
Commentary

Should We Regulate 'Utilization Management?'

by Marilyn J. Field and Bradford H. Gray

Calls for regulation are a familiar response to change. Recently, this response has been evident in proposals to regulate private organizations that provide utilization management services for employers and other sponsors of health benefit plans. Several states have passed legislation to regulate utilization management, and others are considering it. The American Medical Association's (AMA's) House of Delegates has directed AMA staff to develop model legislation, and the American Medical Peer Review Association devoted a session at its October 1989 meeting to the question. Given this upsurge in interest and activity, an analysis of the pros and cons of regulation is timely.

In October 1989, the Institute of Medicine's (IOM's) Committee on Utilization Management by Third Parties issued its report on how utilization management works, what its effects appear to be, and what role it should play in the future.¹ Although much of the activity and interest in regulating utilization management became apparent after the committee's last formal meeting in February 1989, growing pressure for regulation was becoming apparent, and most of the basic approaches were known. This Commentary summarizes the IOM committee's analysis of the question, "Is public regulation of utilization management desirable and feasible now?" and explains why its answer is "No."

The Rise Of Utilization Management

Definition. The IOM committee adopted a relatively narrow definition of utilization management as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision." Although benefit design,

Marilyn Field is senior staff officer at the National Academy of Sciences' Institute of Medicine in Washington, D.C. Brad Gray is executive director of the Yale Program on Nonprofit Organizations and professor (adjunct) of research and public health at Yale School of Medicine. Field is director of the IOM study on utilization management, a position Gray held prior to moving to Yale.

financial incentives, and other strategies can influence medical decisions, the committee focused on prospective case-by-case approaches because of the significant change they entail in the way that patient care decisions are made and because they have been adopted rapidly with little systematic study. The major forms of utilization management are (1) prior review of proposed medical services through such means as preadmission or admission review for elective or emergency hospital admissions, continued stay review for hospitalized patients, and preprocedure review for selected inpatient and outpatient services; and (2) high-cost case management. To date, programs have been aimed at the site, timing, and duration of care, focusing on hospital use. Recently, the focus has begun to include case-by-case assessments of the medical need for particular procedures.

Development. Although some prior review dates back to the 1960s and before, initial efforts to avoid payment for unnecessary services emphasized review after care had been provided or even after it had been reimbursed. Such efforts have serious limitations as ways to influence medical decisions and control costs. First, most private health plans lack the power to deny payment to a physician or institution when the “unnecessary” services had already been provided—although the growth of contracting arrangements with providers has altered the situation somewhat. Absent such contracts, the burden of payment denials falls on the health plan member. Complaints by individuals faced with such unexpected expenses create employee relations problems for purchasers and public relations and marketing problems for review organizations. The risk of litigation also weakens the will to apply retrospective review vigorously. Furthermore, although one could deny payment for inappropriate care after the fact, the patient would already have undergone the service’s risk and inconvenience. In theory, all parties would benefit if such care were avoided in the first place.

Virtually all insurers and third-party administrators and many health maintenance organizations (HMOs) and preferred provider organizations (PPOs) now offer some utilization management services.² Many statewide peer review organizations (PROs) that monitor utilization and quality of care for Medicare beneficiaries have private clients. Dozens of independent companies provide utilization management services. Surveys by benefit consulting firms show that one-half or more of large employers include utilization management provisions in their health benefit programs, up from as few as 5 percent in 1984.³ The American Hospital Association (AHA) reports that individual hospitals may now deal with 50 to 250 different review organizations.⁴ As recently as 1984, the Mayo Clinic worked with just one prior-review program administered by the Minnesota PRO for Medicare. Now it faces over 1,000 programs, many de-

veloped by review organizations to meet individual employers' demands.⁵

Process and impact. The utilization management programs are far from uniform. However, they tend to share certain basic features. The initial contact with the organization may be made by the patient, the physician's office, or the hospital. Registered nurses generally collect information from these sources and, for prior review cases, make the initial evaluation of whether the proposed services meet medical necessity requirements for coverage under the patient's health plan.⁶ If the nurse reviewer cannot certify the care as clinically necessary or appropriate based on the organization's review criteria, then the case is referred to a staff or consultant physician for final determination, often after discussion with the patient's physician. The emphasis seems to be on changing behavior through education, persuasion, and negotiation, and it appears uncommon for the process to end with refusal to certify the necessity of services that the patient's physician adamantly contends are needed. For high-cost case management, the focus is on evaluating alternative treatment approaches that could reduce costs for patients who are embarked on a very expensive course of care, and then—if the patient, family, and attending physician agree—coordinating implementation of the alternatives. Less costly services not normally covered by the health plan (such as intensive home care) may be approved if appropriate. The IOM report describes the operational elements and variations in utilization management at considerable length.

The rise of utilization management has been fueled by purchasers' frustration with ever-increasing health care costs and by the perception, backed by growing evidence, that many services may be unnecessary and inappropriate. This was fertile ground for early reports—disseminated widely by the trade press, conferences, consulting firms, and utilization management companies—that suggested that utilization management could cut hospital use and costs. As the IOM report describes, the early evidence was methodologically weak, and many expectations were overblown. Yet, utilization management quickly became a routine part of the health care system. Research evidence is still limited and flawed, but after evaluating it, the IOM committee concluded that utilization management has affected use and costs. Its effects on the quality of care and on providers' costs have not been documented, but it is clear that a significant change has taken place in the autonomy of practicing physicians.

Current Regulation And Oversight

Utilization management in the private sector has developed largely free from systematic oversight or government regulation. Today's operat-

ing environment is governed largely by market forces with backup from a scattering of judicial decisions and voluntary standards.

The market. Purchasers exercise varying degrees of control over utilization management in their decisions to select, continue, or replace particular programs or organizations. Recognizing employers' influential position, the IOM committee offered suggestions on how employers could better fulfill their roles as responsible and informed purchasers. However, not all employers have the resources or the inclination to make truly educated evaluations, and clear, evidence-based standards for distinguishing good performers from bad do not exist. A few private firms offer to evaluate review organizations for purchasers but are used by only larger and more committed employers or review firms.

Voluntary standards. For the utilization management industry, no voluntary organization analogous to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the medical specialty boards exists to set standards or certify organizational adherence to standards. A limited first step toward voluntary standards went public this past summer when the AMA, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America (HIAA) published eight broad guidelines for the conduct of utilization management programs. Several state hospital associations have also proposed guidelines for outside review organizations.

Case law. Although state and federal courts have faced few cases dealing explicitly with utilization management, these cases—combined with a much larger array of decisions relating generally to insurance and health plan administration—have created a broad, but incomplete, picture of the responsibilities and potential liability of review organizations and their clients. On the one hand, purchasers do have the right to evaluate and challenge the medical appropriateness of an attending physician's decisions about services that their health plans are expected to cover.⁷ On the other hand, review organizations are then potentially liable for “defects in the design and implementation of cost containment mechanisms” that cause medically necessary services to be denied.⁸ Such defects could include sloppy program design, incompetent management and monitoring, inadequate documentation, bad faith, and poor judgment about clinical or other patient circumstances.

State regulation. Maryland and Arkansas are establishing registration and certification processes that require review organizations to submit data on such matters as confidentiality policies, clinical criteria used for review, staffing, provisions for appeals of negative decisions, and accessibility (for example, business hours).⁹ North Carolina authorizes the state insurance commissioner to adopt similar regulations and to require the

use of a standardized form for preadmission certification (most reviews are telephone-based). Maine limits its requirements for annual information reports to insurers operating prior review programs. Louisiana requires that review decisions be communicated within two business days unless special circumstances warrant a longer period, and Minnesota requires a decision within ten days after the review organization has received all necessary information. Louisiana also requires—without giving specifics—that decisions be based on “nationally accepted current medical criteria.” Other states have considered, but not passed, legislation requiring that physician reviewers for utilization management organizations be licensed within the state, that no penalties be imposed on patients or providers for ignoring review requirements, and that all reviews, including those now performed by nurses, be defined as the practice of medicine and be done by physicians.

Federal action. PROs responsible for reviewing the appropriateness of care provided to Medicare beneficiaries are subject to extensive and frequently revised regulation, some of which—as a matter of convenience if not mandate—will affect their review programs for private clients. Although the federal government regulates PROs in great detail in many areas, it has explicitly refrained from requiring common clinical criteria for prior and retrospective review. A study commissioned by the Prospective Payment Assessment Commission (ProPAC) found great variation in the substance and specificity of criteria used by PROs.¹⁰

Emphases of regulation. Regulatory approaches fall into two broad categories. Some focus on information development through organizational disclosure of operating procedures, review criteria, and so forth, or through standardization of data used for evaluation and reporting. Other regulations try to protect consumers and providers by subjecting organizations to general oversight and approval, or by specifically prescribing or prohibiting certain practices (such as requiring a standard information form or forbidding use of nurse reviewers).

The Case For Regulation

The case for public regulation of utilization management rests on several points. First, neither administrative processes nor clinical criteria for review are highly standardized, and a number of shortcomings in common review mechanisms may hurt patients and overload providers. Proponents of regulation argue that only government action, rather than market or voluntary mechanisms, offers achievable and acceptable protection against inadequate or unscrupulous review organizations.

Site visits by the IOM committee to a dozen organizations that provide

utilization management services showed that they have some broad operating practices in common but differ on many specifics. These include the clinical criteria for assessing the appropriateness of specific services; the qualifications, training, and supervision of review nurses and physicians; the links to claims administration processes; the extent of computerization; and the procedures for appealing unfavorable decisions. Most organizations say their criteria are adapted from either the Appropriateness Evaluation Protocol or the Intensity Severity Discharge and Appropriateness screens—both widely known. Still, the individual adaptations may vary considerably, and no systematic inventory of criteria exists. The uncertainty about the quality of review criteria was a major concern of the IOM committee.

Physicians have complained that utilization management organizations refuse to disclose their decision-making criteria, although it is difficult to know how widespread this may be. Certainly, some organizations consider certain review criteria proprietary and will not disclose them in full. Other shortcomings identified by the committee include the lack of rigorous evaluation of utilization management techniques and variations; the absence of standard operating procedures for review organizations when they uncover quality-of-care problems; and vagueness, inconsistency, unfairness, or undue complexity in procedures for patients or providers to appeal unfavorable review decisions. Another criticism is that there are only informal mechanisms to press utilization management organizations to weigh the costs that their activities impose on providers of care, particularly those who are willing to appeal decisions with which they disagree. Some firms survey patients about their experiences with utilization management, but the committee found no parallel mechanism for physicians and hospitals.

The current conduct of utilization management may put an unfair burden on physicians to discover the basis for a review organization's decision, find out how the decision may be appealed, and then pursue the appeal. This generates costs—time, money, and stress—for practitioners and their staffs. However, if physicians do not contest ill-considered review decisions and do change their plan of treatment to conform, they may be legally liable should subsequent harm befall their patients.

Relying on the market to weed out poor vendors and procedures could be unsatisfactory because some of the parties most affected are not involved directly in decisions to purchase utilization management services. Moreover, many purchasers know little about what they are buying. Also, the varied contexts in which utilization management is carried out make it potentially subject to the hodgepodge of regulatory frameworks that cover insurance companies, HMOs, PPOs, and em-

ployee benefits. The likelihood of inconsistency, overlaps, and gaps is high. In sum, the case for regulation rests on the perception that serious problems exist and that government regulation can solve these problems.

The Case Against Regulation

Arguments against government regulation of utilization management do not deny that current approaches are variable and suffer from inadequacies. Nonetheless, it is one thing to identify a problem and another to find a satisfactory solution. Those who now oppose regulation emphasize three general points: (1) the lack of knowledge about what and how to regulate; (2) the potential for harm from ill-conceived regulation; and (3) the lack of documented evidence of harm to patients.

The utilization management industry has been called a moving target, so dynamic that it is difficult to crystallize meaningful and responsible rules to fit the activities of a variety of organizations with different objectives, structures, and incentives. The modest available evidence about the effectiveness of particular review strategies appears to some observers to be a rationale for regulation, but others contend that we do not know enough about what works and does not work (and under what conditions) to entrench our suppositions in regulation. They suggest that self-regulation by utilization management organizations is a reasonable first step, though recognizing that self-regulation often lacks public accountability and that no organizational umbrella currently covers all or even most review firms.

Poorly conceived government regulation could lead to premature rejection of utilization management, thereby encouraging further adoption of cost containment methods—such as coverage restrictions and economic incentives—that take less cognizance of the needs of individual patients and that are not designed to affect inappropriate care selectively. Moreover, little or no evidence suggests that utilization management harms patients. In fact, since utilization management aims to eliminate inappropriate services, it may benefit patients—although neither clinical benefit nor harm has been documented. Review programs do generate extra costs and aggravation for health care practitioners and institutions, and their calls for more standard operating methods and review criteria are understandable. However, some would argue that certain regulatory proposals—for example, those to restrict who can do prior review—look more like professional protectionism than efforts to save patients from harm and practitioners from unreasonable red tape.

Overall, the IOM committee concluded that the need for regulation seems not so urgent as to outweigh the need to understand well how to

act. The sophistication with which utilization management is carried out is increasing, and voluntary standards are being developed. Regulations might freeze certain methods in place before better approaches can be substituted. Or they might render ineffective and infeasible one of the few cost containment strategies designed to be sensitive to individual patients' circumstances.

Nonregulatory Directions For Utilization Management

Although the IOM committee did not endorse regulation, it did identify areas in which more standardization is desirable and should be encouraged by purchasers of review services, relevant professional associations, and consumer groups. Such areas include knowledge development, information disclosure, and procedural matters.

Knowledge base. The IOM committee saw clinically validated utilization management criteria as a public good that should be developed through rigorous processes that take into account the scientific literature and reflect a credible professional consensus. No utilization management organization can surmount the limits of medical knowledge and the lack of national consensus that now exists regarding many medical services. In addition, systematic empirical evaluation of different utilization management strategies probably requires some public investment, since broad-based and rigorous research may be beyond the capability and objectives of most individual organizations. Unfortunately, the building of broader clinical and management knowledge bases will not be a quick or comprehensive process. Research takes time, faces ethical constraints in some areas, applies imperfectly to varied real-world settings, and provokes disagreements over interpretation.

Disclosure of review criteria. Whereas the call for more research was easy for the IOM committee to reach, the conclusion that review criteria should be publicly accessible rather than secret or proprietary was less readily achieved. The arguments in favor of disclosure were several. Certainly, it seems only fair that practitioners and patients should know the basis for decisions about whether expensive health services are deemed appropriate for payment. Moreover, disclosing review criteria will expose them to more critical scrutiny. It may also increase the educational impact of review on providers and patients, perhaps improving quality of care. In general, more disclosure should help broaden the path from clinical research to applications.

In the committee's view, utilization management organizations should compete on the basis of data systems, efficiency, and performance, not on the basis of "secret" criteria. It may be argued that disclosure is unfair to

firms that have invested in criteria development and that it will discourage such efforts because firms will not be able to capture fully the benefits of their investment but will have to share them with free riders. This point has some merit, although the most noteworthy investments by review organizations appear to be less in developing criteria than in devising software to make their use practical and efficient.

Disclosure of criteria may also facilitate gaming by practitioners and reduce the cost-effectiveness of utilization management by making it easier for physicians to gain approvals and by adding more costs for monitoring. The committee believes that the appropriate response to this concern is not secret criteria but rather the development of greater consensus about appropriate care and better means for verifying information provided during the review process.

Other issues. Since overly burdensome or obscure appeal processes could discourage physicians from challenging questionable decisions by review organizations, there is much to commend more standard appeals mechanisms and better materials to explain them. With respect to procedures for organizations to follow when they identify serious quality-of-care problems, the immediate need is not for uniformity but rather for organizations to adopt explicit policies in the first place. Finally, more standardization in data collection and reporting is needed in both utilization management and other aspects of the health care system.

Conclusion

Proposals to regulate utilization management involve uncertainties and risks that should be understood. This rapidly evolving activity could become a major pathway to disseminate and apply standards for appropriate care that are being developed through research and consensus mechanisms. To the extent that regulation raises the cost or diminishes the effectiveness of utilization management, it becomes less attractive than other approaches that do not consider individual patient conditions. The cross-pressures in utilization management provide opportunities for dialogue between payer and physician that may educate both parties and permit more sensitivity to patients' needs than do alternatives that provide incentives to reduce services across the board.

The conduct of utilization management merits continued oversight. However, a strong argument can be made now for allowing the field to continue its rapid evolution, for increasing purchasers' scrutiny over utilization management services, and for disclosing the clinical bases for utilization management decisions. State regulation, however, remains an option if abuse becomes apparent involving either harm to patients or

unreasonable burdens on physicians and institutional providers. Federal action may be warranted if highly discrepant state regulations develop.

The authors wish to acknowledge their equal contribution to this Commentary and note that their names are in alphabetical order. Members of the Institute of Medicine Committee on Utilization Management by Third Parties are: Jerome H. Grossman (chairman), Howard L. Bailit, Robert A. Berenson, John M. Burns, Richard H. Egdahl, John M. Eisenberg, Deborah Anne Freund, Paul M. Gertman, Alice G. Gosfield, Michael E. Herbert, Nathan Hershey, Neil Hollander, Karen Ignani, Carol Ann Lockhart, Arnold Milstein, Alan R. Nelson, Robert Patricelli, Cynthia L. Polich, Donald M. Steinwachs, and Bruce S. Wolff.

NOTES

1. Institute of Medicine Committee on Utilization Management by Third Parties, *Controlling Costs and Changing Patient Care? The Role of Utilization Management*, ed. B.H. Gray and M.J. Field (Washington, D.C.: National Academy Press, 1989).
2. Various trade sources list different numbers of utilization management organizations. The 1987 directory published by McGraw-Hill listed 158 utilization management companies, including many PROs. *Business Insurance* listed approximately 125 organizations in 1989, including only a few PROs.
3. Corporate Health Strategies, *The Health Poll*, Fall 1988, 1; J. Gabel et al., "Employee-Sponsored Health Insurance in America," Research Bulletin of the Health Insurance Association of America (Washington, D.C.: HIAA, January 1989); and Health Care Benefits Survey, 1987 and 1988 ed. (New York: Foster & Higgins, 1987 and 1989).
4. American Hospital Association, *Private Utilization Review*, State Issues Forum Monograph Series (Chicago: AHA, August 1989).
5. Mayo Clinic, "The Cost of Effective Utilization Review Programs," statement for the IOM Committee on Utilization Management by Third Parties, 19 May 1988.
6. Although terms such as prior review and prior authorization are often used interchangeably, the approval of benefits in advance of service provision may be contingent rather than final. Retrospective claims review will verify patient eligibility under the health plan, coverage for the category of service provided, and, to a lesser extent, accuracy of information supplied during prior review.
7. *Sarchett v. Blue Shield of California*, 43 Cal. 3d 1, 233 Cal. Rptr. 76, 729 P. 2d 267 (1987), which involved a retrospective judgment of the medical necessity of hospital care, is a key case involving the right of payers to review physician judgments. *Varol v. Blue Cross and Blue Shield of Michigan* reached a similar conclusion in a case involving prior review. See also W.A. Helvestine, "Legal Implications of Utilization Review," in *Controlling Costs and Changing Patient Care*, ed. Gray and Field, Appendix A.
8. *Wickline v. California*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986). For discussion, see Helvestine, "Legal Implications of Utilization Review."
9. H. Meyer, "Two States Lead Move to Regulate Utilization Review," *American Medical News*, 21 April 1989, 1, 45. See also AHA, *Private Utilization Review*; and Helvestine, "Legal Implications of Utilization Review."
10. Project HOPE, Center for Health Affairs, *A Study of the Preadmission Review Process*, prepared for the Prospective Payment Assessment Commission (Washington, D.C.: ProPAC, November 1987).

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