The Role Of Anecdotes In Regulating Managed Care

The much-maligned anecdote can make a valuable contribution to the managed care debate.

by David A. Rochefort

In a recent issue of Health Affairs, the authors of an analysis of managed care media coverage highlight the prominence of negative anecdotes on the subject. Elsewhere in the issue Karen Ignagni, chief executive officer of the American Association of Health Plans, complains that “[c]ritics of managed care have become adroit at selectively publicizing alleged denials of service and failures of care, which are then amplified by the media and become the basis for hastily considered legislation enacted in the name of consumer protection.” This implies that negative anecdotes of this kind are biased and unscientific and have no place in the development of government regulations for the managed care industry.

Such a perspective, however, seriously misconstrues both the importance of anecdotal data and the regulatory function. Anecdotes are a particular form of information with their own strengths and weaknesses. In this, they are like other types of information, including statistics, to which they serve as a useful complement. Contrary to how they are sometimes portrayed, anecdotes are not inherently specious and often can be easily verified. According to the Oxford American Dictionary, an “anecdote” refers to “a real person or event.” Perhaps what best distinguishes anecdotes from other factual data is their relative brevity, the qualitative information they provide, and their illustrative poignancy—that is, their ability to invoke special interest or emotion. Because of all of these qualities, anecdotes can serve several purposes within the regulatory process.

The Worst Of All Possible Worlds

One of the main complaints about negative anecdotes concerning managed care is that the problems they depict are unrepresentative of the industry as a whole. This view holds that these anecdotes—
even if true—are misleading and attract excessive attention among the public and policymakers to issues that are not widespread.

Yet government regulation is not intended to respond to typical or average practices. Rather, its purpose is to set rules for minimum performance and penalties for violating them.\(^4\) Regulators are supportive of industrywide excellence and ongoing quality improvements. But other actors in health care have this as their primary mission, such as internal and external quality assurance agents in the private sector.\(^5\) Public regulation, instead, establishes a baseline of consumer protection, without any assumption about the frequency of standards violations to justify the regulatory presence.

Within this process, anecdotes can help to highlight when new regulatory action may be needed. For example, anecdotal complaints from patients and physicians proved very influential in calling attention to managed care plans’ refusals to pay for emergency room (ER) care.\(^6\) Ultimately, a number of states, such as Maryland in 1993, passed laws adopting the “prudent layperson” standard governing ER payment. The authors of a consumer study of managed care observed, “An individual story cannot and should not be used to substitute for solid [quality] data . . . or be the sole basis [for] new, far-reaching laws.”\(^7\) However, individual stories can be investigated, cumulated, and made a part of broader inquiry into new and existing regulations.

Some in the managed care camp oppose such laws on principle as micromanagement and as unnecessary for most health plans. Others, however, recognize that it is precisely because anecdotal abuses are perpetrated by a few plans that legislation serves a needed role by protecting the industry’s image and by guaranteeing fair ground rules for competition among all providers.

**Where There’s Smoke . . .**

Negative anecdotes on managed care also can function as “sentinel events.” The latter refer to rare or outright bizarre occurrences that are significant for their extreme seriousness or because they signal the potential breakdown of a larger equilibrium.\(^8\) Sentinel events stimulate systematic inquiry into the “root cause” of a problem and provide a basis for preventive intervention. Analysis of sentinel events has been applied fruitfully in several areas of epidemiology, in measuring quality of care and as a tool for administrative learning.\(^9\)

The following personal anecdote illustrates how a particular episode of care can bear on issues of systemic significance.

Carolyn Brooks is what last night’s hearing on managed care and mental health was all about, and her story won applause. “I knew I was experiencing symptoms and I
needed help,” she said, describing a time a year ago when she had suicidal feelings. “I called the 800 number at United Health Plans. They wanted to know all the symptoms and circumstances.” In the end, she said, she saw a social worker, but was denied sessions with a psychologist and was eventually cut off from care. A year later, Brooks was out of work and so distraught that she once couldn’t remember her street name when calling the police with a noise complaint. At her annual physical, she “fell apart” and it was only through the intervention of her doctor that she was able to see a psychologist, she said. Even so, she has been cut off again, and the psychologist is providing the care for free. “If I was successful in committing suicide,” Brooks said, “who would have known that I was denied care?”

From a public policy standpoint, this report touches on key questions of access to care, utilization review, mechanisms for appealing treatment denials, and the management of mental health specialty services. All have become salient concerns for managed care regulation. The report also raises the troubling prospect of patients whose illnesses impair their ability to advocate for themselves and could lead them to drop out of the service system altogether.

Admittedly, one instance does not a trend make. Only further data collection can reveal how typical such a negative experience might be. However, the industry’s complaint of nonrepresentativeness is largely beside the point when one views negative anecdotes as sentinel events. By definition, such episodes are “singular.” The important questions, instead, are: If such occurrences are ever supposed to happen at all, why do they occur, even if infrequently? What can be done to avoid them in the future? Further, if there are repeated occurrences, do they not give strong reason to suspect a “nonrandom pattern,” in the language of epidemiologists?

Disease surveillance has been described as “a state of continuing watchfulness.” The same can be said of regulation, which gives anecdotes even of singular cases a special meaning and value.

**Weapons Of The Weak**

To some extent, the use of anecdotes within discussions of managed care performance is a simple necessity because other kinds of data are not being collected, or, if collected, they are available only to a restricted audience. For example, health facilities have been reluctant to release mortality data and other quality-of-care statistics amid pressure to do so. Thus, when Massachusetts’s Lahey Clinic recently announced that it would provide a detailed report card of its own performance based on medical outcomes data, the *Boston Globe* marked it as the exception to a long-standing pattern of resistance. Even when such data are publicized, however, the objective likely has more to do with marketing than with openness. Sidney Wolfe, director of the Public Citizen Health Research Group, questioned how meaningful the new information could be, since no com-
“The most successful politicians keenly understand the human-interest value of anecdotes and related storytelling.”

parisons with other hospitals were to be provided, nor were adjust-
tments to be made for patient severity levels. If information is power, the distribution of information is the spoils of a continuing war over private versus public prerogatives. Within this struggle, consumers are at a disadvantage. For this reason, a main thrust of current managed care regulatory proposals has been to force plans to disclose a greater amount of information about benefits, operations, grievance processes, and other aspects of service. For health plan executives to rule anecdotal information out-of-bounds in the public debate over managed care approaches a cavalier disregard for the barriers consumers face when trying to use the same information, language, and symbols that they use. Policy analysts also can fall prey to the danger of gearing their work “for those in power and involved in the managing of public problems rather than for those challenging power and confronting these problems in their everyday lives.”

A more balanced approach means combining aggregate data with a “bottom-up perspective” that is open to the subjective and qualitative dimensions of experience. Anecdotes help to supply such information.

Constructing The Political Narrative

Regulatory administration is rooted in politics: first, in the initial design and enactment of regulatory legislation and, second, in the way regulatory policy is implemented. The latter takes place within its own political “subsystem” consisting of the regulatory bureaucracy, a variety of industry groups and other private interests, legislative subcommittees, policy experts, and journalists. At the same time, such a subsystem is permeated by the influence of outside political actors who are more likely to involve themselves when an issue has continuing political salience with the public.

To state that managed care regulation is situated in a political environment is to recognize that it belongs unavoidably to a world of storytelling. As political scientist Deborah Stone explains, “Definitions of policy problems usually have narrative structure. . . . They have heroes and villains and innocent victims, and they pit the forces of evil against the forces of good. The story line in policy writing is often hidden, but one should not be thwarted by the surface details from searching for the underlying story.” Viewed through this lens, aggregate facts and figures are just alternative elements of plot and
not necessarily more reliable than anecdotes. Recent New York Times coverage of statistical manipulation in the national tobacco debate underscores this reality.\textsuperscript{17} Anecdotes do, however, have a certain advantage in political storytelling because they tend to be more dramatic and personalized, and the audience can more readily identify with the experience related. When a newspaper column gives an account of a middle-aged teacher’s repeated denials by her insurance company of a surgery that could save her knee and that is paid for routinely by hundreds of other insurers nationwide, who would not feel sympathy, as well as be moved to ask how such things can happen?\textsuperscript{18}

The most successful politicians keenly understand this human-interest value of anecdotes and related storytelling. It is why presidents giving State of the Union speeches routinely invite heroic guests to sit in the congressional gallery, stationed there as the main protagonists in some morality tale told in capsule form to support a favored principle or policy initiative. And it is why Democratic senators recently vowed to advance a patient protection bill by giving daily speeches on the Senate floor highlighting the cases of sick people denied care.\textsuperscript{19} As Rep. Pete Stark (D-CA), ranking Democrat on the House Ways and Means Subcommittee on Health, described it, “This is perhaps the most important health issue before the public today, the almost obscene indifference of for-profit health plans to their patients. They will deny health care at every opportunity in order to earn higher profits and pay higher executive salaries. We must respond to the overwhelming public demand for patient protection.”\textsuperscript{20}


It would be one thing if this were a one-sided ploy, the managed care industry mercilessly bullied by its opponents’ “horror stories.” However, there is another common tale of woe in health care policy making today, one in which dynamic, efficient, public-spirited private entrepreneurs are shackled by the intrusions of big government. This story comes complete with its own anecdotal accounts of excess and inequity, strategically publicized. It is the basic story line that helped to foil national health care reform in the first part of this decade—for example, a “research bulletin” by the Health Insurance Association of America in 1990 included a special appendix excerpting scattered complaints from Canadian press and radio about access to care under the single-payer system—and it is being revisited today in the struggle to fend off regulation of the managed care industry.\textsuperscript{21} Whether anecdotes would deserve such a central place in public policy decision making in an ideal world is open to question. Meanwhile, in the world as it is, they are essential to the political game, and they are used by all sides in one format or another.
Can Anecdotes Be Misused?

The answer to this question is decidedly “yes.” Taking anecdotes at face value without attempting to corroborate their accuracy is one chief form of misuse. Even though, as already noted, isolated events can have great relevance for policy making, the events must be actual, or else the policy process simply becomes driven by a priori value positions in the guise of empiricism. (Some claim that this is exactly what has happened in regard to regulatory legislation against nonexistent “gag rules,” although researchers’ findings on the practice conflict.)

Anecdotes often serve to draw the spotlight to a particular concern, but, in a field of many competing claims on government, a fuller perspective on incidence, severity, and distribution is needed to gauge a problem’s significance.

Anecdotes are misused when policymakers (and health plan executives) neglect to seize on them as a stimulus for establishing more routine monitoring of care. The problem here is allowing anecdotal complaints to remain either as the sporadic utterances of aggrieved consumers or as the politically manipulated statements of special interests. From a regulatory point of view, there needs to be a supervised framework for capturing anecdotal information for the public record, whether in the form of a registry for complaints, convening of focus groups, or regular public hearings.

Anecdotes may also be prone to eliciting merely symbolic reassurances from public officials. Political scientists have documented how the political process can assuage feelings of injustice even in the absence of any meaningful reallocation of resources or improved consumer protection. Anecdotes are typically emotional expressions (of outrage, victimization, undeserved suffering), which, in turn, invite emotional responses from leaders (of concern, solidarity, commitment). What matters most in regulatory policy making, however, is not the rhetorical uses of public authority but operational interventions. A cumulating mass of negative anecdotes may catalyze the regulatory process, but alone it provides little guarantee of the design and implementation of effective regulatory solutions.

As to the latter, anecdotal reports of abuses certainly should not be used by public officials as an excuse to overreact with new laws or rules that disregard standards of regulatory reasonableness. Regulation-reform advocates have put forward several worthwhile general guidelines that can be applied to managed care, including simplicity, realistic goal setting, use of the least restrictive alternative to promote industry competitiveness, and cost-effectiveness. New standards also can be based on performance levels already proven attainable within the industry, such as the “prudent layper-
son” rule for emergency care. In a field such as managed care, where myriad federal, state, and private regulatory authorities have become involved, the goal of coordinated, nonduplicative regulatory action is one to be taken most seriously.25

Finally, it is worth noting that anecdotal storytelling can be abused as an instrument of political domination. Consider the area of welfare policy making, where negative anecdotes have frequently been used to promote images of recipients as lazy, irresponsible, and dishonest. What is troubling about this is not the role of anecdotes per se, but that the targets are, for the most part, impoverished, unorganized individuals who lack the political resources either to exert much pressure for factual accuracy or to fight fire with fire by formulating “counteranecdotes” tactically in their own defense. As I have already discussed, however, the managed care debate, in which opponents are proving to be rather well matched politically, seems to present no equivalent fairness concerns.

Karen Ignagni properly argues in her Health Affairs paper that the managed care “debate needs to be enlarged” beyond the horror stories of managed care critics versus the defensive dismissals of the industry. She suggests several tasks health plans must undertake to advance the policy process—among them better communication, demonstration of real service improvements, and accepting the managed care revolution as but a “work in progress.”26 If such proposals are the beginning response to a public awareness galvanized at least in part by the spread of anecdotal tales, then we can well appreciate just how valuable anecdotes have proved to be in the managed care debate.

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NOTES
2280–2283.
7. Quoted in ibid., 2283.
12. Thanks to Matthew Reidy, independent Medicaid consultant, for urging me to explore this issue.
20. Ibid.
24. Breyer, Regulation and Its Reform, 184–188.