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Consumer Protection In Managed Care: Finding The Balance

Some options for strengthening consumer protection without undermining the potential of managed care.

by Walter A. Zelman

As the managed care revolution is declared establishment—perhaps because it has been so declared—the industry is experiencing an unprecedented assault, driven by charges and fears that the rush to lower costs will reduce access to care, quality of care, choice of providers, and basic consumer protections. Hundreds of bills have been introduced in legislatures around the country that would (depending on ideological preference) either promote sorely needed consumer protection or unduly restrict managed care plans in their efforts to lower costs and improve health care quality. Even as states rush to enroll the low-income Medicaid population in health maintenance organizations (HMOs), at least thirty-three states have responded to largely middle-class pressures to approve laws restricting or limiting various managed care practices in private managed care plans.

The new wave of questions, while sometimes fueled by those with unstated economic interests in undermining managed care, are for the most part a healthy expression of concern and should be addressed. If carried to extremes, however, the current reexamination of managed care has the capacity to seriously undermine the ability of managed care to do what it does best: lower health care costs. In some cases, proposed reforms also could undermine managed care’s potential to enhance quality. Thus, there is a compelling need to find a balance between, on the one hand, legitimate concerns about quality, access, and choice in managed care and, on the other hand, the need to allow managed care organizations to evolve and experiment, to generate ongoing savings, and, it is hoped, to improve coordination of and quality in health care delivery.

Origins And Essence Of Consumer Concern

Consumers’ concerns focus on a central goal of managed care: to reduce costs, largely by doing less. Particularly alarming is the practice, perceived to be increasingly common today, of fixed prepaid payments to physicians. Such arrangements encourage the perception that the incentive to reduce costs (and care for the patient) is being transferred from the distant insurance company, where it seemed threatening but still removed from the physician/patient relationship, to the physician’s office.

The reduction in choice of physicians that is inherent in most managed care plans intensifies consumers’ concerns. Reduction in physician choice might be less threatening if consumers could change plans. But most employers (especially small employers) offer little if any choice of plans.

Consumers’ fears that physicians may be restrained by so-called gag rules that impinge on their ability to offer forthright advice compound the problem. So, too, do reports of soaring HMO profits (sometimes exaggerated) and multimillion-dollar executive compensation schemes. Finally, there are the related trends of consolidation among health plans (including many larger, national plans acquiring smaller, independent plans) and shifts of hospitals and health plans from nonprofit to for-profit status. These changes, real or perceived, fuel consumers’ fears that their needs will be squeezed between the desire of employers to pay less and of increasingly distant and profit-driven health plans to do less and make more.

But however understandable (and politically compelling) those concerns may be, the anti–managed care, consumer protection case asserted today also is a flawed one. In its most compelling journalistic forms, it suffers from an excessive reliance on individual cases that does not accurately reflect the larger picture.

Additionally, consumers’ fears are sometimes founded on misreadings—most commonly, exaggeration—of trends and realities in managed care. For example, most physicians are still paid according to fee-for-service or salary schedules; when capitation is applied, the actual amount of risk passed to the individual physician is generally modest. With regard to choice, the striking growth in point-of-service options, and the apparent trend toward larger, nonexclusive provider networks, suggest that consumers’ concerns regarding lost choice may be overblown—or at least that they are being addressed. As for quality, while studies do not reflect unanimity on this point, and while some critical exceptions may exist, research in general has found that quality in managed care plans is as good as or better than that in traditional indemnity plans.
Most important, perhaps, the anti–managed care critique tends to implicitly or explicitly idealize a now fading fee-for-service system in which insurers had no more incentive to pay than they do today (they still made more by paying out less); in which a lack of provider organization and communication greatly limited the capacity to coordinate care; in which the incentive was almost always to do more even when doing less might be more appropriate; and in which, as a result, costs rose out of control.

That cost-control failure, more than anything else, precipitated the old system’s decline. But many consumers did not and still do not recognize that flaw, and, consequently, they place minimal value on managed care’s apparent capacity to lower costs. Since employers pay the premiums (at least consumers perceive this to be the case) and insurers pay the bills, both systemic flaws and advances with regard to cost seem less relevant to health care consumers than is usually the case with consumers in general.

In Search Of Balance

Such an analysis suggests an obvious risk for public policy: If the effort (however well-intentioned and appropriate) to strengthen consumer protection in managed care environments is based on a flawed analysis of both old and emerging systems, the results of such efforts could be less than ideal. Such results might include minimum gains in real consumer protection; an undermining of managed care’s potential to lower costs; and an unnecessary limitation on the ability of managed care to adjust, improve, and innovate.

Where, then, is the balance? How do we strengthen consumer protection without undermining real and potential gains that managed care (in its evolving and varied forms) may offer? A full review of consumer protection options is beyond my scope here. But in the search for balance, certain principles and options stand out.

Core consumer protection measures. In any insurance environment, only government is capable of providing certain core protections. Those associated with licensure and solvency are the starting points. In the managed care environment, core protections also may include such features as standards or review criteria for utilization review and provisions for adequate and prompt grievance procedures, especially with regard to denials of care or treatments.

Expansions of core protections also may be required, as at least some states appear to recognize, in the marketing of managed care plans to Medicaid and Medicare recipients. The combination of the rapid expansion of managed care to these populations, the absence of a group (employer) purchaser, the enormous economic advantages associated with effective risk selection practices applied to
these populations, and the higher vulnerability of many Medicaid or Medicare eligibles to deceptive appeals has led to widespread marketing abuses in a number of states.

Additionally, achieving core managed care consumer protection levels may demand increased requirements for disclosure in plan/provider or provider/consumer relationships. It may be inappropriate and unnecessary, though, to require that plans disclose all details of contractual relationships with providers. Also, HMOs may have legitimate concerns about providers' criticizing the HMO or encouraging patients to enroll in another plan, especially one in which the provider has a financial stake. But gag clauses that limit a physician's obligation to fully and freely discuss treatment or referral options undermine the inherent rights of patients and the inherent responsibilities of physicians. And health plans should be required to disclose (although this can be very complicated operationally) the kinds of incentives invoked in contracts with providers.

Particularly worthy as a tool in enforcing core consumer protection needs may be that of monitoring disenrollment from managed care plans. Aggressive efforts to ascertain why consumers left plans can alert regulators to plans that are offering poor service or encouraging higher-risk persons to seek coverage elsewhere.

A focus on disenrollment and on those with higher levels of morbidity also may yield a more meaningful picture of plan performance than do consumer satisfaction surveys based on all plan enrollees. The great majority of enrollees seek only minimal, if any, care in a given year. Few of these persons are likely to express “dissatisfaction.” Regulators and employers, all of whom have limited capacity to actively monitor plan operations, would be wise to put resources into collecting and studying data from high service users.

By contrast, the cases for certain “consumer protection” measures—such as provider rights to participate in networks (any-willing-provider laws), regulations defining the amount of risk that can be transferred to a provider, “freedom-of-choice” or “direct access” laws guaranteeing access to and coverage of services provided by out-of-network physicians or specialists, or “length-of-stay” measures offering such specific patient rights as a forty-eight-hour maternity stay—are much less compelling. In some of these cases the demonstrated need for “protection” is lacking. In other cases the proposals threaten to increase costs while providing only minimal, if any, additional consumer protections. In still other cases the problems may be more amenable to nongovernmental, marketplace solutions. In short, many of these options seem at best premature and at worst unnecessarily costly or inappropriate.

In most cases, rather than enacting restrictive laws on managed
care arrangements and delivery system structures, policymakers might consider four alternatives. First, employ research to determine if the perceived problem is an actual problem (for example, the level of risk being passed to providers). Second, authorize regulators to collect information or impose requirements under general quality assurance mandates (for example, minimum lengths-of-stay). Such regulatory approaches are more flexible than imposing specific statutory requirements. Third, institute disclosure mechanisms to inform consumers of issues and choices (for example, limitations on access to out-of-network physicians). Fourth, provide incentives, assistance, or new rules that better enable consumers or purchasers to address consumer needs (for example, incentives for employers to establish purchasing cooperatives or government assistance in data collection and distribution).

■ Disclosure is cheap. When compared with statutes and regulations mandating specific rules and activities, disclosure is a highly effective, and often less onerous and expensive, means of informing consumers and pressuring plans and providers. Information on such factors as consumer satisfaction, numbers of complaints received per thousand enrollees, percentages of persons who disenrolled from a plan, existence of contracts with centers of excellence, rate of physician turnover, and what quality and utilization data may be available can be of considerable value, especially when widely publicized. Mandated collection of such information would not represent an unreasonable burden on plans, especially if governments, accreditors, and employers develop (as many are doing) standardized data requests. There are multiple opportunities for creative collaboration among these same parties for effective dissemination of such information.

Of course, where the licensed insurer is more a general contractor than a direct provider of services—as may be the trend today—collection and distribution of such information may be of more limited value. In such cases the purchaser or consumer will be more concerned with the performance of a particular medical group or delivery system than with that of the insurer-contractor. But there is, at least, no legal impediment to efforts of purchasers to demand more provider- or network-specific data.

In fact, the tools of disclosure sometimes may be more powerful in the hands of private purchasers than in those of government regulators. The former—under fewer constraints regarding equity or access-to-all concerns—may feel less constrained in the packaging and distribution of certain information. They also may have greater flexibility to demand purchaser-specific services and network arrangements such as increases in geographic coverage, availability of
point-of-service options, or even limits on the amount of risk HMOs pass to individual providers.

Finding the balance, of course, between what must be demanded by regulators and what might be demanded (or requested) by purchasers may not be easy. To be effective in asserting consumer protection demands, purchasers need to (1) know what to ask for; (2) have enough clout to demand it; and (3) care enough to do it. To date, only a modest number of large employers and purchasing cooperatives appear able and willing to cross such thresholds.

**Quality and data collection.** Such logic underscores the reality of increasing opportunities for collaboration in data collection activities that would serve multiple interests—those of regulators, managed care organizations, providers, accreditors, and purchasers. Collaborative efforts among purchasers, among states, between the states and the federal government, and between governments and accrediting agencies all can yield more consensus on what data need to be collected, by whom, and for what purposes. Such data can involve questions of service (waiting times and geographic coverage), performance (immunization rates), outcomes and health status (mortality rates on coronary bypass surgery), consumer satisfaction, and even internal plan procedures (referral mechanisms and levels of risk passed to providers). As implied earlier, means of identifying underservice would be particularly valuable and relevant in an age of rising managed care and capitation.

**Promoting consumer choice and power.** Enhanced levels of consumer protection, including increased competition on quality and service as opposed to price, also might result from a movement from employer to employee choice of plan. Whatever the well-publicized and positive intentions of some large employers, whose purchasing efforts serve as benchmarks, most employers can be expected to put price first. The results of this can be increased consumer concerns that plans may risk quality in the effort to lower costs and increase appeal to employers, and limited incentives for plans to invest in quality improvement.

By contrast, even if rendered more conscious of the costs of insurance, many consumers might be more willing to pay for higher quality and better service than their employers would be. At minimum, consumers might pay more attention to quality issues and send faster signals to plans that improvements in quality can improve market share.

In addition to promoting more aggressive efforts in plan selection strategies, many large employers today also offer employees considerable choice of plans. In doing so they may strike a potent compromise strategy in which the employer narrows the plan choice and
negotiates contracts (using its large number of “covered lives” as leverage) but in which the employee makes the specific choice. In some cases, that employee choice is a particularly cost-conscious one, with employees paying more for more expensive plans.

To most small and many mid-size employers, however, offering choices can generate unacceptable administrative burdens. Moreover, even where employers offer some choice, problems of portability emerge, with consumers forced to switch plans when moving from one employer to another. Here the failed Clinton plan, while clearly overreaching in its original mandate of cooperatives, had it essentially right. Whether sponsored by government or employers, whether many or one, whether mandated or voluntary, the purchasing cooperative construct may offer the best tool for maximizing consumer choice. While facilitating individual choice of plans and reducing administrative burdens for employers, it can both offer more plans and offer the same plans to most employers in a region.

The existence of a purchasing cooperative would not eliminate the need for core, government-secured consumer protections. Moreover, some government intervention and rule setting may be required to both stimulate the purchasing cooperative movement and maximize its potential. However, enhancements of consumer choice and power should reduce the demand and need for more aggressive and regulatory consumer protection activities. Where, after all, consumers have more choice and more freedom to switch plans, the actual and perceived need for specific requirements defining, for example, rights to seek care outside of the network, would be reduced. When combined with improved information collection and dissemination mechanisms (also facilitated in the cooperative structure), the cooperative option can greatly enhance market-based consumer protection.

**Consumer protection and the bully pulpit.** Finally, the effort to define a balance between consumer protection, on the one hand, and managed care–produced savings and innovation, on the other, might benefit from the judicious use of the bully pulpit. Ultimately, consumer protection involves much more than lists of specific regulatory requirements. It is also about public education and effective use of mass communication. Just as two hospitals planning to merge may need an antitrust attorney, a good consumer protection program will need a publicist.

There may be no substitute for tough enforcement programs. However, enforcement should not be limited to legal sanctions. Filing a plan for refusing to provide needed treatment to an enrollee is certainly appropriate. But the market-based punishment that results from publicizing the refusal is more likely to convert the sanc-
tion into consumer protection. Similarly, hiring consumer affairs officers to staff a toll-free telephone number and to resolve individual complaints with insurers may also prove helpful, although perhaps not the best use of regulatory resources. However, compiling complaint statistics and holding a press conference to identify the insurers in the region with the highest numbers of justified complaints per thousand enrollees will have greater impact.

Such tactics must be employed judiciously and with appropriate caveats. But especially given the limited resources of those charged with consumer protection, emphasis must be placed on educating large numbers of people with small budgets.

Organizing the forever unorganized. Almost thirty years ago, when founding Common Cause, John Gardner noted that “everyone is organized but the people.” More recently, in a perceptive paper in Health Affairs, Fall 1996, Marc Rodwin highlighted the need for more organized consumer advocacy in health care policy making. Both analyses may suggest an implicit lesson for our concerns here: In the world of policy and politics, the precondition for defining—and certainly enacting—policy that seeks to balance competing needs may be a balance of power between the organizational forces at play.

The obstacles to organizing the general health care consumer are massive, just as they are in mobilizing utility consumers, renters, supermarket shoppers, or buyers of automobile insurance. Funding problems are endless. Governance and accountability problems are complex. Consumers’ attention spans are notoriously brief and cluttered. Often the best that can be expected is the mobilization of consumers with special interests (those, for example, with specific diseases), or consumer organizations that seek to pursue consumer interests, even if they do not organize or truly represent them. Consumers Union, for example, funds its advocacy efforts primarily by selling a magazine and makes no effort to mobilize its subscribers.

Still, there may be some means of addressing the problem. Check-off devices on enrollment forms could be implemented by which millions of managed care enrollees would have the option of adding one dollar or less to support consumer organizations established (by employers, consumers, or even government) to monitor managed care organizations. (Governance and other problems can be massive here, but so, too, is the potential.) Foundations could endow watchdog organizations, especially if their purposes were limited. Courts could direct funds from class-action or punitive damage awards involving managed care organizations to qualifying consumer organizations. Foundations created by conversions of nonprofit to for-profit organizations could be directed to fund consumer organizations established to further the original purpose of the converted
entity. Government agencies could fund consumer intervenors in regulatory and even legislative proceedings.

Most important, effective consumer advocates often find quick alliance with the media, which are constitutionally prepared and willing to expose (even if they do not always support) the consumer’s case. As a result, when it comes to disclosure at least, consumer groups often can accomplish much with relatively little.

■ A presidential commission on quality. Many such commissions are of limited value; they serve to avoid rather than to address issues. But the commission announced by President Bill Clinton during the recent campaign—whatever its political or other origins—may hold real potential. As the above analysis suggests, the task of defining a balance between consumer protection and flexibility for managed care is difficult but achievable. Accurate perceptions of what is and is not occurring, and balanced dialogue comparing the old and the new, could provide a sound framework from which to devise solutions and compromises that would be acceptable to many interests involved. In short, the potential for finding a balance that is more a win/win than a win/lose is real, especially given that emerging fault lines cut across partisan divisions.

The managed care revolution has produced both concerns and promise. The challenge is to address the concerns without undermining the promise. The above analysis suggests that many goals of various stakeholders are not necessarily in conflict and that, given improved understanding and modest government or market interventions, interested parties may find a sizable piece of common ground. If that common ground can be defined, the gap between what society wants and what it needs from managed care may be greatly narrowed.

NOTES