thus, many subscribers are in a weak position to challenge providers. They do not control funds for purchasing services received—leverage that might make providers heed their complaints. (Third-party payers usually control these funds, and managed care plans are apt to cater to their interests.) Moreover, consumers often are locked into a plan for the short run, which fosters dependency. This is especially true in Medicaid, where fee-for-service or point-of-service plans are usually not options. Patients depend on their managed care plans and physicians for services, and complaining may jeopardize these relationships or subject patients to reprisals.³¹

Grievance procedures within managed care organizations can resolve individual problems but might preserve the status quo. Unlike complaints heard before courts, individual grievance resolutions do not create binding precedents or require organizations to change their policies for other persons with similar problems. Subscribers who lack the support of advisers, advocates, or consumer organizations face obstacles that make many protection measures—despite their potential benefit—much less effective.

Organized Consumer Advocacy

■ **The need to organize consumers' interests.** When policy or markets affect consumer issues, producers often have their livelihoods at stake, whereas individual consumers' interests in such issues often are episodic or limited. The interests of producers usually are concentrated among a small group; those of consumers are spread among a wide group of people who may not know each other.³² Producers have the time and resources to organize, which consumers lack. These differences make it much harder for consumers than for producers to organize and protect their interests.

The disparity between producers and consumers is great in managed care. Third-party payers, managed care plans, hospitals, physicians, and other medical personnel have the benefit of organizations to assert their interests. Consumers of medical services are unorganized and lack the means to exert their purchasing power or to make their voice heard collectively. The lack of funded, institutionalized organizational advocacy for consumers within managed care plans places them at a competitive disadvantage compared with other key constituencies. One way to address this is to create institutions that help consumers to organize or to pool resources and expertise.

Medical consumerism has been most effective where there has been organized advocacy. The women's health movement and the disability rights movement are two examples. People with a common chronic illness, such as polio, acquired immunodeficiency syndrome (AIDS), or breast cancer have organized successfully, and advocates such as the Legal Services Corporation and the National Health Law Program have served defined groups (for example, Medicaid recipients).³³ Although groups with a narrow constituency promote some ends that improve health care for all, their goals often address their particular needs. Our system lacks strong institutions or groups that advocate more generally for medical consumers or that can serve subscribers within their own managed care organizations. The near absence of proposals to foster organized advocacy for consumers of managed care is striking.³⁴

■ **Models of consumer advocacy.** There are several ways to

promote advocacy. One soon-to-be-tested model—the Medicare Rights Center (MRC)—is seeking to organize seniors within a community and to work on their behalf.³⁵ The MRC would serve as an institutional patient advocate: an ombudsman to evaluate managed care plans' performance, respond to telephone queries, and report on the kinds of problems managed care plan members experience. The MRC will seek funds from managed care subscribers by initially selling its services to unions for their members and to firms for their retirees. It also expects to market its services through organizations that provide financial services to the general public. Although some managed care plans might shun working with the MRC or similar advocacy groups, others would appreciate the benefits: a likely increase in enrollment from members or persons these groups already advise; the potential for improved quality of care and patient satisfaction; and publicity about the fact that they are concerned with the consumer's perspective.

There are other examples. Advocacy groups in Wisconsin representing Medicaid Aid to Families with Dependent Children (AFDC) recipients and state employees gathered evidence of problems and induced the state to change contract requirements for managed care plans to serve state-funded recipients.³⁶ They also lobbied the agency administering the programs, which in turn prevailed upon managed care plans to respond to problems.

Similarly, the National Health Law Program has served as a source of expertise for advocates in other states. It also has initiated class-action law suits on behalf of Medicaid recipients in managed care plans. Consider, too, the Older Americans Act, which authorized, for long-term residents of nursing homes, federally funded ombudsmen to recommend ways to change existing federal and state regulations as well as to resolve individual complaints.³⁷

Still other groups have carved out advocacy roles. The Public Citizen Health Research Group has analyzed consumer health issues, testified on behalf of consumers, published information about risks of health care products and services, and monitored the actions of private firms and government agencies. The Children's Defense Fund produces reports that assess the health needs of poor children and the effects of the Medicaid program and other policies. It mobilizes the press, builds coalitions, and lobbies Congress to promote policies that help poor children.

Although such groups and programs are models of consumer advocacy, their focus is not managed care. Our system lacks organizations that represent consumers within their managed care plans or that monitor plans on behalf of members. There is no organizational or institutional nexus to make managed care plans responsive

“Our system lacks organizations that represent consumers within their plans or that monitor plans on behalf of members.”

to their members collectively. Nevertheless, advocates for managed care consumers might adopt the strategies of any of these groups. Groups could function on a national, regional, or local level or could represent consumers within a single managed care plan. They could monitor plans’ performance and policies, influence subscribers’ choices, draw media attention to neglected issues, and press for changes in legislation or administrative rules. They also might activate the support of purchasers, other consumers, or provider groups as allies for negotiating with managed care plans.

Organizations of managed care subscribers are likely to be more effective if they have independent funding and formally represent their subscribers—that is, if the leadership can be replaced by voting members. If organizations have the authority to decide which plans consumers will enroll in, or can influence their members’ choices, they will have added clout in inducing plans to change policies and to resolve grievances to the benefit of their members.

■ **Cooperative ownership and governance.** The American Medical Association (AMA) and other groups have proposed physician-owned managed care plans and physician groups, and medical societies have started several such provider-sponsored networks.³⁸ Likewise, consumers might protect their interests through cooperative ownership of managed care plans. Consumer ownership and/or representation on a managed care plan’s board of trustees is one means to make the plans policies responsive to consumers. Cooperative ownership also might reduce administrative costs by eliminating shareholders’ profits or exorbitant managers’ salaries, thereby enabling reduced premiums or better services.

Despite the use of consumer cooperatives in other fields and a couple of examples of cooperative health maintenance organizations (HMOs), consumer advocates have hardly discussed the idea.³⁹ The main example, Group Health Cooperative of Puget Sound, founded in 1947, has become a major managed care presence in Seattle. (Today, however, most persons who receive services from Group Health Cooperative are enrolled through their employer and cannot vote for the board of trustees.)

A possible reason for this neglect is that securing the capital to start a consumer-owned managed care plan in today’s market would be difficult. Any such plan would have to offer lenders the prospect of a competitive and secure return on investment, which

would require a sizable membership base that could generate revenue from premiums. The most effective way to secure membership would be through a large organization that already represents persons with common interests or provides benefits for them.

Unions might bring their members, although to date they have not explored such options. To the extent that unions have sponsored union-operated health plans or participated in operating Taft-Hartley health plans, the plans have not functioned much differently from those of other private insurers, and the unions have not functioned much differently from employee benefit managers. If unions want to enlist members for a consumer-owned managed care plan beyond the plans they already administer, they will need to convince employers to go along, through either informal discussions or collective bargaining. They may have to show employers that such plans can help them reduce their expenses or attract and retain workers.

Groups such as the American Association of Retired Persons (AARP) also might be in a position to enlist members in cooperative managed care plans. An advantage these groups have over unions is that they can focus on Medicare beneficiaries and not deal with employers. However, to date the AARP has earned revenues through endorsing and selling supplemental Medigap insurance for Prudential Insurance, and it plans to sell managed care plans a seal of approval if they meet certain quality standards. Both are roles that might conflict with promoting a consumer-owned and -governed cooperative managed care organization.⁴⁰

Yet another obstacle comes from proposed legislation. The Balanced Budget Act would prevent consumer groups from coming together for the sole purpose of forming health insurance purchasing cooperatives.⁴¹ The Health Insurance Portability and Accountability Act of 1996, as initially proposed in the Senate version, would have specifically authorized such groups. However, no mention of cooperatives was made in the version enacted in August 1996.⁴²

■ **Alliances.** Alliances with employer purchasing groups are another way to promote consumers' interests. Many employers have formed purchasing cooperatives to bargain with managed care plans about what they will pay and receive. Controlling employer expenditures is a key aim, but getting good value also is important. Purchasing cooperatives have the resources to monitor managed care plans. Since they can deliver or withdraw their employees, they also have economic clout. Typically, they require plans to provide data on quality of care and organizational policies and practices, then negotiate the terms under which they will pay the plans and which ones their members will use. They can use their clout to promote consumer interests. The Pacific Business Group on Health (PBGH), for

example, has pushed managed care plans to increase preventive care programs, requiring them to target specific preventive services and to provide data on how many members have received them. Plans can lose up to 2 percent of their premiums for all of the PBGH's members if their performance falls short of the year's goals.⁴³

Purchasing cooperatives now act for the benefit of employer/purchasers and only indirectly for the benefit of employees. The history of labor/management relations suggests that employers may act in ways that are contrary to workers' interests. Nevertheless, alliances can exist. If labor and consumer groups are represented, cooperatives may become such an alliance. What is missing is a means to represent consumers/employees in cooperatives.⁴⁴

Consumer groups also could ally themselves with physician groups. Many consumer protection bills introduced recently in federal and state legislatures were drafted and backed by coalitions of consumers and physicians. These bills seek expanded choice of providers for patients and promote due process rights for consumers who believe that they have been improperly denied services and for physicians who think that they have been unfairly deselected. Consumer/physician alliances also might jointly own managed care plans or pool resources for advocacy within those plans.

Such alliances, however, have risks. Physicians have conflicting loyalties and incentives to act in ways that do not promote patients' interests.⁴⁵ For example, the AMA has lobbied to have provider-sponsored networks exempt from financial reserve requirements, leaving consumers at risk of losing insurance coverage if a network became insolvent.⁴⁶ Also, many bills drafted by consumer/physician coalitions would allow consumers to use the services of "any willing provider." Such clauses impair plans' ability to control quality or costs and have jeopardized the enactment of legislation that would generally help consumers more than doctors.

In short, interests diverge. On some issues consumers have common interests with physicians rather than with plan management; on other issues the reverse is true; and on still other issues consumers' interests are aligned more closely with those of employers or purchasers. These are realities consumers must live with.

■ **Prospects.** Organized consumer advocacy could provide a degree of influence comparable to that achieved by purchasing cooperatives on behalf of employer/purchasers. It could create a process to make managed care organizations more responsive to consumers on an ongoing basis and also could spur state or federal agencies or private accrediting groups to action on behalf of consumers.

That said, three points must be recognized. First, powerful consumer organizations and alliances do not exist yet because formida-

ble obstacles make it difficult to organize disparate individuals with diffuse interests. Creating and sustaining such organizations will be difficult and might not occur. Second, as useful as organized consumer groups would be, they would not be sufficient to protect consumers. Governmental agencies still have an important role to play in setting standards, monitoring compliance, and penalizing illegal conduct. Third, when scandals begin to mount, the public is likely to call for government to recreate the regulatory system that the 104th Congress is attempting to dismantle. A new and better oversight system will be created if vigorous, nongovernmental consumer organizations promote it; once in place, it is likely to be even more effective if it is monitored by such organizations.

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