A Health Plan’s View Of Government Regulation

A Kaiser Foundation Health Plan executive suggests a role for federal and state governments in regulating managed care.

by Steve Zatkin

State legislators and regulators are focusing unprecedented attention on the regulation of managed care. Early federal regulatory efforts addressed standards for federal programs and voluntary standards, such as in the Health Maintenance Organization (HMO) Act of 1973. Currently, Congress is considering numerous proposals to regulate health plans. To date, there has been more attention to the content of standards than to the question of how the responsibility to regulate should be apportioned between the states and the federal government. This paper discusses the issue from the perspective of a large, nonprofit health plan with nationwide membership.

The Role Of Government

Health care is a complex, personal service. The primary means for assuring quality of care and service should reside with health care professionals and health care organizations. However, the financing and delivery of health care is so connected with the public interest that there also must be public accountability. Government has a basic responsibility to ensure that health plans and providers are qualified and operate in the public interest.

Moreover, public confidence in our health care system is not as high as it should be. While managed care has become the dominant form of health care financing and delivery, support for it, with some exceptions, is not deep. The best features of managed care provide public benefits beyond those available in the fee-for-service system: comprehensive benefits, evidence-based high-quality care, well-coordinated services provided through integrated delivery systems, and accountability for quality improvement. However, managed care is often promoted and perceived as a means to control costs rather than to improve quality. Those whose economic interests are challenged by managed care have been relatively successful in raising doubts about it, largely by focusing on anecdotes rather than on evidence-based analysis. Appropriate public oversight can identify and eliminate features that are not in the public interest and thus enhance consumer protection. Greater public accountability also can result in increased consumer trust.

The Focus Of Regulation

The regulation of fee-for-service indemnity insurance focused on plan solvency, marketing conduct, and benefits. As managed care plans evolved to take responsibility for arranging care, regulation began to address access to services and quality assurance processes. More recently, changes in the delivery of health care as well as more aggressive cost containment practices by some plans have led to efforts to regulate provider contracts and other plan practices. Grievance and appeals procedures and medical necessity determinations...
are now the focus of state legislative action.

Subject areas that are being addressed in comprehensive standards for managed care plans include marketing conduct; plan solvency; rating and underwriting; accessibility of services; confidentiality of health care information; continuity of care; disclosure of information; standards for covering emergency care; determinations of coverage exclusions because care is experimental; determinations of medical necessity; development of drug formularies; member grievances and appeals processes; prohibitions against discrimination; out-of-area coverage; performance measurement and data reporting; quality assurance processes; provider communication with patients, provider credentialing, and reimbursement incentives; and utilization management.

Proposals to regulate each of these areas should be considered on their merits. Does the proposal provide real consumer protection? Or is it, instead, an effort to micromanage health care or protect economic interest in the guise of protecting the public? Such proposals increase costs unnecessarily, codify medical practice based on today’s knowledge, and increase the difficulty of making health care more widely available.

Alternative Approaches To Standard Setting

The traditional approaches to establishing public accountability are state licensing of health plans, purchaser monitoring of health plans, and voluntary accreditation. Each approach has contributed to consumer protection and accountability. States have the greatest experience in regulating managed care. State-based organizations such as the National Association of Insurance Commissioners (NAIC) have led the way in developing new models for improving regulatory activities. Enlightened purchasers such as the Pacific Business Group on Health (PBGH) and the California Public Employees Retirement System (CalPERS) have moved beyond cost containment to focus on accountability for quality. Accreditation organizations such as the National Committee for Quality Assurance (NCQA) have established sophisticated systems for monitoring health plan activities.

However, each of these standard-setting approaches has its limitations. Private standards imposed by purchasers, accreditation agencies, and trade associations contribute to quality improvement but are not substitutes for adequate public standards. By definition, private standards do not apply to all health plans in all circumstances. Often, less-qualified health plans avoid them.

There also are limits on the ability of states to regulate effectively. Variations in standards can affect purchasers and health care organizations. Workforces have become more mobile, and employers want the ability to establish multistate health benefits arrangements. Purchasers and health plans seek seamless health benefits arrangements that cross state lines unimpeded by local rule differences. Although the delivery of health care is a local activity, many health plans, through affiliations, are creating a national capacity to better respond to the service requirements of their customers. Variations in standards can increase the administrative costs of responding effectively to these needs.

States also vary in their capacity to regulate. Whereas many states do an excellent job of overseeing managed care, others, for lack of will or resources, lag behind. States also are limited in their authority to regulate. The federal Employee Retirement Income Security Act (ERISA) limits the ability of states to address certain self-funded arrangements.

Federal Regulation

Early examples of federal standards for man-
aged care include the HMO Act and standards for Medicare risk contractors. Federal jurisdiction has been extended to private-sector continuation requirements, as stipulated in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). In August 1996 Congress enacted health plan portability standards and rules governing coverage of maternity care and the provision of mental health benefits in the Health Insurance Portability and Accountability Act.

Congressional action to regulate managed care reflects the pressures that are at play in the states. In addition, the movement toward national standards is a response to limits on the reach and capacity of state and private standard-setting activities. It also may reflect a realization that managed care is a nationwide phenomenon.

The development of national standards for health plans is likely to continue. The challenge is to develop an approach that will work for consumers, plans, providers, purchasers, and the government. Health care financing and delivery are dynamic activities; innovation that leads to quality improvement and efficiency should be fostered. Excessive regulation can stifle innovation.

In promoting national standards for health plans, Congress should avoid enacting highly detailed statutes on technically complex and evolving issues. Rather, it should identify principles that are important to consumer protection and should provide authority to an entity with experience and appropriate input to promulgate standards that implement those principles. Some have suggested delegating standard-setting authority to a Financial Accounting Standards Board (FASB)-like entity. This approach is intended to muster expertise and shield the process from the political pressures inherent in the regulatory activities of federal agencies. These are laudable objectives. However, given the widespread interest in these issues and the vast array of interest groups that would seek representation, the politics of this standard-setting process could be as heated as a more traditional approach would be. A traditional model would provide regulatory authority to a federal agency, such as the Department of Health and Human Services, and obtain expertise through the public comment process and perhaps an advisory body of experts.

The practical capacity to enforce federal standards resides with the states, primarily in the state insurance and health departments. Large public purchasers such as the Health Care Financing Administration (HCFA), the Federal Employees Health Benefits Program (FEHBP), and state Medicaid agencies will likely want to continue monitoring activities on behalf of their programs and beneficiaries.

If federal standards are adopted, a key issue is whether states should adopt more rigorous standards or adopt standards on matters not addressed by Congress. Many will want to view federal standards as the “floor” upon which additional state standards may be adopted. However, where Congress has addressed the issue, a strong case can be made for federal preemption. Consistent standards can benefit consumers, purchasers, health plans, and providers through lower administrative and compliance costs.

Whatever form regulation of health plans may take, it is important that the basic objective be kept in mind—to provide high-quality, patient-friendly, affordable health care through arrangements that are both accountable to the public and open to innovations that will improve quality and affordability.

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