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Working Paper No. 239

An ethical framework for cost-effective medicine Confronting the risks in managed care

by

[Walter Cadette](#)

The Jerome Levy Economics Institute

A response to the demand of employers 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 limited the health care choices that insured Americans once had.

In all, managed care has introduced a measure of market discipline into the practice of medicine that was conspicuously absent in the regime of comparatively open-ended health insurance it replaced. When it comes to health care, market discipline is surely crude and imperfect. But prospects for controlling once runaway health care costs are brighter than they have been in a long time.

Managed care has also transformed the American health insurance market. Almost 30 percent of Americans who were insured in 1997 were covered by health maintenance organizations (HMOs), as compared with just under 20 percent as recently as 1992 (Employee Benefits Research Institute 1998). The percentage is bound to continue to rise in coming years as governments goad Medicare and Medicaid beneficiaries (who thus far have remained almost entirely in fee-for-service medicine) into managed care in order to match the savings that employers have already achieved. Another 40 percent of insured Americans are covered under "preferred provider organization" (PPO) plans, which require subscribers to use physicians who have agreed to provide health care at discounted rates (Employee Benefits Research Institute 1998).

The shift to managed care has also had profound impact on the economy at large. Almost half of the decline in the GDP deflator's rate 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.¹ With health care now almost 15 percent of GDP, and thus rivaling manufacturing in size in the economy at large, 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.

Cost-conscious medicine 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. As the post-World War II baby boom ages, health care's share of GDP is apt to increase once again. But, for now, it seem to have stabilized after decades of seemingly relentless rise.

Virtually all U.S. health care is managed in some ways. Even the least restrictive fee-for-service plan now requires subscribers to follow some 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 (a) prepaid and (b) provided by physicians who are governed by clinical practice guidelines--neither of which applies in a PPO or in a fee-for-service plan even with the many managed care features both of these insurance types have taken on. The term is thus used 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 were separate and distinct.

Growing national debate

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; women sent home prematurely from a hospital after giving birth; commonplace diagnostic tools denied to patients with tumors that later metastasized.

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* (Dec. 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 the one side of the debate about the merits of managed care are those who, like the Massachusetts doctors and nurses, argue that cost-control has come at an unacceptably high price. Economies, they claim, will have far-reaching consequences on health outcomes long into the future, and even now are all too real for vulnerable groups: those with chronic illnesses, the elderly, and the poor (Miller and Luft 1997). Something is perverse, they maintain, in a payments system that makes well-intentioned physicians look on patients as a drain on their income (Rodwin 1993).

Apologists for managed care cite the benefits of its emphasis on preventive care and of its having cut out marginally beneficial (and sometimes even harmful uneconomic) care. Outcomes data for the vast majority of Americans, they contend, fail to indict managed care as inferior to the more expensive, often wasteful, fee-for-service medicine of the past. The economies managed care has brought about, they maintain, do not raise life and death issues. As they see it, the issues are an extra day in the hospital, a visit to a specialist, an expensive drug--and only when the stakes are low and confidence in the diagnosis high (Hall 1997).

This paper joins in the debate. It examines the features of HMOs and their associated ethical problems. And it points to a framework of needed consumer protection. The problems seem to flow from the very design of HMO medicine. One is prepayment. Every revenue dollar is also potentially a profit dollar when not spent on direct patient care--a temptation, if not also an incentive, not only to economize on care but to skimp on it. Another problem is the oversight of physician practice by nonphysicians. That may yield significant savings, but it also threatens physician autonomy and, more important, physician capacity to act as patient advocate.

The public policy concern is with how HMO medicine addresses the trade-offs between quality and cost and with the ethical issues those trade-offs raise. In particular, it is about the change in the role of physician from agent of the patient to agent of the health plan as well--under compensation arrangements, moreover, that commonly reward physicians for doing less for patients and penalize them for doing more. To what extent do those financial arrangements undermine the fiduciary role of physicians? How are physicians to act in their patients' best interests without compromising their own? Behind these questions lie broader ones of 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 say that consumers of health care answer these broader questions when they make the insurance decision. That is fair enough in the abstract. But it is flawed as a practical matter. In a regime of employment-based health insurance, many consumers have all too little choice. They are, moreover, at an enormous information disadvantage not only as patients but as buyers of health insurance.

Physicians traditionally have played a fiduciary role precisely because of the information disparity. 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.

An increasingly complex health care marketplace suggests an increased role for government to protect consumers. Government should not do so, however, by micro-managing that marketplace, as it has, for

example, by stipulating hospital length of stay after childbirth. It is, rather, the fundamental issues that need attention: in particular, the financial incentives physicians work under and the restrictions on their communications with patients about care options that are not reimbursed under a health plan. Health plans also must be held fully accountable for decisions to withhold care, which they can often escape under current law.

I. Features of the new model

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, if any, 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, it was often too little, too late. Medicine. And commodity rationing--applicable, for example, in the intensive care unit and on the battlefield--prevailed as well. 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 after advances in technology had spurred health care costs at a previously unheard-of rate. Extraordinarily expensive interventions--ranging from hip replacements to organ transplants--became commonplace. And so did CT scans, MRIs, and other costly diagnostic tools. It was only 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 still must act as fiduciaries for patients--a responsibility flowing out of the disparity between the knowledge of the physician and of the typical patient. But they also assume some responsibility for the financial well-being of the managed care organization that employs them. They are required to practice cost-effective medicine under formal guidelines or protocols as to exactly what is to be done in each case. The distinguishing feature is control by insurance companies of health care choices traditionally made within the patient-physician relationship (Rodwin 1995).

The rationing is thus as fiscal as well as commodity in character. The physician becomes a guardian of society's resources as well as fiduciary for the patient. 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).

Financial incentives, which include penalties as well as bonuses, enforce that guardian role. And so does selective contracting with physicians, hospitals, and other providers, which has made it possible for managed care organizations to drive down costs down or keep them from rising as they otherwise might.

Trend to a network model

HMOs have moved away from the staff model (in which physicians are salaried, and the health plan, like Kaiser Permanente, is nonprofit) to a network model (in which the physicians remain independent contractors or work in a group practice, and the health plan is investor-owned). The trend also has been to "capitation"--to the payment of a set amount for every enrolled patient.

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, unexpectedly low expenses on patient care add to physicians' income. The incentives include bonuses, "withholds" (which are distributed, say, at the end of the year if the plan comes in below budget), and "subcapitation" (which is to cover specialist and other outside services, and

which are also distributed at the end of the year if expenses come in below budget).

Fee-for-service payment, discounted for the HMO, is also used, although mainly for services by specialists. Here, the health plan seeks to control costs through its market power to set fees as well as through its practice-management techniques.

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. 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.

Hospitals have mobilized to counter the growing market power of HMOs by buying physician practices, and thus linking the fortunes of the physicians with the hospitals rather than with the health plans. As of now, however, almost all U.S. physicians work under contract with one or more managed-care health plan. 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 company.² An estimated one-third of them had at least one capitated contract as of 1996, as compared with one-fourth in 1994 (Miller 1996). And, if withholdings 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).

Large organizations have come to dominate the market. Of almost 600 HMOs in this country, fewer than 50 of them are responsible for the health care of almost 90 percent of the enrollees (Fletcher and Engelhard 1995).

New players

Another distinguishing feature of the new model is that a whole new set of actors, besides the once highly autonomous physician, become important in medical decision-making. The writers of the protocols, who all but determine what physicians may do under the rubric of cost-effective care, play a important role. And so do those who interpret the protocols, and decide, for example, whether a patient can see a specialist or take a particular 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 a primary care physician commonly did in the past. Case managers, who are often nurses, typically determine 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 themselves have assumed complex new management responsibilities under managed care (Moskowitz and Nassef 1997). Once passive bill payers, they now are active participants in deciding what health plans will reimburse. And they have become an essential part of 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, for example, a bone-marrow transplant for the child, or for the spouse, of an especially valuable employee, which was denied by health plan officials, be looked at against the broader interest of the firm? Even just a few years ago, issues of this kind would have been considered the inviolable business of patients and their physicians.

Fixed budgets, but not a closed system

The underlying principle of managed care is that allocating medical care must have a social as well as 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 does not have the opportunity to have, say, elective surgery, because the costs loom large relative to the expected benefits, the resources will be used elsewhere in the group. The aim is a larger fairness--something that makes it easier to say "no" to British and Canadian patients than to their American cousins (Menzel 1990). If nothing else, those patients have the consolation that someone else in need in the group will gain from their 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, especially with the trend to investor-owned HMOs. The opportunity cost of a medical procedure is not kept internal to the system. The savings 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, in more than a few cases, well into the seven-figure bracket. Strikingly, the founder of U.S. Healthcare received over \$900 million in cash and stock when the company was sold to Aetna in 1996.³ In this key respect, today's HMOs are unlike the prepaid medical plans organized by labor unions and employers like Kaiser in the 1940s and 1950s. Those nonprofit plans were closed systems, designed for the benefit only of those in the care group.

II. Potential ethical problems

What made fee-for-service medicine inherently inflationary was its incentives to overtreat patients. Use it if it might help coincided with--indeed promoted--physicians' own economic interests. And it stimulated advances in medical technology, which in turn benefited physicians financially as well as patients medically.

The incentives in managed care pose the opposite danger of undertreatment. Every decision taken in a for-profit HMO to forgo an expensive diagnostic test--because it promises little, even if some, benefit--goes directly to the bottom line, if not of the organization itself then of its contract physicians through incentive payments. And, yet, every such decision poses some, even if small, health risk to the patient. It thus sets up an inevitable conflict between the financial health of the organization or the physician and the physician's traditional fiduciary duty to the patient.

The theory is that such conflict can be resolved by the quality control mechanisms of the HMO, plus its appeals process. But it takes a willingness on the part of the physician to make a case for care outside the protocol, or on the part of the patient to appeal a denial of possibly beneficial care to health plan management.

The hurdles in both cases loom large. The penalty of being dropped from the network if physicians go outside health plan guidelines in the best interest of their patients has become ever larger as HMO medicine has become increasingly concentrated. Moreover, the practice patterns of decentralized network HMOs are difficult for centralized quality control mechanisms to monitor (Povar and Moreno 1988). Patients rarely are in a position to challenge care decisions made by a health plan, especially if they do so without their physician's support.

Undertreatment is not a risk in a hospital-owned physician practice. To the contrary, linking the economic well-being of the physician and of the hospital evokes the old fee-for-service model, with its potential for overtreatment. But such linkage tends to foster a two-tiered health care system. The incentive is to keep privately insured patients in a costly hospital setting. But it is also to restrict the length of stay of Medicare patients, whose bills under federal regulation are fixed in advance on the basis of their diagnosis when admitted (Rodwin 1993). In most states, these same constraints on hospital bills and thus on length of stay apply to Medicaid patients as well.

Concerns about capitation

Capitation is a way for the insurer to share financial risk with the physician. It relieves the insurer from intervening directly in medical decision-making as a means of cost-control (Miller 1996). And, albeit within a fixed budget, it thus restores some of the clinical autonomy physicians had lost. Capitation, however, adds to the dilemma physicians face as double agents. Besides the risk of being delisted, they face day-to-day conflict between the needs of patients and their own need to make a living.

Capitation was designed to force physicians into the cost-conscious practice of medicine, because it put their own economic interests in such practice at stake. But that is also why it is ethically dubious. It pits the interests of physicians directly against those of patients, making physicians not just double, but triple, agents. It compromises the ability of physicians to offer disinterested advice (Rodwin 1993). Worst of all, unless the capitated payments are adjusted for the medical needs of patients, or cover groups of patients large enough so that the costs of caring for those patients are easily subsumed in a large aggregate, they act 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 payments paid to primary care physicians. As "gatekeepers," HMO physicians have a hopelessly conflicted role. Gatekeeping may be a role natural to modern medicine, with its many specialties and sub-specialties. But it becomes hopelessly conflicted when undertreatment can be rewarded.

Medical ethics traditionally has required physicians to provide all necessary care to their patients, irrespective of cost. Now, however, a growing body of physicians is being compensated under arrangements that conflict with rather than, as in the past, 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.

Honest discourse

When care that could prove to be beneficial is denied, HMO subscribers may want to purchase it on their own. In that case, health plan physicians are obliged to lay out the costs and benefits of the nonreimbursed care--that is, to continue to act as agent of the patient even if not also as agent of the HMO that denied the care. What if, however, the 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 nonreimbursed care is an option, the risk is that HMO physicians will downplay its merits. The risk is especially large when patients lack financial resources, but it is not confined to them. Many other patients will opt to appeal a denial of care, putting the physician in the middle of an often painful process.

To discourage appeals, health plans often encourage physicians to downplay the potential of nonreimbursed care to be medically useful. Many states have outlawed gag rules, which limit physicians in educating patients about medical care choices beyond those a health plan is willing to reimburse. But, with patients at an enormous information disadvantage vis-à-vis physicians, compliance has been difficult to enforce.

Managed care organizations routinely include gag clauses in employment contracts (Martin and Bjerknes 1996). These may be 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, with implicit threat of termination, from fully informing patients about treatment options outside the plan. The Congressional Budget Office (1997) has found that two-thirds of the 529 HMOs it canvassed used contracts that because of such clauses could be interpreted as limiting communication about treatment options.

Gag rules not only discourage appeals, they also undermine informed consent--a patient right of autonomy to be informed about treatment options that has been integral to the practice of medicine in the United States for decades. However disguised, 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 treatment they believe is indicated, and even from honest communication with patients about alternatives outside the health plan, physicians will be tempted to exaggerate to health plan management the consequences of not following what they prescribe, or otherwise shade the truth, in the interest of getting care for their patients they otherwise would have to forgo. 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.

ERISA preemption

HMOs can be sued for malpractice when their contract or staff physicians make serious medical mistakes. And HMO physicians remain personally liable for malpractice. They may well be more exposed to law suits than those in independent practice because of reduced scope to pursue what are seen as marginally beneficial procedures.

It is difficult, however, to hold health plans legally accountable for decisions to limit care that ultimately cause grave harm if they are acting on behalf of self-insured employers--a powerful protection since the vast majority of Americans 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. Albeit not all, 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 harm as a benefit determination under the 1974 Employee Retirement Income Security Act (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, using their sophistication as purchasers and their clout in the marketplace (Zelman 1996). The incentive for them to do so included exemption from state regulation of benefits and state taxation of insurance, which was growing rapidly at the time.

While not the intent, the ERISA preemption has afforded health plans a remarkable degree of protection against compensatory damages. While an HMO would be liable when one of its surgeons makes a serious medical mistake (e.g., leaves a sponge in the stomach of a patient after an operation), it would not have to fear a lawsuit when a patient suffers comparably grave harm after a utilization review nurse rules, say, that an inexpensive diagnostic test is called for rather than an expensive, but 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 pay-masters 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 by for-profit companies themselves and unilaterally imposed on physicians (Reinhardt 1996). In application, the guidelines may well miss some of the most important elements in real-time clinical situations. They can easily miss, 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.

Freedom and choice in the insurance decision

Many analysts stress that the 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 wants to "pull out all the stops" (Hall 1997). Rather, it is whether "a cross-section of the healthy would pay their share 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).

Emphasizing choice at the level of insurance, however, glosses over the 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 design the benefit packages--a by-product of the tax exclusion enjoyed by employment-based health insurance (Cadette 1997).⁴

Even when employees can choose between a traditional indemnity health 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 plans officials, rather than their physicians, view as worth the cost--forgoing care that falls outside that boundary.

What that means in practice is almost impossible for them to know. Even if insurance policies could be written

to describe the care to be provided in given circumstances, they would not be understood. Indeed, understanding does not seem to be the aim at all, judging by the jargon and the caveats that characterize them. It is fair to ask: Can people be held to contracts entered into without freedom or understanding? Surely society's answer is *Ö* when it comes to the care of the newborn. Resource limits get pushed out very far, precisely because there was 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 fundamental 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 (Morreim 1995). 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 agree to restrict their right to informed consent to major invasive treatments when they make the insurance decision itself. The theory is that, except in those circumstances, people cede informed consent to the 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 refusals)--just as they agree to being subjected to a regime of blood pressure and temperature checks and similar small routines when hospitalized.

Some people will 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 *Ö*bottom line^Ö thinking in care decisions.

III. Regulatory response

As public concern with managed care has grown, the response of policymakers at both the state and the federal levels has been to second-guess the protocols, and often override them by regulation or statute. Not surprisingly, the intervention at both the federal and the state level has been on matters that have captured headline attention: 24-hour hospital stays after routine childbirth, out-patient mastectomies, and other 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 micro-management role it cannot hope to perform well. And they may well encourage the kind of "cookbook" medicine that critics of managed care accuse it of providing. These interventions are, moreover, regulation around the edges of the problem. Government might better focus on building a regulatory framework that would deal with more fundamental issues: financial incentives, disclosure, and professionalization, important among them.

Capitation may be an efficient way of forcing physicians to practice cost-effective medicine. The challenge for regulators, however, is to retain the power of the economic incentive, but to separate it from the welfare of individual patients. This could be done by limiting the extent to which a physician's total income that is at risk; by spreading the risk across large numbers of health plan participants and physicians; and by calculating the incentive payments less, rather than more, frequently. The object would be to weaken what otherwise might be a 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.

Limiting the income subject to risk for an individual physician or a relatively small group of them, however,

provides little protection to patients. It spreads the income risk over too few of them 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 needed to 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--were riding on the kind of care they were given. Unexpected expenses from only a few patients need not be all that large even 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 current 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 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 of individual patients. 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, not from withholding, care (Martin and Byerknes 1996). 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. That, to be sure, would not further trust. But the lack of trust lies not with transparency about the financial incentives, but with 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 its 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 gag clauses from physician contracts ought to be pursued (Martin and Byerknes 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 widespread 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 implicit recognition that gag rules, in fact, restrain costs. Treatment denials should be truthfully disclosed, as the proposed legislation would require. And they should be disclosed even if such disclosure would have the effect of making denials difficult to enforce, the reason why gag rules help contain health care costs. Fortright denials surely trespass less on the physician's obligation as a fiduciary than does complicitous silence. Patients may have agreed to cost-effective 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.

Roles for purchasing cooperatives

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). At a minimum, the cooperatives would 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.

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 might be the Pacific Business Group on Health, a coalition of large employers (located mainly in Northern California) that collects health plan performance data and disseminates them to participating employers and their employees.

A better informed public would push the managed care marketplace in the direction of competition on the basis of quality and price rather than marketing. Even if the cooperatives did little more than disseminate information on the medical loss ratios of plans (the percentage of revenue spent on direct patient care), they would be of value. These ratios averaged 82.0 percent at for-profit plans in 1995; 86.5 percent at nonprofit plans (HCIA 1997). While many factors could account for the difference, the pressure to produce earnings to support share prices, which is of little, if any, direct benefit to subscribers, is surely important among them.

Purchasing cooperatives would also bring the benefits of pooling to the health insurance market faced by relatively small employers. 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 other overhead—all of which would diminish when contract disputes could be settled promptly with third-party rulings.

Reasserting clinical criteria

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 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 managed care organizations to establish a medical staff structure similar to that at hospitals (AMA 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.

Consideration also ought to be given to amending ERISA to ensure that health plans can be held liable when decisions adopted for cost reasons turn out to do grave 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 touch the traditional sphere of medical ethics in decisions to provide or withhold care or provide it one way rather than another. As ordinary business enterprises, however, they have no moral obligation other than the square-dealing required by business ethics. Regulation is needed to hold the health plans accountable for both sets of obligations.

ERISA, moreover, creates an uneven playing field in its overriding 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. For sure, 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. ERISA should be amended not only to make health plans accountable, but also to become a vehicle for a broader exemption from state mandates. That would be at little, if any, potential cost to health care quality and, quite possibly, large potential benefit.

Yet another reason for amending ERISA is that it impedes efforts by the states to enact health care reform, this again by its blocking their application 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 economies that managed care has forced on private hospitals have 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).

New variant of 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.

Their core quality 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).

Ironically, PSNs--whether made up of physicians only or, as is increasingly the case, linked to hospitals and other care givers in a "integrated delivery network"--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.

If the network 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.

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. Integration of these and other care settings, by reducing redundant procedures and red tape, would make for a more humane as well as more

efficient health care system.

The federal government was instrumental in promoting PSNs in last year's Balanced Budget Act when it offered Medicare beneficiaries the option to select a PSN among a wider choice of health plan 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 of physician practices, which were typically linked to hospitals, were in a position to be state-licensed as a health plan.

The broader issue for federal regulation is whether solvency standards for PSNs are all that important after all. Because of ERISA, more and more employers have found it cost-effective to self-insure (as they avoid state mandates and state insurance taxes). But they may underwrite only the fee-for-service and PPO plans that their employees select. For HMO coverage, they have remained dependent for the most part on insurance carriers. They are unable to contract directly with providers because of state solvency standards and other licensing requirements for underwriting. Those standards are of major concern to people who purchase health insurance as individuals and as small employers. But they are a distinctly secondary consideration to a General Motors or to Corporate America generally. It also makes a major difference to solvency standards that the assets of PSNs are in health care delivery itself, not merely in administrative substructure.

Allowing employers to contract directly with PSNs would be a major step forward. Just as before, the employers could count on relatively fixed costs for health care--in this case, what in effect would be a global capitation payment. But their employees would have the benefit of health care decisions influenced more by strictly clinical considerations. Both would benefit from eliminating the "middleman," and using the savings to lower health care costs or otherwise stretch a fixed health care dollar to added services.

A key question is just how much financial risk PSNs assume, and thus how much they should be regulated like insurance companies.

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.

Alternatively, PSNs could be required to carry re-insurance, which would transfer risk back to the insurance market. There could be a role for the federal government to 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 well-suited. For managed care to avoid its inherent ethical problems, much if not all of the risk of financial failure has to be put on those who properly make care decisions.

IV. Second-stage challenge

Further spread of managed care is almost a certainty 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. Employers can be counted on to continue to keep a lid on benefit costs, even as technology pulls in the opposite direction. And the federal government is relying on managed care as part of a long-range plan to rein in outlays for Medicare and Medicaid.

Managed care's ability to control health care costs will be tested as never before, however. 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. And thus managed care can no longer generate rapidly rising earnings and, at the same time, provide the quality health care Americans are apt to continue to demand. The real test of managed care as an instrument for both cost-effectiveness and 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. But that 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, as they are often not under ERISA, and that consumers have an opportunity to prevail in disputes with health plans when the merits of their case can be shown (Kinney 1996).

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Notes

1. Author's calculation based on Table B-3, Appendix B, *The Annual Report of the Council of Economic Advisers*, February 1998.

2. Source: *New York Times* , March 25, 1998, page D1. 3. Source: *Wall Street Journal* , April 2, 1996, page 2.

4. The tax exclusion is a major reason 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 pretax, not after-tax, income (Cadette 1997).