Health Law 2000: Regulation, Litigation, Or Strangulation?

A call for evenhanded legal treatment of managed care plans.

by Jeffery Boyd and Lauren Kelley

WILLIAM SAGE PRESENTS a thorough and cogent overview of the principal legal trends affecting the health care industry today that portend increased regulation and litigation. Such increases would hamper innovation in health care delivery and would result in markedly higher health care costs. The legal system should accommodate the creation of a variety of approaches to the delivery of high-quality, cost-effective health care in our free enterprise system and hold participants accountable based on the functions they perform and the obligations they assume.

Tools Of Managed Care

The managed care industry has developed techniques that have improved health care for millions of people by reducing inappropriate care, increasing coordination of care, and providing coverage for preventive care.[1] Even the most commonly criticized aspects of managed care provide value not just in reducing costs, but in improving the quality of care.[2] The closed provider network's systematic credentialing of physicians protects consumers who previously had only word of mouth to rely on in choosing physicians. The use of primary care physician gatekeepers promotes coordination and continuity of care and prioritizes appropriate services. Utilization review acknowledges that optimal treatment levels exist and provides corrective feedback to physicians in the event of overtreatment or undertreatment. Many health plans identify members with special needs and direct them to appropriate care. Managed care techniques are constantly being refined, much as medical technology is being improved, to improve the quality of care. For example, new triage methodology and specialty management may replace gatekeepers eventually.

Regulatory Guideposts

As with any tools, the effectiveness of those used in managed care depends on how they are wielded; few would argue that regulation is unnecessary or inappropriate. Health care and health insurance are among the most heavily regulated commercial activities. Regulators are increasingly challenged by the variety of legal structures used to deliver health benefits and by the many competing interest groups that support or oppose reform. However, existing regulation seems to provide the basic framework to assure high-quality care.

Independently, the managed care industry has endeavored to promote high-quality health care. The industry's National Committee on Quality Assurance (NCQA) is an accreditation organization that examines all aspects of health plans' operations relating to health care delivery. NCQA accreditation is a significant factor in employers' choice of health plans. This is an incentive for plans to strive for excellence in utilization management, credentialing, member services, preventive health care, and medical record maintenance. Similarly, the American Association of Health Plans (AAHP) has promulgated a statement of philosophy of care that has been adopted by many member plans. The state-

Jeffery Boyd is executive vice-president and general counsel and Lauren Kelley, director of Medicare programs, at Oxford Health Plans, a for-profit health plan in Norwalk, Connecticut. Health Affairs *invited their response to William Sage's paper, which precedes this Perspective.*

ment recognizes the right of plan members to receive the right care at the right time and the role of patients and health care professionals as the ultimate health care decisionmakers.[3]

Areas Of Accountability

We do not subscribe to the "irrefutable logic" of bringing medical malpractice claims against health plans. It is difficult to see what societal interests are served by adding managed care defendants to a practice environment that is already hobbled by skyrocketing malpractice insurance premiums and the practice of defensive medicine. Ultimately, consumers will bear the additional costs of judgments levied against managed care enterprises. Moreover, we do not believe that the courts should be deceived by the concept of "convergence of coverage and care," which attempts to confuse the separate and distinct legal responsibilities of health plans and physicians.

"Plans should be held accountable for the quality of their credentialing, just as physicians should be held accountable for the quality of their care."

Coverage is insurance—a contractual obligation to pay for covered benefits; medical care is delivered by clinicians, despite the application of population-based health care management techniques. Managed care goes further than traditional indemnity insurers when health plans recruit and credential selective provider networks. Contracted physicians within these networks are paid to exercise professional judgment and expertise in the care of members. The functions of network development and maintenance are clearly distinct from the delivery of care. Health plans should be held accountable for the quality of their credentialing, just as physicians should be held accountable for the quality of their care. If a health plan has exercised due care in credentialing, absent other culpable activity by the plan, there is no basis for holding the plan liable for malpractice by a network physician. Health plans generally require physicians to carry their own insurance so that injured plaintiffs have a source of recovery.

More difficult issues arise in disputes about coverage of a particular treatment recommended by a physician. Managed care tools are designed to support and complement the provision of clinical care, not to intervene in it; thus, disagreements between plan and doctor over treatment recommended by the physician are the exception rather than the rule. Principles of contract interpretation come into play when policy language excludes coverage for a particular procedure. Most health plans rely on widely accepted standards adopted by authoritative medical bodies in making determinations related to appropriateness of care; but challenges do occur, and in some instances legislators have been moved to codify clinical standards. Negligent credentialing, wrongful denial of coverage, and other wrongful acts by a health plan can be determined through fact-finding and can be dealt with appropriately through the courts. It stands to reason that plans should be held accountable only for that which they can control.

Arguably, capitation and other forms of physician incentive compensation or risk sharing may be seen as influencing the delivery of care. This argument, however, questions the very essence of the Hippocratic oath. Under fee-for-service, physicians and hospitals are financially motivated to overtreat, but patients are assured that the ethics of the individual physician will protect them. Is it possible that the same doctors who would not overtreat for financial gain would undertreat? We do not think so—most physicians will look to preventive measures and efficiency improvements. Of course, there may be those at the margin whose ethics give way to financial incentives. Under the fee-for-service system, there is no mechanism to detect overtreatment. In managed care plans, utilization

review can detect undertreatment and will eventually be able to identify poor outcomes.

Capitation is one of many managed care payment arrangements offered to physicians. Many other risk-sharing models are being implemented across the country. Physicians generally applaud the more advanced models. These methods are aimed at putting more control in the hands of the physician, who is in the best position to determine appropriate care, and should not provide a basis for increased liability on the part of health plans. In all cases, the physician has free will and is paid to exercise sound judgment in the provision of care.

Proposed Legislative Solutions

Sage accurately points out that much of the proposed "anti-managed care" legislation is driven by provider groups aiming to guard traditional prerogatives. Although there may be political support for some of these initiatives, there is little empirical evidence to support them as good public policy. Pressured by lobbyists, some states have passed laws providing dubious member benefits and driving medical and administrative costs higher. Simultaneously and somewhat schizophrenically, these same states have encouraged Medicaid and other state health programs to use managed care to contain costs. The managed care industry could probably head off some of this legislation with a more forceful response to certain troublesome issues, such as physician "gag clauses" in provider contracts. In fact, many leading companies have deleted or waived these clauses voluntarily.

Legislation that favors one type of health plan over others is of even greater concern. Sage highlights anomalies raised by the application of the Employee Retirement Income Security Act (ERISA) to employee benefit plans. There are many other examples of legislation that discriminates among health plans, requiring some to offer mandated benefits and products or to serve individuals and Medicaid, while other plans have no such duties. Often taxes and surcharges are imposed unevenly. The perpetuation of an uneven playing field in this business raises important policy issues. For example, proposed legislation would allow "provider-sponsored networks" to offer health plans directly to members without the same regulatory protections relating to benefits, quality of care, and solvency that apply to health maintenance organizations (HMOs) and insurers. We are concerned that this will result in poor quality of care and insolvencies in provider-sponsored networks, thereby tarnishing the entire managed care industry.

In Defense Of For-Profit Health Care

We believe that arguments against investor-owned, tax-paying health care will fade as the facts are better understood. Theories asserting that investor-owned managed care companies take excessive profit margins compared with nonprofits (or other health care enterprises such as hospitals and pharmaceutical firms) have been disproved.[4] Likewise, quality of care is not a function of the profit status of a health plan. Independent surveys in certain markets have shown higher levels of customer satisfaction among for-profit health plans competing with nonprofits.[5]

It also has been argued that investor-owned plans siphon capital out of the health care system by distributing profits to shareholders. To the contrary, most nonprofit health plans seeking to change to for-profit status have done so to raise capital for investment in the health care system. Further, publicly traded companies have raised vast amounts of new private equity capital for investment in the health care system.

Contrary to popular perception, investor-owned plans distribute only a tiny fraction of their retained earnings to investors, a sum that is dwarfed by the amounts earned or raised and reinvested in plans. For example, several publicly owned health plans that converted from nonprofit status have experienced an aggregate increase in shareholders' equity of approximately $3.7 billion, repre-

senting additional funds available for deployment into the health care system.[6] Moreover, companies converting to for-profit status have contributed or propose to contribute more than $3.5 billion to charities established to improve health care delivery in the states where they originally were organized, and we expect this pattern to continue.[7] The high valuation that Wall Street has accorded these firms has had a direct impact on an enormous flow of capital into the health care system. Increases in share values realized through stock option plans, not cash compensation, is the basis for the high levels of executive compensation mischaracterized in the media. Executives have recognized benefits because shareholders, such as public pension funds, mutual funds, and other investors, have benefited from the companies' fundamental creation of value.

The suggestion that investor-owned corporations are inherently lacking in ethics is both offensive and incorrect. Health care companies are generally managed by people with a serious commitment to providing high-quality care, and this commitment is reflected in company policies. Our colleagues at Oxford are regularly reminded that they may be entering members' lives at difficult times and that compassion and concern for customers' well-being is what matters most. Those companies that ignore their ethical obligations will pay the price in a competitive marketplace and at the hands of regulators.

Conclusion

Managed care has grown rapidly as government and business have recognized the value inherent in the high-quality, cost-effective care delivered by these plans. Cost-effectiveness, choice of plans, quality of care, and health outcomes should continue to improve in the context of a competitive, free-market system that provides incentives to deliver superior service. Health care companies will continue to recognize that they are held to a higher standard and, like other regulated industries, must voluntarily adhere to high standards of quality and ethics. Courts and legislators must wade through self-interested petitioning by the myriad parties affected by the changing health care marketplace. It seems unlikely that we will return to the expensive fee-for-service system. Under these circumstances, legal reform should strive to encourage further development of managed care through evenhanded regulation to assure quality and solvency and to discourage the proliferation of legal actions that will provide little public benefit at great public cost.

NOTES

1. M. Langa et al., "The Effect of Cost-Containment Policies on Rates of Coronary Revascularization in California," *The New England Journal of Medicine* 329, no. 24 (1993): 1784–1789; G.F. Riley et al., "Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees," *American Journal of Public Health* 84, no. 10 (1994): 1598–1604; P.J. Muraia et al., "Quality Measures for Prenatal Care: A Comparison of Care in Six Health Care Plans," *Archives of Family Medicine* 3, no. 1 (1994): 43–49; and R.H. Miller et al., "Managed Care Plan Performance since 1980," *Journal of the American Medical Association* 271, no. 19 (1994): 1512–1519.
2. P. Braveman et al., "Insurance-Related Differences in the Risk of Ruptured Appendix," *The New England Journal of Medicine* 331, no. 7 (1994): 444–449.
3. American Association of Health Plans, *Philosophy of Care* (Washington: AAHP, February 1996).
4. H.J. Bryce, "Profitability of HMOs: Does Non-Profit Status Make a Difference?" *Health Policy* 28 (1994): 197–210.
5. CareData Reports, "1995/96 Annual CareData Health Plan Member Survey, New Jersey Survey Report" (New York: CareData, 1995); CareData Reports, "Competitive HMO Health Plan Review," Compass Report Series (New York: CareData, November 1994); and Sachs/Scarborough HealthPlus, *The Managed Care Digest* (New York: Sachs/Scarborough, 1994).
6. Merrill Lynch and Co., "Not-for-Profit Health Plan Conversions and Subsequent IPOs" (Unpublished analysis completed for Oxford Health Plans, 6 June 1996).
7. Merrill Lynch and Co., Unpublished analysis completed for Oxford Health Plans, 6 June 1996.