THE NEGLECTED REMEDY

STRENGTHENING CONSUMER VOICE IN MANAGED CARE

BY MARC A. RODWIN

Managed care seems finally to have done what health care reformers a few years ago couldn't accomplish: stir demands for more government regulation. After some health maintenance organizations cut hospital maternity stays to a maximum of 24 hours, the caption of one editorial cartoon read "HMOs—Heaving Mom Out," with an image of a mother in a catapult hospital bed. Then the press learned that managed care organizations had contract clauses, dubbed "gag rules," that bar doctors from making critical comments about the organization to their patients, discussing unauthorized treatment options, or disclosing how they are paid. On its cover *Time* magazine pictured a doctor gagged with a surgical mask. Soon federal and state legislators, including Republicans, were falling over each other in the rush to regulation.

Were these freak exceptions in the era of deregulation? Maternity is, well, a motherhood issue, and gag clauses overtly trample on patients' and doctors' rights. But while distinctively resonant as symbols, drive-through deliveries and gag rules illustrate a more general problem: the folly of relying exclusively on market choice to protect the interests of health care consumers. Yet government rule making about medical care isn't the only alternative. There's another option: giving consumers a more direct voice in managed care organizations.

EXIT, VOICE, AND MANAGED CARE

Health policy today gives too much credence to the efficacy of markets and too little to the efficacy of consumer voice. Consider the ideal system envisioned by Alain Enthoven, perhaps the single most influential thinker about health policy in recent decades. Enthoven's core idea is that the best way to control health care spending and increase the availability and quality of services is to give consumers a choice among competing managed care organizations. Enthoven does acknowledge a need for oversight by purchasers, government, or quasi-public "sponsors" to encourage competition over price, quality, and service. And he would limit consumer choice to standardized benefit packages to allow for easier price and service comparisons. But, for Enthoven, the engines driving change are financial incentives for individuals to shop for a health plan that offers the best value. If the performance of an organization declines, its customers or members will become dissatisfied, and their defections will signal the firm to clean up its act.

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But will consumers switch to a competing health plan they prefer? Will they have a genuine alternative to switch to? The limitations of Enthoven's model become clear when compared to the ideas of the economist Albert Hirschman, author of the classic, *Exit, Voice, and Loyalty*. In Hirschman's model, there are two choices: not just exit but voice—complaints, grievance, protests, and political pressures. Sometimes exit and voice reinforce each other, while at other times they may be at cross-purposes. Each has strengths and limitations. Exit, for example, sends a powerful signal that something is wrong, but little or no information about the problem or the remedy.

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Health policy now emphasizes consumer exit—switching providers and plans. That emphasis underestimates the limitations of exit as well as the potential role for consumer voice as a complement and an alternative to exit. For example, the Health Maintenance Organization (HMO) Act of 1973 requires an annual period of HMO open enrollment to allow consumers to change providers—but it requires no consumer voice. Federal antitrust law promotes consumer opportunities for switching providers as a desirable goal. Health care researchers focus on how consumers choose among competing managed care organizations and the kind of information consumers want and need to make effective choices. Consumer groups and others rate managed care organizations and issue report cards to facilitate consumer choices. What does such choice entail? Exiting from one managed care organization to another.

Private employers, particularly large ones, typically allow employees to switch health care insurance plans on an annual basis. So does the Federal Employees Health Benefits Program (FEHBP), which provides employees choice of more than 400 health insurance plans meeting minimum standards. The new managed care organizations also foster more choice. The fastest growing types of managed care—independent practice associations, preferred provider plans, and point-of-service plans—allow consumers to opt out of the preferred list of providers if they shoulder greater copayments. This is a change from the traditional HMOs, which limit services to their own staff physicians.

Advocates of medical savings accounts (MSAs) would provide consumers more opportunities to switch; individuals would have no restrictions on choice of providers and increased incentives to shop for low-priced providers. "Any willing provider" laws would also increase choice of providers within managed care organizations so that consumers could choose new physicians without leaving the health plan. And Clark Havighurst, a leading health care lawyer, would expand choice by allowing consumers to contract for different standards of care.

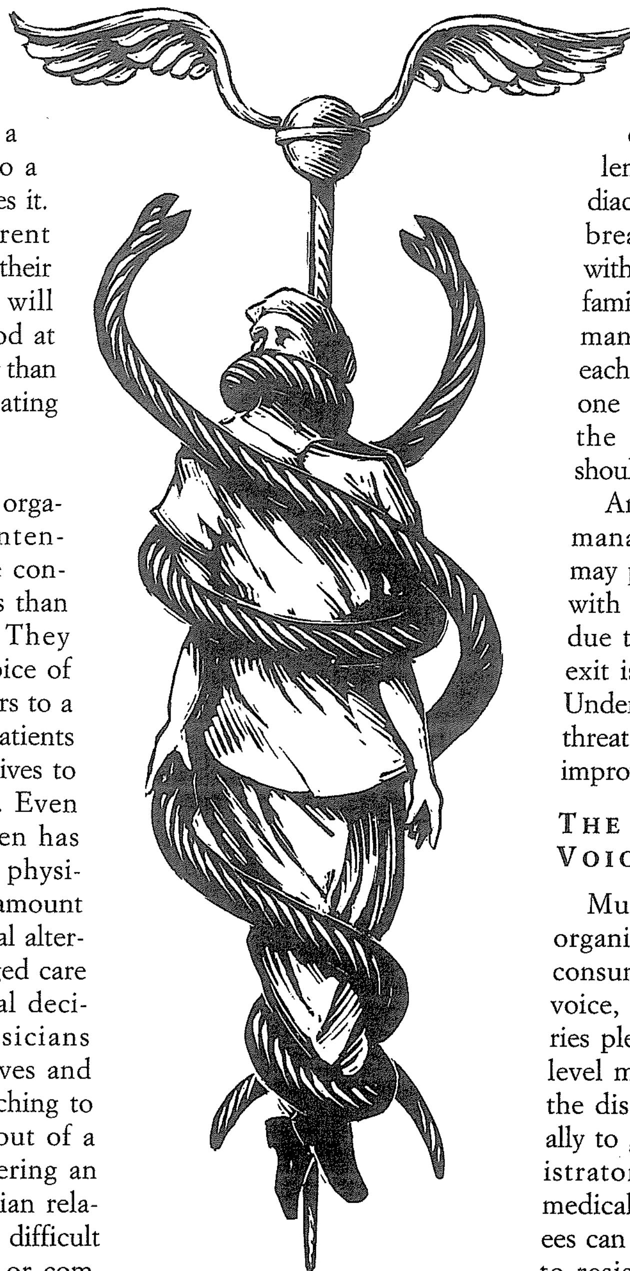
The Limits of Exit

Policy favoring exit is one thing, but market reality is another. Most firms—particularly small and mid-sized firms—offer employees little choice. In 1996, 52 percent of mid-sized firms offered workers only one plan and only 24 percent offered three or more. The poor, in particular, have few exit options. Some state Medicaid programs lock beneficiaries into a managed care plan, generally the one with the lowest premium.

Clearly a powerful tool for change, exit is often limited as an option or in its effect because of unusual features of medical markets. Ownership of managed care organizations and hospitals is becoming concentrated. Some analysts believe that a few oligopolies will soon dominate the market and that these organizations will become complacent about the risk of losing market share and therefore less responsive to consumer switching. Hirschman calls attention to what he calls lazy monopoly or collusive behavior. In a restricted market, a firm may choose to be rid of its difficult customers rather than change its behavior to please them. If a problem is endemic among all rival plans, dissatisfied customers will only be able to switch to an equally unresponsive competitor.

Consumers can't switch among health insurers more than once a year in most employer-sponsored insurance plans. Current law allows Medicare beneficiaries to leave HMOs with 30 days' notice, but proposed legislation would limit changing plans to once a year. There are some sound reasons for this policy.

If people can switch between plans at will, they may first opt for a low-cost plan with limited benefits until they need a service and then jump to a high-cost plan that provides it. But if the rates of different plans reflect the health of their subscribers, the market will reward plans that are good at avoiding sick people, rather than plans that are good at treating them.



Managed care organizations intentionally give consumers fewer exit options than traditional insurance. They either restrict patient choice of doctors and other providers to a closed network or offer patients significant financial incentives to use preferred providers. Even when available, exit often has limited value. Switching physicians within a plan may amount to no choice among clinical alternatives because the managed care plan regulates the clinical decisions of *all* of its physicians through financial incentives and organizational rules. Switching to another provider, in or out of a plan, may also mean severing an established patient-physician relationship. Exit is especially difficult for patients with chronic or complex conditions that require coordination among medical personnel or particular knowledge of the case. And especially for the sick and the frail, shopping for medical care may be physically and emotionally difficult. Exit in medical care is most useful as a last resort. If a managed care organization's performance is mediocre but not bad enough to make consumers willing to leave, they may simply suffer poor quality and the market will not do its work.

The fact that managed care is a bundle of varied medical services, medical providers, and health insurance also makes exit a crude tool. Consider a family of three, each with different medical problems: the father with a cardiac problem, the mother with breast cancer, and the child with asthma. Suppose that the family can choose among three managed care organizations, each of which is strong in only one area of medical care that the family needs. Which should the family choose?

And, most perverse of all, managed care organizations may prefer to lose subscribers with high-cost illnesses since, due to fixed premiums, their exit is the organization's gain. Under these circumstances, the threat of exit will not encourage improved performance.

The Virtues of Voice

Mute exit does not tell an organization the source of the consumer's dissatisfaction, but voice, as the term implies, carries plenty of information. Top-level managers also often need the dissatisfied consumer as an ally to get clinicians and administrators to change. Similarly, medical staff and other employees can use the patient as an ally to resist undesirable practices imposed by managers.

Voice comes in many varieties. Individuals can complain, file grievances, appeal to higher authority, leak information, participate in governance, bargain collectively, or become active in politics. They may express their concerns to management, potential customers, or influential outsiders such as policymakers, the press, or activists who may take up their cause. Voice can be exercised episodically as special circumstances arise or continuously through established consultative mechanisms.

Within managed care organizations today, consumers lack effective institutional means to express their voice. Physicians and other providers often serve on committees that set medical standards; purchasers decide what benefits are to be covered and bargain with managed care organizations over what their contract will provide. Consumers' main options, however, are only to file complaints or grievances and to express their opinions in membership satisfaction surveys.

Market theory suggests that if enough consumers had wanted longer maternity stays than were standard, at least some managed care organizations would have tried to lure them away from competitors by catering to their wishes. That didn't happen, so the political process delivered what market exit did not. Twenty-eight states and Congress passed statutes that prevented managed care organizations from imposing short maternity hospital stays. Similarly, 19 states have prohibited gag clauses, the federal government has prohibited their use in the Medicare program, and bills are pending in Congress that would outlaw them entirely.

Still, consumers can't depend on legislation whenever markets fail. Law is costly and insensitive to individual circumstances—not a desirable or feasible means for consumers to express their everyday wishes. Special circumstances made it easier to enact limits on drive-through deliveries than to get action on other consumer issues. The problem was visible and easily understood, and the number of potential beneficiaries was large and easily organized. Gag rules threatened to deny all consumers enrolled in managed care the opportunity to hear information about alternative treatments.

Gag rules highlight the limited options for consumer voice. Managed care plans wrote such clauses to restrict the flow of negative information about their policies from physicians to patients in the hope of decreasing consumer exit to competitors. They sought to chill physician speech and thereby to repress potential consumer complaints as well. The clauses may never have been legally enforceable if tested in court, but their prohibition may do little to answer the underlying public concern. When the contracts of troublesome physicians expire, managers of health plans can simply not renew them, rendering anti-gag clause legislation ineffective. Legislation prohibiting managed care organizations from suppressing physician and consumer voice won't be sufficient; we need laws and institutions that actively foster voice within managed care organizations.

In fact, well-run managed care organizations do make efforts to find out what their consumers want. Consumer satisfaction surveys are a form of voice. Like polls in electoral politics, they shape how leadership responds to the public, and perhaps even displace more traditional forms of voice, such as protest and complaint. Consumer satisfaction surveys have led managed care organizations to increase the hours for appointments with physicians, to train medical personnel in communicating and empathizing with patients, and to create new ways of compensating physicians to reward consumer satisfaction.

Not surprisingly, managers typically undertake consumer surveys more for internal use or public relations. The information can bolster their own control by helping them to respond preemptively to problems. Managers can disclose results that show the organization in a good light and keep other data confidential. In short, consumer satisfaction surveys are not the instruments of consumers, who have no role in developing or analyzing them or disseminating the results.

Fostering Consumer Voice

While patients are vulnerable to poor care in any setting, managed care organizations pose two special problems. They have an incentive to withhold services, and they exercise control over doctors, hospitals, and other providers, which means there may be fewer independent checks to failure. These features make it important for consumers to have means to resolve their problems and to make managed care organizations responsive to them. Consumer voice can be a useful tool, but it will not thrive without institutional support.

Public policy could promote the use of voice by creating communication channels and lowering the cost of voice. Governments could finance or create incentives for managed care organizations to give consumers a voice. The institutions that accredit managed care organizations might set standards for consumer voice.

Hirschman distinguishes between vertical voice (individuals privately and separately expressing themselves to the organization's management) and horizontal voice (organized discussions and activities of consumers

or employees). Each kind requires different channels. Many people become concerned with policy only when it affects them directly. Their initial response often is through grievance: It is direct, tied to individual concerns, and often produces results quickly. Some problems, however, require changes in policy and even a consumer role in governance.

Grievance. Managed care organizations should create mechanisms for resolving formal grievances that are fair, speedy, and easy to use. Most plans do have grievance procedures, but except for Medicare HMOs, there are no uniform standards in force, and consumer groups have found existing procedures deficient.

Most complaints today are reviewed solely by the managed care organizations themselves. In effect, the consumer is seeking redress from an interested source. Many consumer groups and legislative proposals, therefore, would allow patients to appeal to a neutral independent party if their doctor or the managed care organization decides that a medical service is unnecessary or inappropriate. The managed care industry has not yet adopted such proposals for all denied services. In California, however, the industry supported legislation, recently enacted, that would allow appeals to neutral experts outside the managed care organization whenever it denies a bone marrow transplant or other experimental therapy. And Medicare already contracts with an expert organization, the Center for Health Dispute Resolution, to review all denials of services for beneficiaries in HMOs.

Grievance procedures would be fairer if the individuals who adjudicated grievances were in all cases independent, justified their decisions in writing, and had authority to reverse an organizational practice or decision without fear of retaliation. There should also be some kind of institutionalized advocacy for consumers. If purchasers paid for independent professional advocates to assist consumers, it would inspire confidence in the grievance process. Finally, there needs to be protection for individuals who initiate a formal grievance, and prompt and visible penalties against the organization if it retaliates.

Grievance mechanisms, however, are usually designed to resolve individual complaints, not the underlying institutional problems. Managers sometimes placate individuals who voice complaints—making exceptions to policy or working out some special accommodation—rather than deal with the source of the problems that affect complainers and the silent alike. Indeed, firms may use grievance mechanisms as an escape valve for angry consumers who might otherwise complain to public authorities or other consumers.

Complaints and grievances may be harbingers of systematic organizational problems that are best addressed through governance. Yet, consumer complaint mechanisms typically do not include adequate provisions for publicizing or analyzing the problem or informing the public about them. Publicizing the kind and number of complaints and appeals for services denied and how they were resolved would spur organizational change. Funding for an independent party—an ombudsman—to prepare summaries and analysis of complaints and disseminate the information would help.

Dissemination of information about complaints to shareholders, prospective members, and the press would create public pressure on managed

care organizations to respond to consumers and would prevent complaints from being buried in obscure files. Voice then would complement exit. Prospective enrollees might choose managed care organizations based on how they addressed complaints, which in turn would encourage management to resolve problems. Members might publish summaries of complaints in a newsletter, informing individuals with similar problems and facilitating the formation of groups to address common concerns. State insurance departments could provide more intelligent oversight of managed care organizations.

Consumers are often reluctant to complain or file grievances, especially for medical care. One study found that only one-third of consumers with complaints voiced them, complaints were resolved to the patient's satisfaction only a third of the time, and consumers' complaints in medicine were resolved less satisfactorily than 10 of 11 service categories surveyed. To cope with the reluctance of patients to complain, independent parties should conduct surveys of health care consumers and publicize the results. Independent parties are more apt to design their surveys in ways that will reveal critical comments. Their surveys also are more likely to reveal unsuspected problems, allow comparison across health plans, and identify flaws undetected by a formal grievance process.

Governance. Not-for-profit health care organizations are governed by boards that broadly represent the community, including consumers. To be sure, trustees in not-for-profits are usually nominated and chosen by management, which makes them less than ideal representatives of consumers. But although some not-for-profits behave like for-profits, many have pursued community missions and interests that a profit-oriented organization would probably not have undertaken. With for-profit managed care organizations growing in number and size, even this indirect form of consumer participation in governance is fading.

In light of problems with current health care markets and the disillusionment with traditional governmental regulation, consumer participation in governance ought to get another look. Since owners can govern, consumers might form cooperatives to own managed care organizations (or jointly own them with other groups) and elect their own trustees and management. Coops could require consumer approval for key management choices and strategic planning. The Group Health Cooperative of Puget Sound is an example. Founded in 1947 as a cooperative jointly owned by physicians and consumers, it now serves more than half a million members and is considered an exemplary HMO with a consumer orientation.

Nevertheless, maintaining consumer involvement is difficult, even in cooperatives. Today, about 6 percent of individuals insured by Group Health are coop members with voting rights. Voting in elections has been around 5 percent for most of the last decade, but because of controversial issues in the last two years turnout has been around 15 percent. Since 1989 less than 1 percent have attended the annual meetings that determine what goes on the ballot. Most consumers simply do not have the time or inclination to become involved in governance. Consumers who attempted to start a cooperative HMO today would face immense hurdles, particularly raising capital and obtaining contracts with large firms. Even Group Health has had to form an alliance with Kaiser Permanente to be able to compete for contracts with multistate employers.

An option for publicly owned managed care organizations is to establish elected consumer councils to provide continuing advice and feedback without formal authority to make management decisions. Councils could express their views on issues that affect members and work with management to improve the organization's performance.

To be sure, resort to consumer voice in managed care organizations would often be cumbersome and annoying to those in charge and those who exercise it. But the regulatory oversight and micromanagement that follow the public outrage at such problems as drive-through deliveries and gag rules may ultimately be even more costly and burdensome. Building voice into managed care organizations can help build stronger organizations by putting managers in touch with the experience and desires of their customers, the patients. If those customers become sufficiently discontented, they will eventually call on legislatures to act on their behalf. The spate of consumer protection legislation regulating managed care suggests that the industry will face increasing constraints. Those who claim that increased consumer voice is impractical should contemplate the alternatives.❑