‘Putting Patients First’:
A Philosophy In Practice

Humana’s chairman and CEO explains the rationale and goals for the American Association of Health Plans’ new initiative to show consumers that health plans are attentive to their concerns.

by David A. Jones

More than 1,000 health plans serving more than 120 million Americans are participating in an industrywide initiative called “Putting Patients First.” Developed under the auspices of the American Association of Health Plans (AAHP), this is either an unprecedented effort to advance the frontiers of health care or a transparent public relations ploy designed to fend off insurance regulators. The question is, which of these assessments is correct?

My view is that Putting Patients First needs to be seen in context. Ten years ago, managed care was still marginal, at least in the sense that the great majority of Americans had had no direct experience with it. Today more than 75 percent of working Americans are enrolled in a managed care plan. From all of the evidence, most are well satisfied with the arrangement.

All things considered, the transition from fee-for-service to managed care has been successful—for most Americans. But, as hardly anyone needs to be told, that transition has not been without controversy. Failures of care, even tragedies, have occurred within the managed care sphere, even as they did and still do under the old system. The difference is that the defenders of the old system have been adroit at amplifying individual failures into wholesale indictments of managed care. The result has been a great deal of public confusion and apprehension about what managed care is and whether it is somehow synonymous with denial of care.

Health plans have long been aware of the need for greater clarity about how they organize care to meet the needs of the persons they serve. But until relatively recently, they lacked a crucial kind of leverage—the capacity to continually examine policies and practices industrywide and to hold themselves, as a community of health

David Jones is chairman and chief executive officer of Humana Inc., which is based in Louisville, Kentucky. He also serves as a member of the board of the American Association of Health Plans.
plans, accountable for constantly adhering to high standards of quality and service. In the absence of such a mechanism, there is no effective way to raise the bar of performance across the board.

This is, of course, one of the inherent flaws of fee-for-service health care, revealed most starkly in studies confirming wide variations in care from one practitioner to another, one facility to another, one metropolitan area to another. It all added up to a general failure of accountability that resulted in the system’s tolerating inadequate care and sometimes dangerous overuse of services. These forces drove fee-for-service costs to the point of crisis and beyond.

Managed care has the great advantage of being able to promote accountability and continual improvement within a defined system—that is, within the universe of a health plan and its affiliated practitioners. But there is still the challenge of how best to advance these goals across the board.

Taking advantage of the opportunity for unity offered by the creation of the AAHP (by the merger of the two major associations that had been representing health maintenance organizations [HMOs], preferred provider organizations [PPOs], and similar plans), we first acted to broadly codify performance criteria in a Philosophy of Care—in essence, a declaration of principles designed to guide the organization and delivery of health care services. In the long run, effective management of care requires that all of those involved see themselves as partners. Every policy, every practice needs to be tested against this principle to determine whether it strengthens or weakens the sense of partnership. Every AAHP member plan now attests, as a condition of membership, to the Philosophy of Care, which stresses the goal of assuring that every patient has access to the right care, at the right time, and in the right setting.

A cynic might dismiss this as so much rhetoric. But that can be said of any declaration of principles. The job of such a document is to provide a platform on which to build—a framework within which to develop specific policies and promote specific actions consistent with an underlying philosophy. In explicitly endorsing a patient-centered approach to care, AAHP member plans are saying in effect that they have nothing to hide—that they are willing to examine each and every policy and practice and if necessary make changes to remove any doubts about their overriding obligation to put patients’ interests first. It is a matter of some pride that our industry showed leadership by responding to these needs on its own.

Some may wonder why Putting Patients First should be an issue in the first place. My view, however, is that there is an inevitable tension of interests in health care and that we should not be shy about calling attention to it. Those of us who are charged with
guiding and administering health plans must constantly balance the competing interests of cost cutting, unlimited choice, and practitioners’ desire to be left alone. What should be immediately clear is that none of these demands can be accommodated without affecting the others.

But a philosophy alone is not enough. The AAHP’s board, recognizing the need to give its philosophy teeth, took steps to develop an initiative designed to resolve any conflicts of policy or practice in ways that strengthen the core partnership between patients and plans. Strictly speaking, this initiative did not have to be given a name. But since “putting patients first” is what the initiative is all about, the name aptly reflects the mission.

**How Putting Patients First Works**

Under the Putting Patients First initiative, when an issue arises that suggests the need to reexamine how health plans as a group deliver care, AAHP board members and other health plan representatives look for ways to resolve the conflict, if there is one, either by clarifying the issue or, if necessary, by recommending how services can be provided to improve access to appropriate care. As a practical matter, high-priority issues are likely to be those that receive widespread public attention, usually by virtue of having been misrepresented by critics of managed care and then magnified by the media. Perhaps it is this that gives rise to charges that Putting Patients First is a public relations ploy. I would answer that one of the hallmarks of a responsible organization or industry is its commitment to resolving issues that stand in the way of its working in partnership with its clients. What follows here is a brief review of how Putting Patients First has addressed various issues that have arisen since its inception in 1996.

- **Outpatient versus inpatient care.** Health plans had been falsely accused of denying adequate care to mothers and newborns by requiring “drive-through” deliveries (the issue really was whether physicians should have to request authorization for longer-than-normal hospital stays) and requiring breast cancer patients to have mastectomies as outpatients. In both cases, an AAHP review of plans’ policies and practices indicated that the accusations were largely based on misinformation. In the latter case, there was much
public and media confusion about the difference between a lumpectomy (surgical removal of breast tissue) and a mastectomy (partial or entire removal of a breast). Lost in the uproar were two key facts: that lumpectomies are routinely performed on an outpatient basis under both fee-for-service and managed care, and that most of the controversies that had arisen were in fee-for-service situations. However, after reviewing the issues and determining the need for greater clarity, the AAHP, with the strong support of its member plans, issued a policy statement that member plans do not require outpatient mastectomies and that physicians in consultation with their patients should decide whether outpatient or inpatient care is preferable following a mastectomy.

■ Information for patients. In response to confusion and misrepresentations about whether health plans were adequately informing members about policies on such matters as coverage of treatments deemed experimental, the AAHP adopted a new policy. It broadly affirmed that health plans should (1) routinely inform members about their plan’s structure and provider network; the benefits covered and excluded, including out-of-area and emergency coverage; and cost-sharing requirements; and (2) provide information about precertification and other utilization review procedures; the basis for a specific utilization review decision with which a member disagrees; whether a specific prescription drug is included in a formulary; a summary description of how physicians are paid, including financial incentives (short of disclosing specific details of individual financial arrangements); and the procedures and criteria used to determine whether experimental treatments and technologies are covered services. The goals here were twofold: to ensure that all members have the information they need to make the best use of their membership, and to ensure that patients involved in disputes about coverage or treatment have all of the information they need to help them resolve the dispute.

■ Patient/physician communication. A few health plans had adopted contractual provisions over the years requiring physicians to check with the plan before discussing treatment options or services that the plan might not cover. However, this did not prevent critics from claiming that these were “gag rules” restricting what physicians could tell their patients. The AAHP Philosophy of Care explicitly encourages full and open communication between physicians and their patients to ensure that patients avail themselves of timely and appropriate care. But the AAHP decided to go further and adopted a policy explicitly affirming that health plans, by contract or policy, will not prohibit physicians from communicating with patients concerning medical care, including medically appropriate treatment op-
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...tions, whether covered or not.

■ Appeals. Responding to public confusion about how to appeal an unfavorable coverage or treatment determination, the AAHP adopted a policy that (1) health plans should explain, in a timely notice to the patient, the basis for a coverage or treatment determination with which the patient disagrees, accompanied by an easily understood description of the patient’s appeal rights and the time frames for an appeal; and (2) appeals should be resolved as rapidly as warranted by the patient’s situation, with an expedited appeals process available for situations in which the normal time frame could jeopardize a patient’s life or health.

■ Emergency care. Although there is little doubt that millions of Americans rely on emergency rooms in nonemergency situations, there has been confusion about why health plans seek to steer patients to primary care physicians, who can provide nonemergency care and continuity of care more effectively and affordably, and about why plans sometimes elect not to cover emergency room costs incurred in situations later determined to be nonemergencies. Seeking to clarify matters and to promote consistent practice in this important area, the AAHP adopted a policy that (1) health plans should cover emergency room screening and stabilization as needed for conditions that reasonably appeared to constitute an emergency, based on the patient’s presenting symptoms; (2) emergency conditions are those that arise suddenly and require immediate treatment to avoid jeopardy to a patient’s life or health; and (3) to promote continuity of care and optimal care by the treating physician, the emergency department should contact the patient’s primary care physician as soon as possible.

■ Quality improvement. In the latest Putting Patients First policy announcements, the AAHP has reaffirmed the central role of physicians in directing health plans’ quality assessment and improvement programs, developing and implementing practice guidelines, monitoring use of health care services, and reviewing prescription drug formularies. In each of these areas, critics have suggested that health plans are more interested in limiting access to care than in improving it and that physicians have little involvement in the quality improvement process. AAHP members recognized the need for greater clarity. AAHP policy is that (1) quality assessment and improvement programs should be physician-directed, with properly
credentialed participating physicians involved in their design and implementation; (2) practice guidelines should be based on current scientific and medical evidence, with participating physicians involved in their development and review; (3) utilization management programs similarly should be based on current scientific and medical evidence, should be physician-directed, should provide for the involvement of physicians affected by utilization management decisions, and should include a process to request exceptions for situations in which a physician believes that a utilization management determination did not adequately take into account a patient’s unique characteristics; and (4) health plans should involve participating physicians in developing, reviewing, and regularly updating prescription drug formularies, which should provide for coverage of nonincluded drugs as warranted by scientific medical evidence. The theme running throughout these policies is the same: that health plans’ policies to systematically improve care regimens should be developed and implemented in active collaboration with participating physicians for the benefit of patients.

I am confident that any dispassionate observer reviewing these policies would conclude that they reflect an extraordinary commitment to putting the interests of patients above all other factors affecting the organization and delivery of health care services. The policies confirm that, as the AAHP maintains, Putting Patients First is a mission, not just a motto.

I am also enough of a realist, however, to know that Putting Patients First will not put an end to criticism of managed care. But then, that is not its purpose. Rather, its purpose is to demonstrate that health plans have the capacity and commitment to continually review their policies and practices and to clarify or modify them as necessary. In a larger sense, its purpose is to show health care consumers that health plans are true partners, closely attentive to consumers’ concerns and expectations.