MANAGED CARE AND CONSUMER PROTECTION: WHAT ARE THE ISSUES?†

*Marc A. Rodwin, J.D., Ph.D.**

† This Article is part of the *Seton Hall Law Review's* Symposium issue on Consumer Protection in Managed Care.

* Marc A. Rodwin, Associate Professor, School of Public and Environmental Affairs, Indiana University-Bloomington, 47405; B.A. 1977, Brown University; B.A./M.A., 1979, Oxford University; J.D. 1982, University of Virginia; Ph.D. 1991, Brandeis University.

Research on this article was funded by an Investigator Award of the Robert Wood Johnson Foundation. I owe thanks to Diane Archer, George Annas, Deborah A. Freund, Dwight Golann, Karl O'Lessker, Mark Nadel, Jane Perkins, and Joan Stiber for comments on drafts. I also owe thanks to Emily Balfe, Heidi Tsang, and Maureen Hickman for research assistance and to Heather Almeter for secretarial assistance. Stanley Wallack, Marc Cohen, and Nundu Kumar of LifePlans stimulated my thinking about consumer protection issues with a consulting assignment on consumer protection and long-term care. This Article draws on my article, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319 (1996). The theme of organized consumer advocacy is further developed in another of my articles, *Consumer Protection and Managed Care: The Limitations of Reform Proposals and the Need for Organized Consumer Advocacy*, 15 HEALTH AFF. No. 3 (forthcoming 1996).

I. MANAGED CARE AS A SOURCE OF POTENTIAL CONSUMER PROBLEMS

Managed health care[1] is growing rapidly in the private sector.[2]

---

[1] Managed care refers to health insurance combined with the controls over the delivery of health services. Managed care organizations (MCOs) exercise control over the kind, volume, and manner in which services are provided by choosing providers, or by controlling their behavior through financial incentives, rules, and organizational controls.

Under traditional indemnity insurance and fee-for-service medical practices, the insurers enter into a contract with the insured party and reimburse the individual for certain medical expenses that are incurred. The individual receives medical services from any provider he or she chooses and usually pays a fee for each service rendered, with the insurer having no control over the choice of provider or provision of services.

Managed care changes this relationship either (1) by directly providing the contracted-for services; or (2) by exercising control over the services provided. There are many ways to do this. Traditional *Health Maintenance Organizations* (HMOs) provide comprehensive medical care to subscribers using a closed panel of physicians. Members pay a fixed monthly premium and only nominal fees for services rendered (copayments). Because the organization is liable for the cost of services rendered, it has an interest in ensuring that services are used frugally. *Staff Model* HMOs own medical care facilities and employ a group of doctors on salary. *Group Model* HMOs contract with groups of physicians. *Network Model* HMOs contract with physician groups and Independent Practice Associations (IPAs). Preferred Provider Organizations (PPOs) are groups of providers that agree to deliver services to a health insurance organization or employer at discounted prices. IPA HMOs contract with a separate organization, which in turn contracts with physicians in private office practice. *Point of Service Plans* are like HMOs except that individuals can receive services from outside the closed panel of physicians if they make a copayment, usually about 20% of the cost of the service.

Many indemnity insurers now provide managed care in that they exercise control over their beneficiaries' use of medical services. They require pre-authorization for elective overnight hospital visits or other expensive referrals or procedures. They do not reimburse claims from medical providers for services rendered if the organization decides they were not necessary. A new trend is to have specialized firms manage care for a particular illness or problem. For example, employers or managed care firms may contract with firms that specialize in disease management to cover the specialized services. *See generally* Symposium, *Mental Health in the Age of Managed Care*, 14 HEALTH AFF. (1995); David Mechanic, et al., *Management of Mental Health and Substance Abuse Services: State of the Art and Early Results*, 73 MILBANK Q. 19 (1995); Carol Hymowitz & Ellen Joan Pollock, *Psychobattle: Cost-Cutting Firms Monitor Couch Time as Therapists Fret*, WALL ST. J., July 13, 1995, at A1.

There are many different ways in which MCOs are organized and financed. *See* Robert E. Hurley & Deborah A. Freund, *A Typology of Medicaid Managed Care*, 26 MED. CARE 764, 764-74 (1988) (providing a discussion and typology of managed care); James C. Robinson, *Payment Mechanisms, Nonprice Incentives, and Organizational Innovation in Health Care*, 30 INQUIRY 328, 328-33 (1993); Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 74 (1993); Pete W. Welch, et al., *Toward New Typologies for HMOs*, 68 MILBANK Q. 221, 221-43 (1990).

[2] For a discussion of the role and growth of managed care in the United States, see generally John K. Iglehart, *The American Health Care System: Managed Care*, 327 NEW ENG. J. MED. 742 (1992). *See also id.* at 744-45 (detailing the varying types of managed care plans); John K. Iglehart, *The Struggle Between Managed Care and Fee-For-*

Congressional proposals for Medicare reform include increased options for Medicare beneficiaries to enroll in managed care organizations (MCOs).[3] In addition, states are also increasingly shifting their Medicaid recipients into such plans.[4]

These trends can offer consumers real benefits.[5] MCOs can

Service Practice, 331 NEW ENG. J. MED. 63 (1994); Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512 (1994); John K. Iglehart, *Physicians and the Growth of Managed Care*, 331 NEW ENG. J. MED. 1167, 1169 (1994) (noting that "[a]lthough most doctors who become affiliated with managed-care plans do so on a contractual basis, some are forming their own physician controlled plans or networks rather than relinquishing control to a health insurance company"). *See also infra* notes 128-30 and accompanying text (highlighting potential conflicts of interest between consumers and physician alliances).

For a discussion of the role of developments in the market for health insurance, see James C. Robinson, *Health Care Purchasing: Changes in California*, 14 HEALTH AFF. 117 (1995); James C. Robinson, *The Growth of Medical Groups Paid Through Capitation in California*, 333 NEW ENG. J. MED. 1684 (1995) (discussing methods by which HMOs contract with these medical groups); *See also generally* Marsha Gold, et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678 (1995); Harold S. Luft, *Modifying Managed Competition to Address Cost & Quality*, 15 HEALTH AFF. 23 (1996); Alain C. Enthoven and Sara J. Singer, *Managed Competition and California's Health Care Economy*, 15 HEALTH AFF. 39 (1996); James C. Robinson & Lawrence P. Casalino, *Vertical Integration & Organizational Networks in Health Care*, 15 HEALTH AFF. 1 (1996).

For a discussion of how proposed changes in Medicare may affect the market for managed care and insurance, see Henry J. Aaron & Robert D. Reischauer, *Debating the Future of Medicare*, 14 HEALTH AFF. 8 (1995); Uwe E. Reinhardt, *Demagoguery and Debate Over Medicare Reform*, 14 HEALTH AFF. 101 (1995).

[3] *See* H.R. Res. 2491, 104th Cong., 1st Sess. § 8001(a) (1995) (amending the Medicare statute to create provisions for allowing enrollment in various types of MCOs), *reprinted in* 141 CONG. REC. 12,509, 12,582 (Nov. 15, 1995).

For a discussion of the Republican proposal, see Julie Johnson, *Medicare's Bumpy Ride into Private Sector*, 38 AM. MED. NEWS 1 (June 12, 1995); Sharon McIlrath, *30 Years of Medicare*, 38 AM. MED. NEWS 13 (August 7, 1995); Robert Pear, *G.O.P. Announces Plan to Overhaul Medicare System*, N.Y. TIMES, September 15, 1995, at A1, A11.

[4] *See generally* DEBORAH A. FREUND, MEDICAID REFORM: FOUR STUDIES OF CASE MANAGEMENT (Am. Enterprise Inst. 1984); ROBERT E. HURLEY, ET AL., MANAGED CARE IN MEDICAID: LESSONS FOR POLICY AND PROGRAM DESIGN (Health Admin. Press 1993); John K. Iglehart, *Medicaid and Managed Care*, 322 NEW ENG. J. MED. 1727 (1995).

[5] By consumer I mean the individuals who are enrolled (or may become enrolled) and entitled to receive services from an MCO, rather than those who pay for services. Consumers are not only patients, because they include individuals who are not ill or under the care of a physician. Debates about who is a consumer are frequent in discussion of consumer protection issues. *See, e.g.*, David Vogel & Mark Nadel, *Who is a Consumer: An Analysis of the Politics of Consumer Conflict*, 5 AM. POL. Q. 27 (1977).

For many purposes, however, it makes sense to use the consumer metaphor for individuals enrolled in MCOs as similar issues arise with regard to consumer protection in other contexts. For an analysis of various metaphors used to understand relations between doctors and those they serve, see Analee E. Beisecker & Thomas D. Beisecker, *Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism*, 5 HEALTH COMM. 41 (1993); Leo G. Reeder, *The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship*, 13 J. HEALTH &

eliminate incentives for overuse of services present in fee-for-service practice and can reduce financial barriers by cutting out-of-pocket costs.[6] MCOs can organize teams of competent general practitioners and specialists and they have the potential to coordinate services and deploy modern information systems for monitoring quality and assessing the performance of individuals and organizations.[7] Yet some recent surveys indicate subscriber dissatisfaction with MCOs and there have been notable scandals.[8]

There are three main problems that MCOs create for consumers.[9] First, the manner in which MCOs are reimbursed creates incentives for the MCOs to skimp on services. Because MCOs receive a fixed payment per member, any expenditures for providing services reduce revenues.[10] Cutting services earns profits for share-

---

SOC. BEHAV. 406 (1972). For a thoughtful discussion of metaphors in medicine, see generally George J. Annas, *Reframing the Debate on Health Care Reform by Replacing Our Metaphors*, 332 NEW ENG. J. MED. 744 (1995).

6 Peter Franks, et al., *Gatekeeping Revisited—Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 426-27 (1992).

7 *See generally* HAROLD S. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE (1987). *See also* Dolores Clement, et al., *Access and Outcomes for Elderly Patients Enrolled in Managed Care*, 271 J.A.M.A. 1487 (1994); W. RICHARD SCOTT, ORGANIZATIONS: RATIONAL, NATURAL AND OPEN SYSTEMS 21-26 (3d ed. 1992) (stating that organizations are "vital mechanisms for pursuing collective goals in modern societies").

8 For investigative reports, see generally (article series) Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *Managed Health Care Floundering in Florida*, Nov. 26-29, 1995; Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *Profits from Pain*, Dec. 11-15, 1994; Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *Risky Rx: The Gold Plus Plan for the Elderly*, Oct. 21-24, 1990; Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *The HMO Maze: How Medicare Fails Seniors*, Nov. 7-11, 1993.

See also Cathy Burke, et al., *What You Don't Know About HMO's Could Kill You*, N.Y. POST, Sept. 19-21, 1995 (series); Michael A. Hiltzik & David R. Olmos, *The Health Care Revolution*, L.A. TIMES, Aug. 27-31, 1995; Julie Johnson, *Dad's Protest Lead to Record Fine Against California HMO*, 14 AM. MED. NEWS 1 (1994); Robert Tomsho, *Some Health Insurers Leave Patients to Foot Excessive Copayments*, WALL ST. J., 21 Aug. 1995, at 1, 4.

For surveys showing negative attitudes towards MCOs, see ROBERT BLENDON, SICK PEOPLE IN MANAGED CARE HAVE DIFFICULTY GETTING SERVICES AND TREATMENT (Robert Wood Johnson Found. 1995). THE COMMONWEALTH FUND, *Patient Experiences with Managed Care: A Survey*, July 19, 1995; Karen Davis, et al., *Choice Matters: Enrollees' Views of their Health Plans*, 14 HEALTH AFF. 99 (1995).

For surveys showing positive attitudes towards MCOs, see GROUP HEALTH ASSOCIATION OF AMERICA: HIGHLIGHTS OF MAJOR SURVEYS SHOWING HIGH SATISFACTION LEVELS AMONG HMO MEMBERS (1995).

9 Managed care also may present some more traditional consumer problems such as overbilling, unfair trade practices, and fraud. Managed care firms use their purchasing power to extract discounts from hospitals, doctors, and providers. The *Wall Street Journal* reported that some firms charged patients 20% copayments based on the ordinary provider fees even though the MCOs had negotiated discounts and paid only a fraction of that amount. *See* Tomsho, *supra* note 8, at 1, 4.

10 Proponents of MCOs discount the effect of incentives to reduce services and

holders and handsome salaries for top managers of many investor-owned MCOs—a process Uwe Reinhardt calls "bounty hunting."[11] Most HMOs and some Preferred Provider Organizations (PPOs) shift part of their financial risk for providing services to doctors, giving them an incentive to make frugal use of diagnostic tests, referrals, and hospitalization.[12] Physician risk-sharing can bias physician judgment and lead doctors to deny appropriate services.[13]

---

earn profits for shareholders. They claim that the interests of MCOs conform to the interests of patients, that MCOs have incentives to use preventive services to reduce their costs, and that MCOs offering high-quality care will attract members and prosper. However, unless reimbursed for preventive services, there is sometimes no economic incentive for the MCO to provide such services. The savings from reduced treatment costs may not come for many years—by which time consumers may reside elsewhere or may have switched to a competitor. (One exception may be for prenatal care or childhood immunizations). And, providing quality health services for patients with high-cost chronic illnesses may lure such patients. It is more profitable to cater to the relatively healthy and drive the seriously ill to competitors.

[11] *See, e.g.*, Milt Freudenheim, *Penny-Pinching HMOs Showed Their Generosity in Executive Paychecks*, N.Y. TIMES, April 11, 1995, at C1; *see also* Milt Freudenheim, *Top Salaries at Big HMOs Averaged $7 Million in 1994*, L.A. DAILY NEWS, April 11, 1995, at B3 (noting that large HMO executive salaries and shareholder profits often are made possible by cutting costs); Uwe E. Reinhardt, *For a Fist Full of Dollars: Health Reform Through Bounty Hunting*, Address before the Association for Health Services Research, June 13, 1994.

[12] Eliminating *inappropriate* medical services can cut costs while improving quality and making more resources available. Yet cutting spending can limit useful services and improving quality sometimes increases costs.

Recent federal regulations promulgated in line with the Omnibus Budget Reconciliation Act of 1990 set standards for Medicare and Medicaid MCOs that allow doctors to bear substantial financial risk. *See Medicare & Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Health Care Organizations*, 61 Fed. Reg. 13,430-13,450 (Mar. 27, 1996). However, these regulations would not significantly restrict the current range of risk-sharing arrangements and do very little to address the problems stemming from risk-sharing. Moreover, the regulations hold that physician groups bear substantial risk for service that they do not provide only if they are at risk for more than 25% of their potential payments. There are exceptions, however, notably, exemptions for physician groups with more than 25,000 patients.

See also generally FREUND, *supra* note 4; Peter Franks, et al., *Gatekeeping Revisited—Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 429 (1992); John M. Eisenberg, *The Internist as Gatekeeper*, 102 ANNALS OF INTERNAL MED. 537 (1985); Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23 (1986); Michael D. Reagan, *Physicians as Gatekeepers*, 317 NEW ENG. J. MED. 1731 (1987); Roger A. Rosenblatt & Ira S. Moscovice, *The Physician as Gatekeeper*, 22 MED. CARE 150 (1984); Anne R. Somers, *And Who Shall Be the Gatekeeper? The Role of the Primary Physician in the Health Care Delivery System*, 20 INQUIRY 301 (1983).

[13] For a discussion of how risk-sharing works and a summary of the pros and cons, see generally MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993) (especially chapters 5 & 6). For a discussion of other ways in which physician loyalty is divided and the resulting implications for the so-called fiduciary nature of the patient/physician relationship, see Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health*

Second, MCOs, as most complex organizations, are vulnerable to organizational pathologies.[14] Well-run organizations can orchestrate complex tasks, deliver services efficiently, and institutionalize memory despite changes in personnel. But large organizations can impede change, become unresponsive, and limit the appropriate use of discretion by professionals. They can diffuse authority and diminish personal responsibility, thereby reducing accountability.[15]

Third, MCOs restrict choice: an escape valve for consumers if doctors or MCOs perform poorly. Once enrolled, medical choices are mediated by the organization's rules and procedures.[16] Consumers must use providers from a closed panel—otherwise known

---

Care System, 2 AM. J. LAW & MED. (1995); Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604 (1994).

See also Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 235 J.A.M.A. 338 (1995); Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 J.A.M.A. 330 (1995); Ezekiel J. Emanuel & Nancy N. Dubler, *Preserving the Physician-Patient Relationship in an Era of Managed Care*, 273 J.A.M.A. 323-29 (1995); John Merline, *Making Money by Denying Care*, CONSUMERS' RES., Sept. 1994, at 10-15; David Orentlicher, *Health-Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141 (1995); Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920 (1992) (conflicts between patients and physicians are not limited to those based upon financial incentives).

For a discussion of other conflicts between doctors and patients, see generally Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from the Physicians*, 55 U. PITT. L. REV. 291 (1994); Steffie Woolhandler & David U. Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706 (1995).

14 *See generally* W. RICHARD SCOTT, INSTITUTIONS AND ORGANIZATIONS (1994).

15 *See* W. RICHARD SCOTT, ORGANIZATIONS: RATIONAL, NATURAL AND OPEN SYSTEMS 332 (1981) (insisting that an unintended but inevitable consequence of organization is the shift of power from the majority into an oligarchic bureaucracy, thus fueling the nonresponsiveness of the organization to its beneficiaries). *See also* Sulmasy, *supra* note 13, at 921-22 (declaring that primary physician gatekeeping causes diminished accountability and that the possibility of public misunderstanding about who possesses the ultimate responsibility for rationing might leave policymakers within the MCO unaccountable to consumers).

16 Traditional economic theory holds that consumers are sovereign in making purchasing decisions. Some commentators, however, have argued that producers can mold consumer preferences. *See, e.g.*, JOHN K. GALBRAITH, THE NEW INDUSTRIAL STATE (1985); VANCE PACKARD, THE HIDDEN PERSUADERS (1957). The consumer choice situation is even more limited with respect to health insurance. Approximately one quarter of all employers offer their employees no choice of health insurance plans. Other employers may offer very limited choices among health plans.

The idea of choosing between competing MCOs is even further diminished in rural areas where there will be limited providers, where patients lack income to choose all but the lowest price options, or where employers limit the choice of managed care plans. *C.f.* Charles D. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1375-78 (1984) (arguing that increasing patients' choice of physicians can constitute an anticompetitive restraint of trade).

as a "network"—or pay more out-of-pocket.[17] Opting out is not possible in all plans and not feasible for people with limited resources.[18] For consultation with a specialist, consumers typically need approval from a primary care physician who is subject to incentives for limiting referrals. Utilization reviewers can also block use of expensive services.[19]

These problems explain why consumers sometimes receive shoddy treatment from MCOs and demonstrate the need for consumer protection.[20] What options, then, exist to protect consum-

---

[17] *See* Gregory Devine & Edward Zalta, *Should HMOs Use "Gatekeepers" to Control Care?*, WASH. POST, Jan. 17, 1989, at 20 (arguing that HMOs "nearly always" provide more benefits per dollar than traditional plans); Ron Winslow, *Health Care: HMOs May Impair Ties to Specialists*, WALL ST. J., July 9, 1993, at B1 (reporting that HMOs claim to improve the quality and management of care).

[18] In California's proposed plan for expanded Medi-Cal managed care, for example, participation by Medi-Cal recipients is mandatory in selected areas. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA'S EXPANSION PLAN 2 (1995) [hereinafter GAO, COMPETITION AND OVERSIGHT].

In Medicaid managed care plans there typically is no option to choose providers outside the network for additional payment as in preprovider organizations. Even if such options existed, they would be unlikely to provide significant choice. People on Medicaid are poor and lack funds to make high copayments to shop outside the network.

However, the Maryland Patient Access Law requires HMOs to offer a point-of-service option when contracting with an employer, association, or other private group. Also, when a provider is terminated from a network, patients are allowed to stay with that provider for 90 days so they do not have to switch physicians on short notice. 1995 Md. Laws §§ 604, 605. *See also* 1 Managed Care Rep. (BNA) No. 15 at 350 (Oct. 18, 1995).

[19] To control spending, MCOs also create administrative barriers to services. Primary care doctors act as gatekeepers restricting access to specialists. Utilization reviewers must approve elective hospitalization, expensive tests, and procedures. *See* Peter Franks, et al., *Gatekeeping Revisited—Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 424 (1992) ("Over 90 percent of [HMOs] use primary care physicians as gatekeepers, whose role is to authorize access to specialty, emergency, and hospital care and to diagnostic tests").

See also Diana J. Bearden & Bryan J. Maedgen, Emerging Theories of Liability in the Managed Health Care Industry, 47 BAYLOR L. REV. 285, 325 (1995); Linda V. Tiano, *The Legal Implications of HMO Cost Containment Measures*, 14 SETON HALL LEGIS. J. 79, 79 (1990).

[20] Although data does not indicate that there is a systemic quality deficiency, several studies reveal problems (existing in other health organizations as well). A series of articles in the Florida Sun-Sentinel documented organizational break-downs, poor quality and unscrupulous practices by a few Medicare and Medicaid MCOs. *See generally* (article series) Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *Managed Health Care Floundering in Florida*, Nov. 26-29, 1995; Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *Profits from Pain*, Dec. 11-15, 1994; Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *Risky Rx: The Gold Plus Plan for the Elderly*, Oct. 21-24, 1990; Fred Schulte & Jenni Bergal, FLA. SUN-SENTINEL, *The HMO Maze: How Medicare Fails Seniors*, Nov. 7-11, 1993.

ers and how effective would they be?

This Article analyzes the emerging debate over managed care in the context of consumer protection policies. Part II examines various policy approaches to consumer protection. Part III shows that the goal of protecting consumers is not a uniform goal and that there are trade-offs in protecting different consumer interests. Part IV delineates the main consumer protection proposals—including recent legislation—and their limitations. Part V concludes by identifying one flaw common to many current reform proposals: they neglect the importance of addressing general consumer interests and, instead, focus on the interests of individual consumers.

II. POLICY APPROACHES TO CONSUMER PROTECTION

Consumer groups, the press, and producers can all help protect consumer interests, but governmental policy plays a special

---

Problems included denial of care resulting in death or endangering the patient's life, as well as the lack of adequate quality assurance and grievance procedures, and marketing abuses. A recent report of the Health & Human Sevices (HHS) Inspector General indicated that serious problems exist for a significant number of enrollees in Medicare HMOs, including access to services. *See* INSPECTOR GENERAL, BENEFICIARY PERSPECTIVES OF MEDICARE RISK HMOs, OEI-06-91-00730 (Dep't Health and Human Servs. 1995).

The rapid expansion of managed care and the reduction of federal and state oversight further increases possibilities for abuse. When California introduced managed care in Medicaid during the 1970s, marketing abuses and denial of services created scandals which prompted the legislature to enact the Waxman-Duffy Act which sets standards. For a discussion of the problems in Medicaid managed care in California in the 1970s, see David F. Chavkin & Anne Treseder, *California's Prepaid Health Plan Program: Can the Patient Be Saved?*, 28 HASTINGS L.J. 685 (1977); Carol N. D'Onofrio & Patricia D. Mullen, *Consumer Problems with Prepaid Health Plans in California*, 92 PUB. HEALTH REP. 121 (1977); Bruce Spitz, *When a Solution is Not A Solution: Medicaid and Health Maintenance Organizations*, 3 J. HEALTH POL. POL'Y & L. 498 (1979).

Legislation attempted to resolve these problems. *See, e.g.*, Waxman-Duffy Act, CAL. WELF. & INST. CODE, §§ 14200-14482 (West 1995). Nevertheless, problems persist. For a recent discussion of similar problems in California, see Michele Melden, *Medicaid and Managed Care: Testimony Submitted to the House Subcommittee on Health and the Environment*, 24 CLEARINGHOUSE REV. 1139 (1991); Claire Spiegel, *HMO Wins Medi-Cal Pact Despite Critical Audits*, L.A. TIMES, Dec. 18, 1994, at 1, 30.

Today, federal waivers used for promoting experimentation with MCOs reduce oversight and standards. Congressional bills to change Medicaid and Medicare would have the same effect. Yet, when MCOs have grown rapidly, they have sometimes created networks, organizations, and quality assurance systems that did not function well. That was the experience in California and Florida, and it now appears to be repeating itself in New York and Tennessee. For a discussion of emerging problems in New York, see Ian Fisher, *Blending of Managed Care and Medicaid Hits Snags*, N.Y. TIMES, Aug. 24, 1995, at A11; Cathy Burke, et al., *supra* note 8.

For a discussion of similar problems in Tennessee, see Martin Gottlieb, *A Free-for-All in Swapping Medicaid for Managed Care*, N.Y. TIMES, Oct. 2, 1995, at A1, A12.

role.[21] The federal government can halt the enrollment of new members in managed care plans under the Medicaid risk-contract program. In addition, most state departments of insurance must approve the insurers offering managed care. Government agencies establish the rules within which markets operate, set legal standards to which producers are held accountable, and foster institutional mechanisms that promote consumers' interests. These measures can enhance the public welfare by regulating products and marketing, promoting market competition, increasing consumer voice, and ensuring the solvency of health insurers.

A. *Product Regulation*

Regulatory agencies use five kinds of measures to improve the quality of products.[22] These measures range along a continuum (Figure 1) from the most to the least restrictive: from prohibiting certain products or features that are either dangerous or ineffective (measure 1) to requiring producers to disclose information to purchasers (measure 5).

FIGURE 1
REGULATORY APPROACHES TO PRODUCT REGULATION

More Restrictive				Less Restrictive
1. Prohibit or ban product or product features.	2. Require Agency approval of product before it is sold.	3. Specify mandatory design for product.	4. Require certain minimun standards, design features, or performance goals for	5. Require disclosure of product features to consumers.

[21] For a thoughtful analysis of consumer protection from a political perspective, see generally MARK V. NADEL, THE POLITICS OF CONSUMER PROTECTION (1971); MICHAEL PERTSCHUK, REVOLT AGAINST REGULATION: THE RISE AND PAUSE OF THE CONSUMER MOVEMENT (1982). For an overview of consumer protection issues, see Monroe Friedman, *Research on Consumer Protection Issues: The Perspective of the "Human Sciences,"* 47 J. SOC. ISSUES 1 (1991). For a discussion of new approaches to regulation in health care, generally, see TROYEN BRENNAN & DONALD BERWICK, NEW RULES: REGULATION, MARKETS & THE QUALITY OF AMERICAN HEALTH CARE (1996).

[22] For an articulate argument explaining the role of regulation in quality assurance, see Bruce C. Vladeck, *Quality Assurance Through External Controls*, 25 INQUIRY 100 (1988).

For key sources on consumer protection law, see generally MICHAEL M. GREENFIELD, CONSUMER TRANSACTIONS (1983); MICHAEL M. GREENFIELD, CONSUMER TRANSACTIONS: SELECTED STATUTES & REGULATIONS (1983); DEE PRIDGEN, CONSUMER PROTECTION & THE LAW (1986).

Examples of prohibitions and disclosure abound. The Massachusetts Division of Insurance, for example, prohibited the sale of cancer insurance and other single dread disease policies because it believed that such insurance was deceptive, preyed on consumer fears, and did not provide good value.[23] Likewise, accrediting agencies such as the National Committee on Quality Assurance are beginning to issue report cards that disclose MCO performance. Some state legislation would also require that MCOs disclose information on financial incentives for physicians as well as other data.[24]

Between the poles of prohibition and disclosure, regulators can employ other measures. For example, they can require approval before the product is sold (measure 2). Many state insurance departments must approve policies before insurance companies can sell them. Additionally, regulators can also mandate the product design (measure 3) or require that products meet minimum standards (measure 4).

Mandated designs require eliminating or severely curtailing producer and consumer options in the realm of coverage. For example, regulations can specifically determine the categories of policies sold, the benefits covered, deductibles, and various other terms. Federal and state government also mandate the types of policies that may be sold to supplement federal Medicare coverage. The federal government allows only ten categories of policies for Medigap insurance; Massachusetts allows only four.[25]

State regulators (often state insurance departments) establish minimum standards of coverage for health insurance policies.

---

[23] *See* American Family Life Assurance Co. v. Commissioner of Insurance, 466 N.E.2d 1061, 1066-67 (Mass. 1983) (reversing a lower court ruling that the Commissioner's standards for single dread disease policies were "arbitrary and capricious").

Prohibition is also used in other contexts. *See, e.g.*, 42 U.S.C. § 4801 *et seq.* (1988) (where, in the Lead-Based Paint Poisoning Prevention Act, federal legislation banned the use of lead-based paint); 21 U.S.C. § 360(e) (1988) (banning the sale of prescription drugs, biologics, or medical devices unless the FDA finds them to be "safe and effective").

[24] In other contexts, packaged foods must disclose contents and nutritional information and credit contracts must disclose financial terms and total costs. *See* 15 U.S.C. § 1691 (1988) (Equal Credit Opportunity Act); 15 U.S.C. § 1601 (1988) (Consumer Credit Protection Act). *See also infra* notes 64-67 and accompanying text.

[25] Medicare supplemental insurance—often called MediGap—provides insurance coverage for certain medical care not covered under the Medicare programs, as well as for copayments. *See generally* 42 C.F.R. § 403 (1995) (providing the regulations relating to Medicare Supplemental Health Insurance Policies); MASS REGS. CODE tit. 211, §§ 714-19 (1996) (encompassing former § 49, dealing with state MediGap provisions).

See also Milt Freudenheim, *Elderly Would Benefit from Curbs on Sale of Overlapping Health Insurance*, N.Y. TIMES, Oct. 29, 1990, at B9.

Massachusetts, for example, requires that all health insurance policies cover in vitro fertilization and other fertility services.[26]

Regulations for MCOs may include specifying the benefit packages, setting quality standards, and requiring MCOs to disclose information to consumers.[27] The federal government has set standards for federally qualified HMOs, Competitive Medical Plans, Medicare Risk Contracts, and Medicaid HMOs. State insurance regulations also require minimum standards for operation of MCOs. Organizations such as the National Committee on Quality Assurance and the Joint Commission on Accreditation of Health Care Organizations set standards for accrediting MCOs.

The degree of regulation for specific catagories often involves a balancing of interests. For example, when a market or product is new, a less strict approach often facilitates innovation. However, the product's risk and benefits and the consumer's vulnerability also should influence regulatory policy. It makes sense to set requirements or minimum standards for MCOs if there is significant risk to consumers and a consensus on ways to address it. Disclosure is more appropriate when risks are low and are such that individuals may reasonably differ on who should bear those risks. Choice is important to consumers, and information facilitates consumers' choice.[28]

---

[26] MASS. ANN. LAWS ch. 176(A), § 8(k) (1955); MASS ANN. LAWS ch. 175, § 47(h) (1955); MASS ANN. LAWS ch. 176(G), § 4 (1955); MASS. REGS. CODE tit. 211, § 37 (1955).

In other contexts, the FDA promulgates minimum standards to which food products must conform to bear a particular label. For example, the FDA requires that to use the label "peanut butter" the product must contain at least 90% peanuts. *See, e.g.*, Corn Products Co. v. Dep't of HEW, 427 F.2d 511 (3d Cir. 1970). *See also* 21 U.S.C. § 343 (1988) (Federal Food, Drug & Cosmetic Act); Federal Sec. Admin. v. Quaker Oats Co., 318 U.S. 218 (1943); Richard A. Merrill & Earl M. Collier, Jr., *Like Mother Used to Make: An Analysis of the FDA Food Standards of Identity*, 74 COLUM. L. REV. 561 (1974).

[27] *See generally* Health Care Financing Administration, 42 C.F.R. §§ 400 through 429 (1995).

The federal government can halt the enrollment of new members in managed care plans under the Medicaid risk-contract program. Most state departments of insurance must also approve insurers who offer managed care prior to it being offered. For example, the New York State Health Department recently published regulations to establish standards for the organization, operation, and certification of MCOs participating in the state's workers compensation pilot project. Regulations include those for setting second opinion panels and criteria for obtaining care outside managed care networks. *See* 1 Managed Care Rep. No. 21 (BNA) at 587 (. , 1995).

[28] For a general discussion of the limitations of disclosure as a consumer remedy, see Marc A. Rodwin, *Physicians' Conflicts of Interest: The Limitations of Disclosure*, 321 New Eng. J. Med. 1405 (1989). For a discussion of the use of information as an aid to consumers, see generally, Howard Beales, et al., *The Efficient Regulation of Consumer*

B. *Regulating Marketing*

MCOs now often do not adequately supervise sales agents. Agents are often compensated by commission, and are allowed to engage in door-to-door high-pressure marketing and to inappropriately discriminate in sales. These problems could be addressed through state agencies that regulate insurance or oversee the Medicare and Medicaid programs.[29] State insurance agencies also have authority to review the sales brochures and advertising of insurance companies. In some states, the agency that regulates insurance produces a descriptive brochure and requires that insurers send it to prospective purchasers.

Regulations can generally protect consumers from deceptive and unfair marketing tactics in several ways. One approach includes licensing, certification, and training of insurance brokers and sales personnel. Certification allows regulators to exercise some control over those who engage in sales by requiring training and supervision.

Another kind of policy directly addresses the marketing tactics used to sell products. The Federal Trade Commission Act (FTC Act) and many state laws prohibit the use of "unfair or deceptive trade practices."[30] These legislative devices have been used to stop

---

Information, 24 J. L. & ECON. 491 (1981); Susan G. Hadden, *Regulating Product Risks Through Consumer Information*, 47 J. SOC. ISSUES 93 (1991).

Increasingly, firms disclose information to consumers to protect themselves from potential liability—so much so that the volume and complexity of such information is often daunting for consumers and the increased disclosure of health care information may spawn an industry of health insurance advisors.

Already, advocacy groups such as the Medicare Beneficiaries Defense Fund provide information on Medicare consumers. The New York-based Center for Medical Consumers provides information on different medical treatments. Families U.S.A. publishes books to help consumers choose among MCOs. Similar ventures are likely in the future. *See* Thomas W. Maloney & Barbara Paul, *The Consumer Movement Takes Hold in Medical Care*, 10 HEALTH AFF. 272 (1991); Information on the Medicare Beneficiaries Defense Fund from an interview with Diane Archer, Executive Director, July 1995.

For information on the Center for Medical Consumers, see their newsletter: CENTER FOR MEDICAL CONSUMERS, HEALTH FACTS. For information on Families U.S.A., see MARC MILLER, ET AL., HEALTH CARE CHOICES IN THE BOSTON AREA: A GUIDE TO QUALITY AND COST (1995).

[29] For example, California's Omnibus Medi-Cal reform measure prohibits door-to-door sales of Medi-Cal managed care plans. *See* 1 Managed Care Rep. (BNA) No. 17, at 402 (Oct. 4, 1995).

[30] Patricia Bailey & Michael Pertschuk, *The Law of Deception: The Past as Prologue*, 33 AM. U. L. REV. 848 (1984); FTC Policy Statement on Policy on the Scope of Consumer Unfairness Jurisdiction, 4 Trade Reg. Rep. (CCH) ¶ 13,203 at 20,908 (Dec. 17, 1980) (finding that a substantial consumer injury, usually monetary loss is required); FTC Policy Statement on Deceptive Acts and Practices, 4 Trade Reg. Rep (CCH) ¶ 13,205

advertising that is misleading or that omits information consumers reasonably need to make purchasing or investment decisions. Over the years, the FTC has stopped coercive sales practices such as preying on vulnerable groups (e.g. children) and the use of onerous contract clauses. Administrative bodies could use FTC trade practice standards to supervise the marketing of managed care plans, but as yet, there do not appear to have been any such cases or orders.

Some scholars, however, argue that government regulation usually ends up restricting market competition, thereby harming consumers. They advocate increasing the use of markets rather than regulation as a protection strategy.[31]

C. Promoting Market Competition

Theory and experience have taught us that monopoly, market failure, and anticompetitive trade practices often harm consumers and that antitrust policy and promotion of competitive markets often help them.[32] For markets to work, however, certain conditions must be met. These include free entry and exit by sellers and buyers, readily available and accurate information, and many sellers and purchasers so that no one party can dominate the market. These conditions are often absent in medical care and insurance

---

at 20,913 (Oct. 4, 1983). *See also* 15 U.S.C. § 45 (a)(1) (1988); 16 C.F.R. § 436.1 (1995).

In many states, both consumer protection agencies and private parties can bring suits against sellers. Some state laws fine parties treble damages and make them pay the plaintiff's attorneys' fees if they engage in unfair or deceptive practices. *See, e.g., generally* MASS. GEN. LAWS ch. 93, § 64 (1990).

[31] For conservative critiques of consumer regulation arguing that increased market competition can promote consumer interests and that regulation often protects producers, see GEORGE J. STIGLER & MANUEL F. COHEN, CAN REGULATORY AGENCIES PROTECT THE CONSUMER? (1971); RALPH K. WINTER, JR., THE CONSUMER ADVOCATE VERSUS THE CONSUMER (1972); Christopher C. DeMuth, *Defending Consumers Against Regulation*, AM. SPECTATOR, Jan. 1978, at 24.

For a thoughtful analysis of the economics of consumer protection strategies that draws from the conservative critique and examines ways to correct market imperfections caused by high information costs, see Robert B. Reich, *Toward A New Consumer Protection*, 128 U. PA. L. REV. 1 (1979).

[32] For a discussion of antitrust issues, see generally BARRY R. FURROW, ET AL., HEALTH LAW (West 1995) (chapter on Antitrust). Markets cannot, however, address disparities in bargaining power between consumers and producers or equity concerns of consumers. Economic efficiency is an important value, even though it is a limited one. For critiques of efficiency and other economic concepts, see Amartya K. Sen, *Rational Fools: A Critique of the Behavioral Foundations of Economic Theory*, 6 PHIL. & PUB. AFF. 317 (1976). For a discussion of why it is frequently desirable to use approaches to social policy that are inefficient, and avoid traditional market approaches, see generally Steven Kelman, *A Case for In-Kind Transfers*, 2 J. PHIL. & ECON. 55 (1986).

markets where there are regulatory and financial barriers to entry and obtaining information is costly.[33] Additionally, the information, even when obtained by the consumer, is often difficult to interpret.

We can correct these defects.[34] When the source of market failure is the high cost of consumers obtaining information, government agencies can disseminate information or devise incentives for firms to provide the information themselves. Legislatures can establish penalties for fraud and other unfair trade practices.[35] Agencies can also inform consumers by certifying products that

---

[33] *See* KENNETH ARROW, UNCERTAINTY AND THE WELFARE ECONOMICS OF MEDICAL CARE, (1963); Stewart H. Altman & Marc A. Rodwin, *Halfway Competitive Markets and Ineffective Regulation: The American Health Care System*, 13 J. HEALTH POL. POL'Y & L. 323 (1988).

For an articulate statement of why health care markets are not competitive in the absence of significant intervention by a market proponent of managed competition, see generally ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980).

[34] Government agencies can correct market failures but whether they will do so is another issue. Government intervention in the economy is not necessarily for the good of consumers. Many political scholars argue that agencies can be captured by the groups they regulate and that government agencies' policies are adopted to protect the interest of various groups. *See generally*, DeMuth, *supra* note 31, at 24; THEODORE J. LOWI, THE END OF LIBERALISM: IDEOLOGY, POLICY AND CRISIS OF PUBLIC AUTHORITY (1969); Andrew McFarland, *Interest Groups and Theories of Power*, 17 BRIT. J. POL. SCI. 129 (1987); GEORGE J. SEIGLER & MANUEL F. COHEN, CAN REGULATORY AGENCIES PROTECT THE CONSUMER? (1971); George J. Seigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971). For an assessment of the "capture thesis," see generally JAMES Q. WILSON, THE POLITICS OF REGULATION, vii-xii (1980).

Indeed, one strategy for groups that want to engage in anticompetitive practices is to get governments to engage in actions authorizing their activities, because state action will insulate firms from antitrust liability. *See, e.g.*, Parker v. Brown, 317 U.S. 341 (1943); FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992). For further discussion of this phenomenon, see James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459 (1994); BARRY R. FURROW, ET AL., HEALTH LAW (West 1995) (chapter on Antitrust); Eleanor Kinney, et al., *The Merits of State Action Immunity to Promote Hospital Collaboration: Report of the Hospital Anti-Trust Task Force to the Indiana State Dept. of Health*, 28 IND. L. REV. 1169 (1995).

It is also an ironic fact that measures of reform can often be turned into instruments of repression. Well-meaning consumer activists often advocate government intervention, but reform measures do not always have the effect they anticipate. Government agencies can also fail. *See* Charles Wolf, Jr., *A Theory of Non-Market Failures*, 55 PUB. INTEREST 110 (1979). Central political questions are whether governments are an independent force or merely serve the interests of particular groups—and if so, which ones.

[35] For example, legislatures can establish penalties for deceptive claims, advertisements, and sales tactics as well as for fraud or other unfair trade practices. *See, e.g.*, 15 U.S.C. § 45(a)(1) (1988). *See also* S. CHESTERFIELD OPPENHEIM, ET AL., UNFAIR TRADE PRACTICES AND CONSUMER PROTECTION: CASES AND COMMENTS (1983).

For a history of the Federal Trade Commission, see generally BERNICE ROTHMAN

meet certain standards.[36]

Such institutional measures are certainly not unprecedented. For example, to promote competition and standards for disclosure in trade and commerce, we have created the Securities and Exchange Commission to oversee the securities markets and the Federal Trade Commission to set more general rules for market competition.[37]

Economist Alain Enthoven has called for "managed competition" in health care markets.[38] The aim of managed competition is to force producers to compete more over price and quality than over differences in coverage that are harder to gauge.[39] Promoting choice among competing MCOs gives MCOs an incentive to respond to consumer wishes. It also gives consumers options when producer performance slackens. Managed competition requires government intervention in the form of a regulatory agency or private "sponsor" to specify the kind or range of products sold or the specific standards of performance that must be met.

The Clinton Administration's health care reform proposal in 1994 was based on a variation of managed competition.[40] Although the proposal was not enacted, the plan contained elements of managed competition such as competing MCOs offering

---

HASIN, CONSUMERS, COMMISSION, AND CONGRESS: LAW, THEORY, AND THE FEDERAL TRADE COMMISSION, 1968-1985 (1987).

[36] For example, the FDA requires that to use the label "cheese," a product must contain a certain percentage of milk. Producers who want to make a similar product with less milk must use another term, such as "cheese product." Similarly, to use the term "fruit juice," that product must contain at least given percentage of juice: otherwise another term, such as "fruit drink," must be used. *See, e.g.*, 21 U.S.C. § 343 (1988) (Federal Food, Drug, and Cosmetic Act); Federal Sec. Admin. v. Quaker Oats Co., 318 U.S. 218 (1943); Merrill & Collier, Jr., *supra* note 26.

[37] *See generally* 15 U.S.C. §§ 77a to 77bbbb (Securities Act of 1933); 15 U.S.C. §§ 78a 78ll (Securities & Exchange Act of 1934).

[38] *See* ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980); ALAIN C. ENTHOVEN, THE THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE (1988); Alain C. Enthoven, *Managed Competition: An Agenda for Action*, 7 HEALTH AFF. 25 (1988); Alain C. Enthoven, *Managed Competition in Health Care and the Unfinished Agenda*, HEALTH CARE FINANCING REV. 105 (1986); Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, 320 NEW ENG. J. MED. 29 (1989) (Parts I and II).

[39] Although the managed competition as proposed by the Clinton Administration has not been adopted, the metaphor of managed competition still is central to health policy debates in the U.S. today. We might describe the current U.S. health care system as "half-way managed competition."

For discussions of managed competition in the U.S. and abroad, see JOSEPH WHITE, COMPETING SOLUTIONS (1995); David Chinitz, *Reforming the Israeli Health Care Market*, 39 SOC. SCI. & MED. 1447 (1994).

[40] S. Res. 1600, 103d Cong., 1st Sess. (1993) (Health Security Act); WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN (1993).

similar coverage, a private market for health insurance, and incentives for providers to be frugal. It is not clear that there is much competition between MCOs based on quality and there is still much market failure.[41] Although some of these failures cannot be avoided, there is room for further government intervention to foster market competition.

D. Amplifying Consumer Voice

Another approach to empowering consumers is through the use of what economist Albert Hirschman calls "voice," in contrast to "exit."[42] In the classic model of market competition, when a business or organization declines, its customers or members become dissatisfied and exit—that is, they purchase their goods and services elsewhere or leave the organization. Such defections signal that the firm or organization must either modify its actions, or, if unable to adjust, lose market share or go out of business. But exit is not always feasible and does not provide information about what the firm is doing wrong, thereby allowing the organization to take remedial measures.

In contrast, the use of voice—that is, complaints, protests and other channels of communication—provides detailed and direct information to firms and organizations. It also may be preferable when the cost of exiting is high or when people are loyal to the organization and reluctant to exit despite its shortcomings. Markets typically rely more on consumer "exit" to send signals, while political systems rely more on "voice." But exit and voice are used in both settings and can complement each other. Current health policy promotes the use of market competition; that is, consumer choice and exit, but not consumer voice.

In oligopolical environments, each firm may willingly write off demanding consumers rather than cater to them. Thus, if a problem is endemic to all producers, dissatisfied consumers may move among firms, but producers will keep approximately the same number of customers. Hirschman suggests that in these circumstances consumer voice might prod producers to change but that exit will not.

---

41 Stuart H. Altman & Marc A. Rodwin, *Halfway Competitive Markets and Ineffective Regulation: The American Health Care System*, 13 J. HEALTH POL. POL'Y & L. 323 (1988).

42 *See* ALBERT O. HIRSCHMAN, EXIT, VOICE AND LOYALTY: RESPONSES TO DECLINE IN FIRMS, ORGANIZATIONS, AND STATES (1970); Rudolf Klein, *Models of Man and Models of Policy: Reflections on Exit, Voice, and Loyalty Ten Years Later*, 58 MILBANK MEMORIAL FUND Q. 416 (1980).

Nevertheless, people often do not like to give or take criticism. Government agencies might encourage firms to foster, record, and take account of consumer voice. Consumer voice can be fostered in MCOs in two main ways: through organizational governance and through grievance and complaint processes. Examples of the first include cooperative ownership of MCOs and consumer representation in MCO governance and in purchasing cooperatives that negotiate with MCOs.

Examples of the latter include consumer advocacy groups and individual complaint and grievance procedures. The impact of individual complaints is reduced if an organization deals with the problems one at a time and thereby avoids changes that will remedy the problem for all consumers. If the nature and frequency of complaints is made public, organizations might remedy the overall situation to improve their reputation.

E. Ensuring the Financial Stability of Firms

Consumers who purchase insurance depend on the financial stability of their insurer. Just as pension funds and investment funds can be poorly managed and firms can become bankrupt, MCOs can also become insolvent. When they do, consumers may lose their access to health services and insurance.[43]

A variety of measures help to ensure the safekeeping of funds.

---

[43] *See*, NAT'L ASSOC. INS. COMM'RS STATE & FED. HEALTH INS. LEG. POL'Y TASK FORCE, WHITE PAPER ON INSOLVENCY (cited in *States Must Guard Against Insolvency in Managed Care, NAIC Task Force Says*, 3 Health Care Pol'y Rep. No. 50 (BNA) at 2214-15.

An interesting example is the 1987 insolvency of International Medical Centers, Inc., a Florida HMO. When it became insolvent, the HMO was purchased by Humana Inc. which operated the organization under the new name, Humana Medical Plan (HMP). But over 200,000 consumers in the plan still faced problems caused by the insolvency. The new HMO had major quality problems for years and was the subject of investigative newspaper reports by the Ft. Lauderdale Sun Sentinel in 1990. *See Risky Rx: The Gold Plus Plan for the Elderly*, *supra* note 8. *See also* General Accounting Office, *Medicare: HCFA Needs to Take Strong Actions Against HMOs Violating Federal Standards*, GAO/HRD 92-11 (1991), *infra* note 50.

The Health Care Financing Administration was aware of these quality problems, but had little leverage in the short run to improve the situation. HCFA was grateful that there was an MCO willing to assume responsibility for providing insurance coverage for the 200,000 individuals. The American Medical Association, which backs the idea of physician-owned networks that provide managed care, argued that such networks should be exempt from state insurance laws which have high financial reserve requirements. *See* Brian McCormick, *Laws Thwart Physician Networks*, 38 AM. MED. NEWS. 1, 42 (Sept. 4, 1995).

Included in the Medicare provisions of the Budget Reconciliation Act of 1995 are provisions which would require Medicare provider organizations to be licensed under state law as risk-bearing entities, as well as provisions setting standards for capital ade-

State insurance regulations safeguard the financial stability of insurance and MCO standards for financial solvency as a prerequisite for doing business, and they help oversee industry reserve pools.[44] However, legislation proposed in the 104th Congress would permit provider-sponsored networks to be exempt from state regulations and subject to less stringent federal regulations to be promulgated in the future.[45]

III. TRADE-OFFS IN CONSUMER PROTECTION POLICY

Consumers have diverse interests. Regulatory measures that produce benefits may also entail costs and force trade-offs. Designing effective rules requires skill to minimize negative effects. A few examples illustrate these trade-offs.

A. Whom to Help: The Average Consumer v. Target Groups?

Most regulatory schemes use uniform rules for industries that affect consumers across the board. Yet consumers have diverse interests, needs, abilities, and values. The question thus arises: For whom should the regulations be designed? If written to protect the most vulnerable consumers, regulations are likely to restrict some choices and impose costs that do not benefit the average consumer.[46] For example, regulations that make MCOs offer certain benefits help those consumers who are most likely to use them but raise insurance premiums for all consumers.[47] Thus, the basic de-

---

quacy and financial solvency. *See generally* H.R. 2491, 104th Cong., 1st Sess., Title VIII, Subtitle A, §§ 1853 (a)(1) & (d) (1995).

[44] *See, e.g.*, MASS. GEN. L. ch. 32B, § 3 (1992) (Reinsurance Agreements); *Failed Promises: Insurance Company Insolvency*, House Committee on Energy and Commerce, Subcommittee on Oversight, Feb. 1990; *Failed Promises: Insurance Company Insolvency*, Hearings Before the House Committee on Energy and Commerce, Subcommittee on Oversight, April 5, 1989, No. Stock Number 552-070-06669-1.

In other contexts, the Employee Retirement Income Security Act (ERISA) ensures that pensions are funded and prudently invested and holds managers to fiduciary standards. *See generally* 29 U.S.C. §§ 1001 through 1461; 12 U.S.C. §§ 1811-32 (1988) (FDIC); 12 C.F.R. §§ 303-65 (1995).

Also, the Medicare provisions of the Budget Reconciliation Act of 1995 require the Secretary of HHS to establish insolvency standards and requires state agencies who certify Medicare managed care organizations to comply with these standards. *See* H.R. 2491, Title VIII, Subtitle A, § 1856.

[45] *See* Budget Reconciliation Bill 1995, H.R. 2491, Title VII, Subtitle A, § 1853.

[46] The same is true for deregulatory strategies. *See* Stephen Brobeck, *Economic Deregulation and the Least Affluent: Consumer Protection Strategies*, 47 J. SOC. ISSUES 169-91 (1991).

[47] *See* Sylvia A. Law & Barry Ensminger, *Negotiating Physician's Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 50-51 (1986) (noting that patient-physician freedom of contract is subject to regulation because "it is now

sign of the regulation will depend on which group the regulation aims to serve.

In the absence of a protective rule, social costs may fall disproportionately on a few individuals who are not able to help themselves, whereas if the cost is spread across all consumers, no one individual bears a large burden. It is sometimes easy to justify restrictions on large classes of consumers that benefit relatively few. For example, child-proof caps increase the cost of medicine minimally but are highly beneficial to children and their caretakers. But the more restrictive the regulations, the less producers can cater to the individual interests of different consumers.

B. Broad Protection v. Individual Choice

Regulations—restrictive by nature—limit certain producer and consumer choices. Sometimes policies designed to restrict undesirable choices also eliminate desirable ones.[48] Thus there is sometimes a trade-off between promoting broad protection and allowing individual market choice. Standards for MCOs can ensure comprehensive coverage or quality, yet they will also limit choice and raise cost as well. However, promoting protection and allowing choice are not always in a zero-sum relationship. Ideally, consumer protection regulations will limit harmful or costly options but not desirable choices.[49] Depending on the activity and design of the regulation, a balance can be achieved that increases consumer protection and choice. The design of regulation also involves trade-offs in approaches used.

C. Comprehensive Regulation v. Targeted Regulation

There are two main models of regulation: those deriving from statutes addressing issues across the board or from courts making rules by deciding individual cases. Attempts to codify regulatory solutions to complex problems are risky. The possibility of exceptional cases and market changes can make the best codes obsolete.

---

widely accepted that it is appropriate to subject this freedom to legislative restriction in order to protect vulnerable people, such as Medicare patients, who cannot protect themselves through individualistic bargaining"). *But c.f.* Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 37 (1993) (observing that "utilitarian cost-benefit analysis or public-choice-driven policy rationales" hold the greatest influence in health care reform debates).

48 *See* David Vogel, *When Consumers Oppose Consumer Protection: The Politics of Regulatory Backlash*, 10 J. PUB. POL'Y 449, 462 (1990) (examining consumer backlash to legislation on seat belts, motorcycle helmets, saccharin, and AIDS drug approval).

49 When individual consumer choice is restricted unnecessarily there is the possibility of consumer opposition to legislation. *See generally id.* at 449-470.

Thus, it is preferable to use flexible regulations that allow exceptions when justified by individual circumstances. This is particularly so when an industry is developing, because less restrictive regulations keep open options for developing new products and responding to consumer problems. When an industry is mature, however, and the nature of the product and consumer problems is well known, comprehensive regulation may be appropriate.

This dichotomy is somewhat oversimplified. Some regulations—even restrictive ones—can stimulate the development of an industry by eliminating activities that discourage responsible businesses from entering a market or which inhibit consumers from purchasing the product. If a few MCOs do not invest in quality assurance measures, monitor the performance of providers, or shirk their responsibility to provide services, the resulting consumer distrust can retard industry growth.[50]

D. Specification v. Goal-Oriented Standards

Another choice is between design and goal-oriented standards. The former specify the features a product must have or how to achieve ultimate objectives. The latter set goals or performance standards but leave to producers the means to achieve them. Consumer activists have urged MCOs to use quality assurance programs and grievance procedures for patients who have been denied services. The issue for regulators is whether to specify how grievance procedures and quality assurance programs should operate or whether to let MCOs make such decisions so long as they satisfy certain policy goals.[51]

---

[50] The scandals in Medicaid managed care in California in the 1970s illustrate how the absence of a regulatory scheme can drive better producers from the market. For background on the early scandals in Medicaid managed care, see generally Carol N. D'Onofrio & Patricia D. Mullen, *Consumer Problems with Prepaid Health Plans in California*, 92 PUB. HEALTH REP. 121 (1977) (declaring that California's 1971 alternative health program for Medicaid beneficiaries had "fallen so far short of its promise that many consider it scandalous" and noting that the state had taken a laissez-faire stance in both establishment and enforcement of its regulations).

See Fred Schulte & Larry Keller, *The HMO Maze*, FLA. SUN-SENTINEL, November 1993. The newspaper reports led to and were confirmed by the General Accounting Office report. *See* General Accounting Office, *Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards*, GAO/HRD-92-11 (1991).

See also Fred Schulte & Jenni Bergal, *Profits from Pain*, FLA. SUN-SENTINEL, Dec. 11-15, 1994; Fred Schulte & Jenni Bergal, *Risky Rx: The Gold Plus Plan for the Elderly*, FLA. SUN-SENTINEL, Oct. 21-24, 1990.

[51] Such choices are present outside of health care as well. For example, in addressing air pollution by coal-burning factories, one can advocate either the use of specific anti-pollution equipment or the establishment of maximum emission levels, leaving the manager to decide whether to achieve the goal by changing equipment or

It is tempting for regulators, who have a sense of what would be effective, to prefer precise specifications that might eliminate loopholes. Design-oriented standards, however, tend to entrench certain interests and do not encourage innovation that might result in the development of better practices. However, performance standards are often harder to devise or enforce.[52]

E. Rules v. Financial Incentives

Traditional regulation includes prohibitions or mandatory standards. Another approach is to use financial incentives to encourage desired activities.[53] For example, the growth of private health insurance was fostered by offering tax deductions to employers providing it. Sometimes regulators combine mandates and incentives. An example is the Medicare hospital prospective payment system that reimburses hospitals a set fee based on the principal diagnosis of each patient.[54] This regulation gives hospitals incentives to use services frugally.

Third-party payers could offer MCOs financial incentives to adopt programs that promote consumer interests. They could reward MCOs for voluntarily adopting innovations and improvements, such as funding patient advocacy services or resolving complaints and appeals in a timely manner. They might offer incentives to achieve significantly higher than average patient satisfaction scores or to provide a high quality of care.[55] In time, market pressure might induce others to adopt such programs and, eventually, they could become industry standards.

---

using cleaner burning coal. BRUCE A. ACKERMAN & WILLIAM T. HASSLER, CLEAN COAL, DIRTY AIR (1981).

52 DEBORAH STONE, POLICY PARADOX AND POLITICAL REASON 231-48 (1989).

53 *See* Alan L. Hillman, *Managing the Physician: Rules Versus Incentives*, 10 HEALTH AFF. 138 (1991).

54 The payment system is a bit more complex. For a discussion of the mechanics, see Bruce C. Vladeck, *Medicare Hospital Payment by Diagnosis Related Groups*, 100 ANNALS INTERNAL MED. 576 (1984). For a discussion of the implications and problems of the payment system, see David M. Frankford, *The Medicare DRG's Efficiency and Organizational Rationality*, 10 YALE J. ON REG. 273 (1993).

55 In contracting with MCOs under their Basic Health Plan, the state of Washington sets higher reimbursement rates if the organization meets certain performance standards. Thus, for example, MCOs that achieve a high rate of childhood immunization will receive a higher reimbursement rate. *See* WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES MEDICAL ASSISTANCE ADMINISTRATION, REQUEST FOR QUALIFICATIONS AND QUOTATIONS FOR MEDICAID MANAGED CARE HEALTHY OPTIONS PLANS, 3, 15-16 (May 30, 1995).

F. *Relevant Criteria: Cost-Benefit and Market Impact v. Social Values*

Many regulations are designed to promote goals without regard to their costs. We have prohibited child labor and have legislated a minimum wage. It is unlikely that cost-benefit analysis showing that these decisions impose high social costs would result in their being abandoned. Generally, however, we strive for policies that increase net social gain.[56] Our regulatory policy is therefore sensitive to the following questions: Will the social benefits of the rule be greater than the cost? Who will pay the cost and who will reap the benefits? Can alternative regulations produce similar results for less cost? What will it cost for producers to comply with the rule and for regulators to enforce them?

IV. MANAGED CARE REFORM PROPOSALS AND THEIR LIMITATIONS

Over the past few years, several groups have sought new means to protect consumers in MCOs.[57] Their proposals have taken several forms: white papers and reports,[58] model legislation,[59] testi-

---

[56] Hearings Before the Senate Judiciary Committee on S. Res. 343; the Comprehensive Regulatory Reform Act of 1995, Feb. 22 and 24, 1995; Hearings Before the Subcommittee on Administrative Oversight of Courts; Hearings on Regulatory Reform, March 17 before the Senate Judiciary Committee; Exec. Order 12291, 46 Fed. Reg. 13193; Exec. Order 12866, 58 Fed. Reg. 51735 Sept. 30, 1993.

See also Comprehensive Regulatory Reform Act of 1995, S. REP. NO. 89, 104th Cong., 1st Sess. 2 (1995) (proposing that federal agencies perform a cost-benefit analysis when promulgating regulations including assessment of benefits and costs, feasibility of using market-based mechanisms, and discussions of reasonable alternatives); Exec. Order No. 12866, 58 Fed. Reg. 51,735 (1993) (proclaiming that agencies should select regulatory approaches that maximize social benefits, including the option of not regulating at all if necessary); Exec. Order No. 12291, 46 Fed. Reg. 13,193 (1981) (proclaiming that regulatory action and objectives shall be chosen to maximize the benefits to society).

[57] For an analysis of current state laws and regulations affecting managed care, see generally GERALDINE DALLEK, ET AL., CONSUMER HMO PROTECTION: A STATE BY STATE COMPARISON (Center for Health Care Rights 1995).

[58] *See, e.g.*, RUTH FINKELSTEIN, ET AL., MANAGED CARE CONSUMERS' BILL OF RIGHTS: A HEALTH POLICY GUIDE FOR CONSUMER ADVOCATES 61-65 (Public Policy & Education Fund/Citizens Fund 1995). The seventh of these enumerated rights deals with the major categories of information which should be made available to consumers. These include (1) plan structure: benefits, number and type of provider, preauthorization procedures, grievance and appeals procedures, and plan governance; (2) how the plan makes decisions, including utilization review standards; (3) how the plan is currently functioning, i.e., which providers are accepting new patients and average waiting times; (4) plan evaluation information; and (5) consumer rights and responsibilities. The Bill of Rights proposes model legislation that would incorporate all five of these elements. *See generally id.*

[59] *See*, e.g., S. 1024, 104th Cong., 1st Sess. (1995) (amending Title XVIII of the Social Security Act to set standards for accessibility and guaranteeing coverage for appropriate emergency room visits); H.R. 2011, 104th Cong., 1st Sess. (1995) (assur-

mony before state and federal legislatures, and bills introduced in federal and state legislatures helping to frame public debate.[60]

---

ing equitable coverage and treatment of emergency services under health plans); S. 969, 104th Cong., 1st Sess. (1995) (disallowing quick discharge from hospitals after birth); S. 839, 104th Cong., 1st Sess. (1995) (setting standards for Medicaid managed care plans in states that obtain from the federal government waivers to expand managed care in Medicaid); H.R. 1707, 104th Cong., 1st Sess. (1995) (amending Title XVIII of the Social Security Act to ensure access to services and amend standards for Medicare supplemental policies); S. 609, 104th Cong., 1st Sess. (1995) (providing for fairness and choice to patients and health care providers); S. 2196, 103d Cong., 2d Sess. (1994) (assuring fairness and choice to patients and providers under managed care health plans); The Family Health Care Fairness Act of 1995 (establishing comprehensive, uniform national standards for managed health care). Section 207 requires plans to provide accurate and understandable marketing materials and information on: plan benefits, a breakdown on how the premium is spent, the number and mix of health professionals and providers, the enrollee's financial obligations, utilization review requirements, enrollee satisfaction statistics, quality indicators and performance measures, grievance and appeals procedures, and the percentage of utilization review decisions overturned on appeal. *See* S. 609, 104th Cong., 1st Sess., § 207 (1995).

For examples of such state bills, see S. 1832, Reg. Sess., (Cal. 1994) (enacted); H.R. 6249, Reg. Sess. (Conn. 1995); H.R. 321, 138th Gen Assem. § 1 (Del. 1995); H.R. 851, Reg. Sess., § 1 (Fla. 1995); S. 2638, Reg. Sess., § 1 (Fla. 1995); H.R. 796, 143d Gen. Assem., Reg. Sess. (Ga. 1995); S. 1023, 18th State Leg. (Haw. 1995); H.R. 1975, 89th Gen. Assem. (Ill. 1995); S. 422, 109th Reg. Sess. (Ind. 1995); H.R. 2086, Reg. Sess., § 1 (La. 1995); S. Paper No. 553, 117th Leg. (Me. 1995); S. 449, Leg. Sess. (Md. 1995) (enacted); S. 780, 179th Gen. Ct., 1st Ann. Sess. (Mass. 1995); H.R. 721, Reg. Sess. (Miss. 1995); S. 2209, Reg. Sess. (Miss. 1995); Assem. Bill 2928, 206th Leg., 2d Ann. Sess. (N.J. 1995); Assem. Bill 6800, 218th Gen. Assem., 1st Reg. Sess. (N.Y. 1995); Assem. Bill 3105-A, 218th Gen. Assem., 1st Reg. Sess. (N.Y. 1995); H.R. 338, 121st Gen. Assem., Reg. Sess. (Ohio 1995); S. 979, 68th Leg. Assem., §§ 2, 4 (Or. 1995) (enacted); H.R. 1866, 176th Gen. Assem., Reg. Sess. (Pa. 1993); H.R. 5160, Jan. Sess. (R.I. 1995) (enacted); H.R. 1311, 99th Gen. Assem., 1st Reg. Sess. (Tenn. 1995); H.R. 911, 99th Gen. Assem., 1st Reg. Sess. (Tenn. 1995); H.R. 2766, 74th Reg. Sess. (Tex. 1995) (vetoed); H.R. 300, 51st Leg. (Utah 1995); S. 5935, 54th Leg., Reg. Sess. (Wash. 1995); H.R. 2815, Reg. Sess. (W. Va. 1995).

[60] *See* The Medicare Beneficiary Protection Amendments of 1995 H.R. 1707 introduced by Representative Pete Stark (D-CA) (setting standards, and guaranteeing coverage for appropriate emergency room visits); the New Newborns' and Mothers' Health Protection Act, S. 969, introduced by Senator Bill Bradley (D-NJ) and Senator Nancy Katzenbaum (R-KS) (disallowing quick discharge from hospitals after birth); the Medicare Health Quality Act of 1995, S. 1024, introduced by Senator Paul Wellstone (D-MI) (setting standards, guaranteeing coverage for appropriate emergency room visits); the Health Quality and Fairness Act of 1995, S. 609, introduced by Senator Paul Wellstone (setting standards, guaranteeing coverage for appropriate emergency room visits); the Medicaid Managed Care Act of 1995, S. 839, introduced by Senator Chafee (R-RI) (setting standards for Medicaid managed care plans in states that obtain waivers from the usual federal government statutes and regulations to expand managed care in Medicaid); the Access to Emergency Medical Services Act of 1995, H.R. 2011, introduced by Representative Ben Cardin (D-MD) (guaranteeing coverage for appropriate emergency room visits). *See also* Budget Reconciliation Bill of 1995, H.R. 2491, 104th Cong., 1st Sess., Title VIII, Subtitle A, § 1852(e) (requiring all Medicare providers to have a quality assurance program).

The American Medical Association has championed a Patient Protection Act. It

took form in federal legislation in the 103rd Congress, as S. 2196, introduced by Senators Paul Wellstone (D-MI) and Conrad Burns (R-MT) and HR 4527 introduced by Collin Peterson (D-MN) and Wayne Allard (R-CO). A model state act has also been promoted. Although the federal statute was not enacted many of its provisions have been incorporated in other federal legislation introduced by Representatives Stark, Wellstone, and Chafee, and in various state bills.

Various states have introduced similar measures. The Omnibus Managed Care Reform Measure, Senate Bill 1832 (Cal.). The Patient Protection Act of 1995; Health Care Consumer Protection Act of 1995, Assembly Bill 6800 (N.Y.); House Bill 1866 (Penn., 1993); The Patient Protection Act, House Bill 2766 (Tx.) (vetoed by Governor George Bush June 16, 1995). *But c.f.* the consumer protection regulations and proposed rules issued following the bill's veto. The Texas Insurance Commission adopted final regulations on November 15.

Other states that have considered bills in 1995 that address patient protection in their title include the following: Arkansas Senate Bill 299; Connecticut House Bill 6249 Patient Protection Act; Delaware House Bill 321 Patient Protection Act; Florida House Bills 841, 851, Senate Bill 2638; Georgia House Bill 796; Hawaii Senate Bill 1023; Illinois House Bill 1975; Indiana Senate Bill 422; Louisiana House Bill 2086; Maine Senate Bill 553; Maryland Patient Access Act, Enacted Mass Senate Bill 780; Mississippi House Bill 721, Senate Bill 2209; Missouri Senate Bill 197; New Jersey Assembly Bill 2928; New York Bill 6899; Ohio House Bill 338; Oklahoma House Bill 1940; Oregon Senate Bill 979 (became law July 18, 1995); Rhode Island House Bill 5160 (signed, August 7, 1995); Tennessee House Bill 911, Senate Bill 1311; Texas Bill 2766 (passed and vetoed; however regulations incorporating parts of the bill were issued); Utah House Bill 300; Washington Senate Bill 5935; West Virginia House Bill 2815.

There were approximately 1000 bills that would affect managed care organizations introduced in state legislatures in 1995. Telephone interview with Allen Jensen, George Washington University Intergovernmental Health Policy Project, September 11, 1995. Many of these may have included some provisions that would affect consumers directly. For analysis of state legislation affecting managed care, see ANNE R. MARTUS, MANAGED CARE: AN OVERVIEW OF 1995 STATE LEGISLATIVE ACTIVITY (George Washington Univ. Intergovernmental Health Pol. Project 1996).

Several consumer groups have set forth their ideas initially in response to the Clinton Administration health care reform plan in 1993 and are developing these ideas now for managed care. *See* Coalition for Consumer Protection and Quality in Health Care Reform, *White Paper on Consumer Due Process Protection*, Nov. 30, 1993; Coalition for Consumer Protection and Quality in Health Care Reform, *White Paper on Minimum Requirements for Consumer Information*, July 31, 1993; Testimony of Linda Golodner, Coalition for Consumer Protection & Quality in Health Care Reform, before Subcommittee on Health and Environment, Committee on Energy and Commerce, U.S. House of Representatives, Jan. 31, 1994 (regarding Health Security Act; Health Care Consumer Protection Act of 1995). For more recent efforts, see CONSUMER COALITION FOR QUALITY HEALTH CARE, DRAFT MODEL STATE LAW ON CONSUMER PROTECTION & QUALITY, (March 18, 1996) (copy on file with author).

There are also federal and state consumer protection provisions that apply to commerce in general: state statutes and regulations that regulate health insurance including managed care; federal and state statutes and regulations for the operation of the Medicaid and Medicare programs. For an analysis of current state laws and regulations affecting managed care, see DALLEK, ET AL.,, *supra* note 57.

The most recent proposals for revamping of Medicare would have the secretary of HHS develop standards on solvency, market conduct, and consumer protection. For a summary and comparison of proposals by the Clinton Administration and the Congress, see 3 Health Pol'y Rep. (BNA) No. 50 at 22194-238 (Dec. 18, 1995).

There are four key proposals: (1) increased informed consumer choice; (2) standards for MCO services and marketing; (3) oversight of MCOs by governmental agencies or private accrediting organizations; (4) administrative due-process rights for consumers denied services.[61]

A. *Informed Consumer Choice*

Many consumers prefer traditional insurance to managed care; however, employers and third-party payers often do not offer it or make it unaffordable. Furthermore, choosing among MCOs is difficult because relevant information is hard to obtain and interpret. Once enrolled, the individuals' choice of providers is restricted, and sometimes the choice of therapies is too.

Several proposals would make managed care optional. Employers would have to offer their employees either an alternative fee-for-service, point-of-service, or a preferred provider plan (possibly at a higher price). These would avoid closed panels but would require higher out-of-pocket payments.[62] Other proposals would make it easier for consumers to switch among MCOs.[63]

Several proposals would require MCOs to disclose information to help individual consumers make better decisions and to foster competition with the expectations that firms will then cater to consumer wishes.[64] Some would provide performance data—so called

---

[61] There are several related concerns, such as access to services, quality of care, and consumer representation in governance. For a more detailed analysis of these issues and alternative strategies for addressing them, see generally Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, Trade-Offs*, 32 HOUS. L. REV. 1319 (1996).

[62] *See* S. 2196, §§ 5 & 6, 104th Cong., 1st Sess. (1995) (option of traditional insurance plan); Health Care Quality and Fairness Act of 1995, S. 609, § 101, 104th Cong., 1st Sess. (choice of point of service and traditional insurance plans). State bills include New York Assem. Bill, 6800, § 6 (point of service plan); Texas House Bill 2766, Art. 21.112 (point of service plan); Georgia C.S. H.B. 1404 (point of service plan, signed into law Apr. 19, 1996) (cited in 2 Managed Care Rep. (BNA) (Mar. 27, 1996), at 301). *See also* the Maryland Patient Access Act, 1995 Md. Laws ch. 604-05.

[63] *See, e.g.*, S. 839, § 3, 104th Cong., 1st Sess. (1995) (allowing Medicaid beneficiaries to terminate their enrollment for cause at any time and providing specifically that fraudulent inducement in enrollment is an adequate ground); H.R. 1707, 104th Cong., 1st Sess., § 301(a)(2) (1995) ("Except in the case of an individual terminating enrollment for cause, an individual may terminate enrollment with an eligible organization . . . only during the open enrollment period . . . ").

[64] Coalition for Consumer Protection and Quality in Health Care Reform, *White paper on Minimum Requirements for Consumer Information*, July 31, 1993; S. 1024, § 10 (introduced by Senator Paul Wellstone). The Consumer Bill of Rights includes consumer information requirements. *See* FINKELSTEIN, ET AL., *supra* note 58. Right number seven deals with the major catagories of information which should be made available to consumers. These include (1) plan structure, including benefits, number

report cards; or other items, such as information regarding financial incentives for physicians to be frugal in providing services, information about grievance procedures, utilization review quality assurance programs, and ownership interests.[65]

Issuing report cards and making other information public presupposes that individuals will make better choices with such information.[66] Individual consumers, however, encounter problems in

---

and type of provider, preauthorization procedures, grievance and appeals procedures and plan governance; (2) how the plan makes decisions, including utilization review standards; (3) how the plan in currently functioning, that is, which providers are accepting patients and average waiting times; (4) plan evaluation information, and (5) consumer rights and responsibilities. The Bill of Rights has proposed model legislation that would incorporate all five of these elements.

Health Care Quality and Fairness Act of 1995, S. 609, § 201 (funding an office of consumer information for each state and reporting on patterns of consumer complaints); Budget Reconciliation Act of 1995, H.R. 2491, 104th Cong., 1st Sess., Title VIII, Subtitle A, Ch. 1, § 8001, Part C, §§ 1851(d) (requiring HHS to disseminate information to Medicare beneficiaries on coverage options) & (e) (providing for a health fair in October 1996 to provide information); § 1852 (c) requires each provider to disclose certain information to enrollees; The Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess., §§ 1805(d), 1853(a) ("Blue Dog" Proposal); §§ 1851(B)(b)(1), (E)(a) & (b) (Clinton Medicare Proposal); Texas House Bill 2766, Art. 21.114 (requiring an annual report on the performance of managed care plans by the office of public insurance counsel); California Assem. Bill 1266 would require more disclosure for HMOs, particularly information about utilization review and limitations on choice of primary care and specialty physicians and referrals; Arizona Law requiring HMOs to distribute information to employers about types of incentives or penalties intended to encourage plan providers to withhold services or minimize or avoid referrals to specialists went into effect December 31, 1995. *See* 2 Managed Care Rep. (BNA) No. 1, at 9. The Washington Engrossed Substitute Senate Bill 6362 would require disclosure of provider incentives. *See* 2 Managed Care Rep. No. 1 (BNA) (Mar. 20, 1996) at 273. New York Assembly Bill 6401 would similarly require disclosure of provider incentives. Washington H.B. 2173 would require health plan carriers to provide disclosure forms so that consumers would have a consistent basis on which to compare plans. Washington H.B. 2189 would permit health plan enrollees to choose a health care provider without referral from another provider to contract administrator. *See* 4 Managed Care Rep. No. 4 (BNA) at 113 (providing information on Washington bills).

65 One of the bills that had the most extensive disclosure requirements is the Health Care Consumer Protection Act of 1995, Assem. Bill 6800 (New York) §§ 2 and 4. *See also* Medicaid Managed Care Act of 1995 S. 839, § 3(c)(4); S. 2196, § 4(b)(1); Penn, H.R. 1866 § 3 (5.9(a)-e, (j), 36 (5.10); CA S. Bill 1832, § 8; CA, Assembly Bill 3801, § 2; Texas H.B. 2766, Art. 21.104; California S. Bill 1832 (information on consumer complaints); S. 2169, § 4(b)(1) and New York bill § 2 (information on plan financial arrangements). Pennsylvania H.B. 1866, §§ 5.2(14), 5.5.

For a discussion of the failure of managed care plans to disclose ownership information see, General Accounting Office, *Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans*, GA0/HRD-86-10 (1985).

For a case on how disclosure can help consumers and examples of what kind of disclosure is needed, see Shoshanna Sofaer, *Informing and Protecting Consumers under Managed Competition*, 12 HEALTH AFF. 76-86 (1993).

66 There is a growing literature on report cards. *See, e.g.*, NATIONAL COMMITTEE

using such data. Report cards convey simplified, partial data and measures of quality that are not up-to-date. Based on a few instances, such information does not reflect the range and variety of medical services among MCOs' providers.[67]

The parents of a child with a cardiac problem or an individual with a high risk of cancer may want to review a report card to decide which MCO to join. The odds are, however, that they will find measures of quality or consumer satisfaction for the MCO as a whole rather than for the specific services they wish to compare.[68] Thus, assessments of overall organizational performance, however useful, obscure contrasts between particular medical services provided by the MCO—precisely what consumers may want to know.

Today, quality experts and consumer groups clamor for more information on MCOs. Too much information, however, becomes noise and is as unenlightening as too little. Some individuals are sure to be interested in detailed data when they have a serious medical problem. But few people are likely to have the time or expertise to make sense of it.[69] And how many will then be able to switch between MCOs quickly or to afford the high out-of-pocket payments for using providers outside the network? Experts, however, can analyze complex data and advise consumers.

FOR QUALITY ASSURANCE, REPORT CARD PILOT PROJECT (National Committee for Quality Assurance 1995); Arnold Epstein, *Performance Reports on Quality—Prototypes, Problems, and Prospects*, 333 NEW ENG. J. MED. 57 (1995); Jesse Green & Neil Wintfeld, *Report Cards on Cardiac Surgeons*, 332 NEW ENG. J. MED. 1229 (1995); LuAnn Heinen & Sheila Leatherman, *Quality Evaluation: A New State of Art*, GROUP PRAC. J. (January/February 1992) at 38; Timothy S. Jost, *Health System Reform: Forward or Backward with Quality Oversight?*, 271 J.A.M.A. 1508 (1994); Jerome P. Kassirer, *The Quality of Care and The Quality of Measurement*, 329 NEW ENG. J. MED. 1263 (1993); John E. Ware, *What Information Do Consumers Want and How Will They Use It?*, 33 MED. CARE 25 (1995).

See also Janet M. Corrigan, *How Do Purchasers Develop and Use Performance Measures?*, 33 MED. CARE 18 (1995); Dennis S. O'Leary, *Performance Measures: How are They Developed, Validated, and Used?*, 33 MED. CARE 13 (1995); Gail Povar, *Profiling and Performance Measures: What Are the Ethical Issues?*, 33 MED. CARE 60 (1995); Bernard M. Rosof, *Quality and Accountability in Practice: Measuring, Managing and Making it All Work in a Reformed Health Care System*, 33 MED. CARE 1 (1995); Robert M. Veatch, *The Role of Ethics in Quality and Accountability Initiatives*, 33 MED. CARE 69 (1995).

67 *See Health Care Reform: Report Cards are Useful but Significant Issues Need to Be Addressed*, G.A.O. Rep. No. 94-219 (1994) (asserting that report cards may be based on "incorrect, misleading, or incomplete" data); *see also* Timothy S. Jost, *Health System Reform: Forward or Backward with Quality Oversight?*, 271 JAMA 1508, 1509 (1994) (arguing that accurate, simple, and impartial reporting is extremely difficult).

68 There have been several popular attempts to issue report cards for MCOs. *See, e.g., The Crisis in Health Insurance*, CONSUMERS REP., Aug. 1990, at 533; MARC S. MILLER, ET AL., HEALTH CARE CHOICES IN THE BOSTON AREA: A GUIDE TO QUALITY AND COST (1995).

69 Judith H. Hibbard & Edward C. Weeks, *Consumerism in Health Care: Prevalence and Predictors*, 25 MED. CARE 1019 (1987).

Because neither too little nor too much information is helpful, the aim should be to provide consumers with just what they want and need and with the tools necessary to become informed. Specifying what information MCOs need to make public would help resolve some problems. The main difficulty, however, is not the amount or quality of data, but rather that consumers lack resources and must deal with their problems as individuals. There is little evidence that MCOs now compete on quality; and whatever information consumers get will not be much help so long as they lack meaningful choices. If MCOs generally adopt similar risk-sharing incentives to encourage physicians to reduce services, or use similar internal grievance procedures, it is hard to see how information on these practices will help consumers.

Managed care plans with options to use physicians outside the network give the MCO an incentive to keep the customer satisfied. Such plans also allow consumers to avoid the organization's limitations. However, although such options may help a few individuals, they will ultimately preserve the status quo, because MCOs may face less pressure to change their policies if quality-conscious consumers with greater income can opt out whenever they wish. Additionally, MCOs lack the means to control out-of-plan quality and costs.

B. Standards for Services and Marketing

Market mechanisms are insufficient means for ensuring that MCOs will be accountable to consumers.[70] Several reforms would help to set better standards.[71] Some bills would oblige MCOs to pay for services rendered by emergency medical personnel if the typical patient in such circumstances would have reacted similarly

---

70 Marc A. Rodwin, *Managed Care and the Elusive Quest for Accountable Health Care*, 1 WIDENER TOPICS L. 65 (1996) (Symposium issue); *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care*, GAO/HEHS Pub. No. 55 (August, 1995); Stuart H. Altman & Marc A. Rodwin, *Half-Way Competitive Markets and Ineffective Regulation: The American Health Care System*, 13 J. HEALTH POL. POL'Y & L. 323, 324-25 (1988); OFFICE OF THE PUBLIC ADVOCATE, MANAGED CONFUSION: HOW HMO MARKETING MATERIALS ARE TRICKING THE ELDERLY AND THE POOR (1995).

71 *See* FINKELSTEIN, *supra* note 58. Standards are discussed under Right five. *See id.* at 50-55. The standards for quality health care cover plan structure, qualifications of providers, accreditation, practice guidelines and treatment protocols, performance measures, and outcome measures. *See also generally id.* at 45-47 (discussing standards for utilization review). Several legislative proposals have also included standards. *See generally* The Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess., §§ 1805(d)(1), (d)(3), ("Blue Dog" Proposal); § 1851(E)(i) (restricting physician incentive plans); *see also* Clinton Medicare Proposal (requiring development of standards for maintaining fiscal soundness).

to the symptoms, even if reviews, after the fact, indicate that emergency care was not necessary.[72] Other federal and state legislation would prevent so called drive-through deliveries—that is, prematurely discharging women from hospitals after giving birth.[73] Still

---

[72] These bills would prevent a common practice: the denial of reimbursement for using medical services when MCO reviewers decide after the fact that the patient could have waited and been treated by the MCO. The issue is complicated because emergency rooms are required by federal statute, requiring an initial screening and treatment for people in emergency situations without regard to their ability to pay. *See* 42 U.S.C. §§ 1395dd(a)-(i) (Emergency Medical Treatment and Active Labor Act). Thus hospital emergency rooms are in a double bind. They can be liable for failing to treat emergencies and also have to bear the cost of treatment even if a patient is insured. *See generally* 42 C.F.R. § 434 (1995) (regulations for Medicaid Prepaid Health Plans).

See also MCOs, Emergency Room Doctors at Odds Over Coverage of Urgent Care (reprinted in 1 Managed Care Rep. (BNA) No. 17 (Oct. 4, 1995) at 302-04); PUBLIC CITIZEN HEALTH RESEARCH GROUP HEALTH LETTER, February 1995 & June 1993. The Insurance Division of the Oregon Department of Consumer and Business Services issued a fine in January, 1996 against PacifiCare of Oregon for improper claim denial. A consistent pattern of denying emergency room claims without sufficient investigation was uncovered. *See* 4 Health Care Pol'y Rep. (BNA) No. 4, at 107.

In addition, many state contracts with managed care organizations for Medicaid do not specify that the managed care organization needs to offer emergency care for children as specified under Early Periodic Screening, Diagnostic & Treatment (EPSDT), so the organizations do not provide them. *See* Lourdes Rivera & Jane Perkins, *EPSDT and Medicaid: Do Health Plans Know What they Are Getting Into?*, 28 CLEARINGHOUSE REV. 1245 (1995).

See generally The Medicare Beneficiary Protection Amendments of 1995, H.R. 1707, § 101(g), 104th Cong., 1st Sess.; The Medicare Health Quality Act of 1995, S. Res. 1024, 104th Cong., 1st Sess., § 7; The Health Quality and Fairness Act of 1995, S. Res. 609, 104th Cong., 1st Sess., §§ 2 & 404; The Medicaid Managed Care Act of 1995, S. Res. 839, 104th Cong., 1st Sess., § 1852; The Access to Emergency Medical Services Act of 1995, H.R. 2011, 104th Cong., 1st Sess.; Congressional Budget Reconciliation Bill, H.R. 2491, 104th Cong., 1st Sess., Title VIII, Subtitle A, § 1852 (d) (1995); § 1851(C)(e) (Clinton Medicare Proposal); "Blue Dog" Proposal, H.R. 2530, 104th Cong., 1st Sess., § 1853(b) (1995) (defining "emergency services," and requiring access to services twenty-four hours a day, seven days a week).

State bills have similar provisions. *See, e.g.*, TX H.B. 2766, Art. 21.109; PA H.B. No. 1866, Sec. 4(4); CA S.B. 1151 (*see* 1 Managed Care Rep. (BNA) No. 17, Oct. 4, 1995, at 402 for more information on the California bill). Georgia C.S. H.B. 1338 (emergency services) (cited in 2 Managed Care Rep. (BNA), at 378 (April 17, 1996) (signed by Gov. Zell Miller on Apr. 21, 1996)). *See also* H.R. 2011, 104th Cong., 1st Sess., § 8(3) (1995). This bill defines an "emergency medical condition" as:

> a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
> (A) placing the person's health in jeopardy,
> (B) serious impairment to bodily function, or
> (C) serious dysfunction of any bodily organ or part.

Id.

[73] The standard may be reasonable from the point of view of providing respite and

other bills would require MCOs to pay for out-of-network patient care if the MCOs did not have equivalent specialists.[74]

Several proposals would require MCO accreditation—either by private organizations such as the National Committee for Quality Assurance, or by the state—based on criteria such as measures of outcome and patient satisfaction.[75] Others would limit the

---

care. However, Kaiser Permanent in California has used a 24-hour maternity stay for many years with no apparent problems. Moreover, many women's groups for years have tried to "demedicalize" birth and have advocated home birth. Still, it is interesting that MCOs have chosen to cut costs by reducing services to consumers rather than by bargaining with providers. The extra cost of additional hospital stays following a normal birth is minimal and many hospitals have low occupancy rates so that they might easily be induced to give MCOs a longer hospital stay for a very small charge. Indeed, in the wake of the publicity over so called "drive through" deliveries, several hospitals have adopted policies saying that they would allow mothers and infants longer hospital stays if they wished even if they were not reimbursed by the MCOs for doing so. For a discussion of legislation on length of stay for deliveries, see George J. Annas, *Women and Children First*, 333 NEW ENG. J. MED. 1647 (1995).

For related legislation, see The New Newborns' and Mothers' Health Protection Act S. 969, introduced by Senator Bill Bradley (D-NJ) and Senator Nancy Kassenbaum (R-Kan.). *See also* Assembly Bill 1841 (Cal.) approved by the Assembly on September 14 and passed by the Senate on September 15. For an article showing how such measures have been generally supported by the press, see Ellen Goodman, *Length of Hospital Stay After Childbirth Needs Re-examination*, BOSTON GLOBE, July 11, 1995, at 1.

Approximately 44 states have enacted or are considering enacting laws on length of maternity stay. *See* 2 Managed Care Rep. (BNA) No. 14 (April 3, 1996), at 327. Massachusetts recently enacted legislation prohibiting MCOs and hospitals from discharging mothers and infants prior to 48 hours if they wish to stay. *See* 4 Health Law Rep. (BNA) No. 46, at 1778. Other states that have enacted similar legislation include Maryland (1995 Md. Laws ch. 503), New Jersey (1995 N.J. Laws ch. 138); North Carolina (N.C.S.B. 345, § 58-3-170); New Mexico (Nov. 30 regulations of State Corporation Commission (cited in BNA Health Care Policy Report, Dec. 11, 1995))); Georgia (CS FA SB 482) (maternity stay) (signed into law April 2, 1996); MInnesota, HF 2008 (maternal length of stay) (cited in 2 Managed Care Rep. (BNA) No. 12 (Mar. 20, 1996), at 275); Indiana, HB 1075 (signed on March 6, 1996 by Gov. Evan Bayh (cited in 2 Managed Care Rep. (BNA) No. 12 (Mar. 20, 1996), at 276); Maryland, SB 433, HB 1271 (cited in 2 Managed Care Rep. (BNA) No. 16 (April 17, 1996), at 373); Maine, PL 617 (cited in 2 Managed Care Rep. (BNA) No. 16 (April 17, 1996), at 375); Tennessee, H. 2410, S. 2722 (birthing) (cited in 2 Managed Care Rep. (BNA) No. 16 (April 17, 1996), at 375); South Dakota, SB 192 (maternity stay) (signed into law on March 14, 1996); (cited in 2 Managed Care Rep. (BNA) No. 16 (April 17, 1996), at 375).

Other states with similar legislation pending include California, Colorado, Connecticut, Delaware, Illinois, Kentucky, Michigan, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, and Wisconsin. The New Mexico Corporation Commission addressed the issue through direct regulation without legislation in an effort to expedite the process of getting the rule on the books. *See* 1 Managed Care Rep. (BNA) No. 22, at 531.

[74] The Medicare Beneficiary Protection Amendments of 1995, H.R. 1707, § 101(c); The Medicare Health Quality Act of 1995, S. 1024, § 7.

[75] The Medicare Health Quality Act of 1995, S. 1024, 104th Cong., 1st Sess.,§ 6; The Medicaid Managed Care Act of 1995, S. 839, 104th Cong., 1st Sess., § 6; The

amount MCOs could allocate to administration and profit rather than on services to consumers. Some firms spend as low as 69% of premiums on medical care, while others spend up to 95%.[76] A California bill would limit to 15% of revenue the amount that MCOs can spend on administrative costs and profit.[77] Still other proposals would require adequate financial reserves.[78]

Health Care Quality and Fairness Act of 1995, S. 609, 104th Cong., 1st Sess., § 301 (setting standards for utilization review); The Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess., §§ 1805(d), 1853(a) ("Blue Dog" Proposal); PA H.B. No. 1866, § 3. *See,* testimony by Allan Tull, American Association of Retired Persons, Senate Committee on Finance, Mar. 1, 1994, ("[a] comprehensive, national approach to quality assurance is required to assure delivery of the same appropriate, high quality care regardless of the site of care").

The Family Health Care Fairness Act of 1995, H.R. 2400, § 102 provides oversight through certification of health plans. The bill proposes that the Secretary of Health and Human Services establish a process to certify health plans according to the standards set forth in the Act. *See also* FINKELSTEIN, ET AL., *supra* note 58. For a discussion of certification as a means of oversight, see *id.* at 24-25. The tenth enumerated right, The Right to Vigorous Enforcement of the Bill of Rights, recommends that all managed care plans and utilization review companies be certified by an appropriate state agency. *See generally id.* at 72-73.

76 CALIFORNIA MED. ASSOC., HMOs CONSUMER HIGHER PERCENTAGE OF HEALTH CARE DOLLAR FOR PROFIT AND ADMINISTRATION (1994); George Anders, *HMOs Pile Up Billions in Cash, Try to Decide What to Do with It,* WALL ST. J., Dec. 21, 1994, at 1.

77 Assembly Bill 3801, April 12, 1994. The Knox-Keen Act already provides a limit of 15% on administrative costs for HMOs. *See* CAL. SAFETY CODE § 1378; CAL. ADMIN. CODE § 1300.78 (1988). Assembly Bill 3801 would change the definition to include profits, while New York Bill 4781 would require a minimum 75% of premiums to be spent for medical services.

78 *See, e.g.,* Patient Protection Act of 1994, S. Res. 2169, § 4; PA H.B. 1866, § 5.6; The Medicare Health Quality Act of 1995, S. Rep. 1024, 104th Cong., 1st Sess. (1995); The Medicaid Managed Care Act of 1995, S. Res. 839, 104th Cong., 1st Sess., § 3(b) (1995) (non-discrimination); The Medicaid Managed Care Act of 1995, S. Res. 839, 104th Cong., 1st Sess., § 3(e) (standards to prevent Medicaid recipients from becoming liable for debts a managed care organization becomes insolvent); The Health Care Quality and Fairness Act of 1995, S. Res. 609, 104th Cong., 1st Sess., § 402 (1995); H.R. 2530, 104th Cong., 1st Sess., § 1851(e) (1995); PA. H.B. No. 1866, § 8(d); S. Res. 2169 § 4; PA. H.B. 1866 § 5.6; The Medicare Health Quality Act of 1995, S. Res. 1024, 104th Cong., 1st Sess. (1995); The Medicaid Managed Care Act of 1995 S. 839, 104th Cong., 1st Sess., § 3(b) (non-discrimination); The Medicaid Managed Care Act of 1995 S. Res., 104th Cong., 1st Sess., 839, § 3(e) (1995) (standards for preventing Medicaid recipients from becoming liable for debts when a managed care organization becomes insolvent); The Health Care Quality and Fairness Act of 1995, S. Res. 609, 104th Cong., 1st Sess., § 402; The Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st. Sess., §1851(e); PA. H.B. No. 1866, § 8(d) (1995).

For a review of issues concerning financial solvency, *see* NAT'L ASSOC. INS. COMM'RS STATE & FED. HEALTH INS. LEG. POL'Y TASK FORCE, WHITE PAPER ON INSOLVENCY, *States Must Guard Against Insolvency in Managed Care, NAIC Task Force Says* (cited in 3 Health Care Pol'y Rep. (BNA) No. 50 at 2214-15 (Dec. 18, 1995)).

However, the Seven Year Balanced Budget Act, passed by Congress and vetoed by President Clinton would allow provider-sponsored networks to be exempt from the usual reserve financial requirements. Such arrangements pose increased risks to pa-

Marketing is an area that reforms have singled out as needing especially strong oversight. Many Medicaid and Medicare MCOs pay employees commissions to enroll subscribers.[79] Often agents solicit door-to-door without supervision, and some firms instruct agents to shun people who are ill.[80] Agents have been known to enroll incompetent or illiterate individuals.[81] Consumers have

---

tients. *See generally* H.R. 2491, 104th Cong. 1st Sess. § 8001(a) (1995) (amending the Medicare statute to create provisions for allowing enrollment in various types of MCO) (reprinted in 141 CONG. REC. H12509 (daily ed. Nov. 15, 1995)); H.R. 2530, 104th Cong., 1st Sess., § 1853(d) (1995). Under the framework foreseen in the bill the secretary of HHS would develop standards on solvency, market conduct and consumer protection. For an analysis of proposals by the Clinton administration and Congress, see 1 Health Pol'y Rep. (BNA) No. 50 (Dec. 18, 1995) at 22194-2238.

[79] HMOs outside the Medicare and Medicaid program also may pay agents' commissions. The poor and elderly, however, have been subject to particular abuse in these areas. Marketing abuses have been a problem in other areas of health insurance, such as sales of supplemental insurance for Medicare beneficiaries and long-term care insurance. *See* General Accounting Office, *Medigap Insurance: Insurers' Compliance With Federal Minimum Loss Ratios Standards: 1988-91*, GAO/HEHS-9497 (1991).

[80] Martin Gottlieb, *A Free-for-All in Swapping Medicaid for Managed Care*, N.Y. TIMES, Oct. 2, 1995, at A1, A12. In fact, many HMOs challenge their marketing agents to use abusive sales pitches. *See generally* General Accounting Office, *Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards* 8 (1994) [hereinafter GAO, STRONGER ACTIONS] (describing the "Kleenex close" sales technique recommended by HMP, a Florida health plan).

Using this tactic, a marketing agent who fails to make a sale explains, on leaving, to the customer that this is how the agent earns a living and that the agent has obviously made a mistake. The agent then asks the customer to explain what information was not properly covered so that the agent will not repeat the mistake in the future. The agent is then advised to ". . . cover it and close [the sale]." *See id.*

[81] *See* GAO, Stronger Actions, *supra* note 80, at 8 (noting that an agent had enrolled a beneficiary with Alzheimer's disease, who was incompetent to make an informed decision); *see also Health Care Reform: Hearings Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 103d Cong., 2d Sess. 474, Feb. 3, 1994 [hereinafter Dallek Statement] (statement of Geraldine Dallek, M.P.H., Executive Director of the Center for Health Care Rights) ("The history of both Medicare and Medicaid HMOs provides ample evidence that HMO marketing activities are open to serious abuse."). Some of these marketing abuses are the subject of pending law suits. *See, e.g.*, Petition for Writ of Mandate and Complaint for Preliminary and Permanent Injunctive Relief and Restitution at 2, Ivy v. Belshe, No. 967194, (Ca. Super. Ct. filed Feb. 9, 1995) (seeking to compel the California Department of Health Services to prevent managed health care plans from "fraudulently inducing Medi-Cal recipients to enroll in such plans and thereby unknowingly forfeit the recipients' existing rights to treatment from their chosen medical care providers"); Complaint for Preliminary Injunction, Permanent Injunction and Damages at 6, Gonzalez v. Cohen Medical Corp., No. 486330-4 (Cal. Super. Ct. filed May 11, 1993) (alleging that a health care provider's sales agents made numerous misrepresentations to consumers). Marketing abuses have been a problem in other areas of health insurance, such as sales of supplemental insurance for Medicare beneficiaries and long-term insurance. *See* General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards* GAO/HEHS 1988-91, at 2-4 (1991) (reviewing regulatory attempts to reduce abusive conduct regarding Medigap insurance).

sometimes signed enrollment forms not knowing what they were.[82] Other consumers were unaware of restrictions on their choice of providers in managed care or that gatekeeping and utilization review could limit their access to specialists.[83]

Several proposals would regulate marketing. Some would prohibit or regulate compensating agents primarily by commissions, and some would require state agency approval of marketing materials.[84] Others would eliminate door-to-door marketing.[85] There are also bills that prohibit discouraging enrollment based on criteria such as medical condition, race, gender, income, or national origin.[86] Still others would require that MCOs disclose their method of physician compensation, grievance procedures, utilization review, and the quality of their performance.

It is true that consumers and purchasers can more easily see differences in premiums than those of quality. Additionally, if some MCOs cut quality to lower premiums and increase their market share this will put pressure on other firms to follow suit. Thus, mandating federal, state, or industry standards will help to prevent a downward spiral in quality.

Standards which are too detailed can also present problems. For example, even though the standards for length of hospital maternity stays specified in legislation probably encourage good prac-

---

82 General Accounting Office, *Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards*, No. GAO/HRD-92-11. (Nov. 1991)

See Dallek Statement, *supra* note 81 ("The history of both Medicare and Medicaid HMOs provide ample evidence that HMO marketing activities are open to serious abuse."); GERALDINE DALLEK, ET AL., MEDICARE RISK-CONTRACT HMOS IN CALIFORNIA: A STUDY OF MARKETING, QUALITY AND DUE PROCESS RIGHTS (Center for Health Care Rights 1993); Michele Melden, *Medicaid and Managed Care: Testimony Submitted to the House Subcommittee on Health and the Environment*, 24 CLEARINGHOUSE REV. 1139 (1991). *See also, e.g.*, Petition for Writ of Mandate and Complaint for Preliminary and Permanent Injunctive Relief and Restitution at 2, Ivy v. Belshe, No. 967194 (Cal. Super. Ct. filed Feb. 9, 1995)

83 *See generally* OFFICE OF THE PUBLIC ADVOCATE, MANAGED CONFUSION: HOW HMO MARKETING MATERIALS ARE TRICKING THE ELDERLY AND THE POOR (1995).

84 Medicare Beneficiary Protection Amendments of 1995, H.R. 1707, 104th Cong., 1st Sess., § 113; Pa. H.R. 1866, §§ 5.9 (f)-(h). *See also* H.R. 2491, 104th Cong., 1st Sess., Title VII, Subtitle A, § 1851(h) (1995) (requiring HHS approval of marketing practices by providers who treat Medicare enrollees); The Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess., § 1853(h); Clinton Medicare Proposal, §§ 1851(B)(b)(3), 1851(h), (Dec. 1995).

85 Medicare Beneficiary Protection Amendments of 1995, H.R. 1707, §§ 114, 115 (1995).

86 *See, e.g.*, Pa. H.R. 1866, § 3; The Medicare Health Quality Act of 1995, S. Res. 1024, 104th Cong., 1st Sess., §§ 5, 6; S. Res. 2196, 104th Cong., 1st Sess., § 4(b)(6)(C) (1995); The Medicaid Managed Care Act of 1995, S. Res. 839, 104th Cong., 1st. Sess. § 3(b) (1995).

tices, such efforts are misguided. Legislatures are not qualified nor able, as a rule, to determine the proper course of treatment for various medical problems. The task is too complex, the variables too many, and medical quality standards change too rapidly. Indeed, identifying quality is difficult even for experts, and the medical profession lacks standards for many medical problems.

Higher standards may raise premium rates and make health insurance unaffordable for the self-employed or for the working poor who are not insured by their employer. It is therefore preferable to set broad standards—for quality assurance programs, utilization reviews, the provision of out-of-network emergency care, finances, reserve requirements and other key variables—and then provide for accreditation and oversight.

C. *Administrative Oversight*

Just as MCOs monitor the conduct of providers, so too there is a need to oversee the performance of managed care firms to ensure that they are accountable, as well.[87] The complexity of insurance issues, rapid market changes, and problems that consumers face make oversight particularly important.

The *Wall Street Journal*, for example, reported that Ohio contracted with American Biodyne to manage mental health services for its employees and only audited the program when significant problems arose. There were major discrepancies between what American Biodyne reported and what auditors found. American Biodyne spent only $2.1 million of its $7 million contract on medical services (rather than the $4.5 million it reported); the firm treated 3495 patients rather than the 5845 they had reported; and the firm took an average of fourteen days to respond to individuals seeking help for routine care, not the five days they had promised.[88]

---

[87] Marc A. Rodwin, *Managed Care & The Elusive Quest for Accountable Health Care*, 1 WIDENER TOPICS L. 65 (1996); General Accounting Office, *Medicaid: States Turn to Managed Care to Improve Access and Control Costs*, GAO/HRD-93-46 (1993); General Accounting Office, *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care*, GAO/HRD-95-155 (1993).

[88] *See* Carol Hymowitz & Ellen J. Pollock, *Psychobattle: Cost-Cutting Firms Monitor Couch Time as Therapists Fret*, WALL ST. J., July 13, 1995, at 1.

Mental health may be an area particularly open to potential abuse because there is less of a consensus regarding standards for treatment. For discussion of a recent case in which United Behavior Systems was fined $100,000 for denying mental health benefits, see *Rhode Island UR Company Agrees to Revise Mental Health Management*, 1 Managed Care Rep. (BNA) No. 5, at 123 (Aug. 2, 1995). *See also* Robert Berner, *HMOs Push Prozac Therapy*, PATRIOT LEDGER, Apr. 8-9, 1995, at 1, 18.

Such discrepancies suggest that contracts are not substitutes for oversight.[89] Several proposals would grant additional oversight powers for state or federal government agencies, or create independent ombudsman programs to help aggrieved consumers.[90]

---

89 For a discussion of the similarities between regulation and oversight of contracts, see Victor Goldberg, *Regulation and Administration Contracts*, 7 BELL J. ECON. 426 (1976).

The experience of Arizona illustrates this point. Arizona contracted out to private sector MCOs the responsibility of providing services to Medicaid beneficiaries. Over time, the state found that it had to set more and more detailed standards as part of the contracts and to monitor them. The result: a process akin to government regulation which they were trying to avoid. *See* JON CHRISTIANSON, COMPETITIVE CONTRACTS AND MEDICAID: THE ARIZONA EXPERIENCE (1986).

90 Linda Goldner, Testimony before Subcommittee on Health and Environment and Committee on Energy and Commerce, House of Rep., (Jan. 31, 1994) (advocating the use of ombudsman programs and citing sucessses in nursing home ombudsman programs); PA. H.B. 1866, §§ 2, 3; N.Y. A.B. 6800, §§ 4, 5; Patient Protection Act of 1994, S. Res. 2196, 103d Cong., 2d Sess. § 4(c) (1994); The Medicare Beneficiary Protection Amendments of 1995, H.R. 1707, 104th Cong., 1st Sess., § 102 (1995); The Medicare Health Quality Act of 1995, S. Res. 1024, 104th Cong. 1st Sess., § 6 (1995); the Medicaid Managed Care Act of 1995, S. Res. 839, § 3, 104th Cong., 1st Sess. (1995); Clinton Medicare Reform Proposal, H.R. 2491, §§ 1851(G), 1851(j), 1857(d), (f), (g), 8012; (IOM study of Older Americans Act and Ombudsman program).

Congress is entertaining some of these proposals. *See, e.g.*, S. Res. 1024, 104th Cong., 1st Sess., § 6 (1995) (requiring the Secretary of Health and Human Services to certify MCO utilization programs and specifying mandatory guidelines for Secretary review); H.R. 1707, 104th Cong., 1st Sess., § 102 (1995) (requiring the Secretary to establish standards governing appeals of a denial of patient services by an MCO); S. Res. 2196, 104th Cong., 1st Sess., § 4 (1995) (requiring the Secretary of Health and Human Services to establish procedures for the review and recertification of qualified MCOs and qualified utilization review programs). Clinton Medicare Proposal, H.R. 2491, 104th Cong., 1st Sess., § 1851(G); Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong. 1st. Sess., §§ 8401-02 ("Blue Dog" Proposal).

In addition, several states are considering their own proposals. *See, e.g.*, Assem. Bill 6800, 218th Gen. Assem., 1st Reg. Sess. §§ 4, 5, 8 (N.Y. 1995) (requiring MCO certification by the Commissioner of Health and review of an MCO's application and the promulgation of uniform regulations regarding reimbursement for emergency care by the Commissioner and the Superintendent of Insurance); H.R. 1866, 176th Gen. Assem., Reg. Sess. § 3 (Pa. 1993) (requiring all MCOs to establish quality assurance programs and have them approved by the Department of Health of the Commonwealth prior to enrolling members and requiring Department review of the programs at least every twelve months thereafter). Section 205 of the Family Health Care Fairness Act of 1995 sets standards for prompt delivery of services, fair and accountable utilization review, and timely payment of claims. *See* H.R. 2400, 104th Cong., 1st Sess., § 205 (1995). It also establishes internal grievance procedures and an outside appeals process. It also prohibits plans from directly compensating utilization reviewers for denying claims.

Consumer groups also have made proposals. *See* FINKELSTEIN, ET AL., *supra* note 58, at 56-60 (Public Policy & Education Fund in cooperation with Citizens Fund 1995). Right number six is the right to challenge decisions a plan makes about any practices or services that impact access to and quality of health care. The Bill of Rights outlines model legislation that would set forth four essential elements of the

Still others would set up procedures under which the medical decisions of managed care plans would be subject to review by outside independent parties.[91]

At present, however, political constraints limit the scope of administrative oversight. Our patchwork system of federal and state oversight for managed care is weakened by dwindling authority and resources.[92] The 104th Congress has passed a budget that would reduce Medicare spending by $270 billion over seven years, limiting what public agencies can do.[93] It has also proposed to reduce federal oversight for Medicare and Medicaid in favor of state regulation.[94] Yet state administrative agencies, already strained,

---

right to appeal, and details what each element should include or seek to accomplish. The elements are (1) the scope of consumers' right to appeal; (2) the right to challenge; (3) an internal grievance procedure, which includes quick action on grievances, representation for consumers, the right to receive a second opinion on the treatment, and written notification of decision; and (4) an external appeals process, which would involve decision making by a neutral third party. *See id.*

[91] The Medicare Beneficiary Protection Amendments of 1995, H.R. 1707, § 101(b).

[92] General Accounting Office, *Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards*, GAO/HRD-92-11. (Nov. 1991); General Accounting Office, *Medicaid: Lessons Learned From Arizona's Prepaid Program*, GAO/HRD-87-14 (Mar. 1987); General Accounting Office, *Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans*, GAO/HRD-86-10 (1985); General Accounting Office, *Medicaid Managed Care: More Competition and Oversight Would Improve California Expansion Plan*, GAO/HEHS-95-87 (1995); General Accounting Office, *HCFA's Oversight of HMOs*, GAO/HRD-92-11, 1-32 (1991).

[93] However, in subsequent negotiations, Republican proposed cuts of $168 billion and Democrats proposed cuts of $124 billion. Telephone interview with Bill Vaughn, Staff of Committee on Ways & Means, U.S. House of Representatives, (Apr. 24, 1996).

[94] Title XIX of the Social Security Act includes standards for the Medicaid program, including allowing recipients to use fee-for-service providers. *See* 42 U.S.C. § 1396a(23) (providing for consumer choice in determining the source of Medicaid services). These requirements for states, however, can be waived by the Health Care Financing Administration under § 1115 or § 1915(b) of the Social Security Act. *See* 42 U.S.C. § 1315 (1988 & Supp. 1993) (codifying Title XIX, § 1115 of the Social Security Act); 42 U.S.C. § 1396n (codifying Title XIX, § 1915 of the Social Security Act). Section 1915(b) of the Social Security Act allows a state to enroll in managed care plans if the state undertakes and evaluates a demonstration program that will assist in promoting the objectives of Medicaid. *See* 42 U.S.C. § 1396n(b). Many states have implemented Medicaid waiver programs. *See* Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 552 (1995).

Waivers, however, rely on states to maintain standards, a difficult achievement given impending federal and state budget cuts. *See The 1915(b) Waiver Experience: Lessons and Limitations for Understanding Managed Care in Medicaid: Hearing on Medicaid: State Flexibility Before the Senate Comm. on Finance*, Fed. Document Clearing House, (July 12, 1995) available in WESTLAW, USTESTIMONY database, 1995 WL 412479 (statement of Robert E. Hurley, Associate Professor, Medical College of Virginia) ("In a block granted environment . . . it is hard to see what agencies within state government will have sufficient independence to vigorously and vigilantly promote beneficiary

are unlikely to take on new responsibilities to fill the void.

Ultimately, consumers will have to organize to represent their interests in and before Congress before there will be significant increases in oversight. Until then, we can consider measures likely to garner some congressional support such as those minimizing the use of substantive standards in favor of processes promoting quality, or by making the MCOs more responsive to consumers. One approach is to require MCOs to be accredited. Another is to require MCOs to adopt quality assurance and independent utilization review programs. Yet a third is to create market incentives for quality by increasing reimbursement for MCOs that meet standards, while a fourth would encourage consumer voice and representation.[95]

D. Administrative Due Process

MCOs sometimes deem medical services unnecessary and deny authorization or payment.[96] Many groups suggest the need

---

protection."). *See also* address of William J. Scanlon, General Accounting Office, *Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight*, before the Senate Committee on Finance (July 12, 1995) ("[C]ontinuous oversight of managed care systems is required to protect both Medicaid beneficiaries from inappropriate denial of care . . . ."); Bruce C. Vladeck, Administrator, Health Care Financing Admin., Testimony before the Committee on Finance, U.S. Senate, (July 12, 1995).

See also ED GILLESPIE & BOB SCHELLUS, CONTRACT WITH AMERICA: THE BOLD PLAN BY REP. NEWT GINGRICH AND REP. DICK AMERY AND THE HOUSE REPUBLICANS TO CHANGE THE NATION (1994). Some proposals before Congress have included such provisions. *See, e.g.*, The Clinton Medicare Proposal, § 1851(E)(e) (Dec. 1995) (requiring each organization to have arrangements for an ongoing quality assurance program focusing on health outcomes).

95 PA. H.B. No. 1866, § 7 would require that at least one-third of the HMO's board of directors be subscribers. For a discussion of the difficulties of representing consumer interests, see Theodore Marmor & James A. Marone, *Imbalanced Markets, Health Planning and HSAs*, 58 MILBANK FUND Q. 161 (1980).

For a discussion of the way financial incentives might be used to encourage quality of care, see MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 156-58 (1993).

96 Denial of services and access is now being viewed as a potential source of fraud by the Department of Justice and the Health & Human Services Inspector General. *See Underutilization in Managed Care New Target of Joint Fraud Efforts*, 4 Health Law Rep. No. 47 (BNA) at 1809-10 (December 7, 1995). *See also* Managed Care Consumer Bill of Rights, FINKELSTEIN, ET AL., *supra* note 58. Right number six is the right to challenge decisions made by plans regarding any practices or services that impact access to or quality of health care. The Bill of Rights outlines model legislation that would set forth four essential elements of the right to appeal, and details what each element should include or seek to accomplish. The elements are: (1) the scope of consumers' rights to appeal; (2) the right to challenge; (3) an internal grievance procedure, including quick action on grievances, representation for consumers, the right to receive a second opinion on the treatment, and written notification of decision; and (4)

for procedures if consumers wish to challenge these decisions—for example, due process hearings and grievance procedures to appeal utilization review decisions denying services.[97]

Some propose internal grievance procedures but do not specify the mechanism.[98] Organizations would establish their own criteria for deciding the appeal and would directly employ the individuals hearing the cases.[99] One problem, however, is that the financial incentives for reducing services (which may lead to inappropriate denials of care) can also bias reviews of such cases. The key issue is often the appropriateness of the criteria the organization sets, not whether it was correctly applied. Internal reviews are unlikely to question organization standards. To eliminate bias, sev-

---

an external appeals process, that would involve decision-making by a neutral third party. *See generally id.*

97 The legalization of medicine is aptly described in David C. Hadorn, *Emerging Parallels in the American Health Care and Legal-Political Systems*, 18 AM. J. L. & MED. 73 (1992). *See generally id.* For a review of the grievance and appeals issues, see Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1676 (1994); Eleanor D. Kinney, *Procedural Protections in Capitated Health Plans*, AM. J. L. & MED. (forthcoming 1996); Eleanor D. Kinney, *Resolving Consumer Grievances in a Managed Care Environment*, HEALTH MATRIX (forthcoming 1996).

Medicare already has a grievance process in place for risk-contract HMOs. *see generally* 42 C.F.R. §§ 417.580-417.694 (1995) (Grievance Procedures for Risk Contracts). *See also Medicare Risk HMOs: Beneficiary Enrollment and Service Access Problems*, Dep't Health & Human Servs., No. OEI-06-91-00731 (1995). However, few Medicare beneficiaries are aware of the process of filing complaints. *See The Beneficiary Complaint Process of the Medicare Peer Review Organization*, Dep't Health & Human Servs., No. OEI-01-93-00250 (1995).

The Medicare reform bill passed by Congress requires expedient processing of patient appeals for denial of coverage and specifies remedies for violations. *See generally* H.B. 2491, 104th Cong., 1st Sess., Title VIII, Subtitle A, Chapter 1, § 8001, Part C, § 1852 (1995).

98 National Association of Insurance Commissioners, Complaint Procedure Model Regulation (Dec. 6, 1994 draft); National Association of Insurance Commissioners, Quality Assurance Model Regulation (Sept. 19, 1994 draft); National Association of Insurance Commissioners, Utilization Review Model Regulation (Aug. 8, 1994 draft); Medicaid Managed Care Act of 1995, S. Res. 839, § 3(d); Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess., §§ 1853(e), (f) ("Blue Dog" Proposal, requiring each MCO to provide "meaningful procedures for hearing and resolving grievances"); Clinton Medicare Proposal, § 1851(E)(c)-(d) (using practically the same language); H.R. 2491, 104th Cong. 1st Sess., §§ 1852(f), (g); PA. House Bill No. 1866, § 5.7.

Many MCOs now have internal reviews and accrediting groups. The National Committee for Quality Assurance also requires such procedures.

99 NAIC Model Grievance & Utilization Procedures, PA. H.B., 1866 § 3. *See also* The Common Sense Balanced Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess., 1853(e) (requiring appeals from denials of coverage to be decided within thirty days and requiring that decisions about denials of coverage based on lack of medical necessity be made only by physicians).

eral consumer proposals would have appeals decided by neutral parties unaffiliated with the organization.[100]

Public records of consumer grievances can be useful sources of information on problems in MCOs for consumer advocates or public officials.[101] When information is publicized, it will encourage firms to change or risk losing customers. Nevertheless, studies show that grievance procedures are often time consuming and costly. Many MCOs set up internal grievance procedures that

---

100 LEGAL ACTION CENTER, PRINCIPLES FOR REGULATING UTILIZATION REVIEW; COALITION FOR CONSUMER PROTECTION AND QUALITY IN HEALTH CARE REFORM, WHITE PAPER ON CONSUMER DUE PROCESS PROTECTION (Nov. 30, 1993);

See also Bente Cooney, Testimony to Coalition for Consumer Protection and Quality in Health Care Reform, House Committees on Energy and Commerce (Nov. 3, 1993) ("The Coalition believes that consumer notice, appeal, and grievance rights, collectively referred to as 'due process' rights, are essential in any national health care plan."); Dallek statement, *supra* note 81 ("All managed care enrollees should have available to them an expedited appeals system operating independently of the managed care plans for denials/delays in treatment that could seriously jeopardize their health or well being."); Alfred Chipman, National Senior Citizen's Law Center, testimony before Senate Committees on Finance and Health (Apr. 29, 1994) ("[A]ccess to an independent and timely appeals process is critical for maintaining quality of care for consumers"); Health Care Consumer Protection Act of 1995, Assem. Bill, 6800 (New York) (Health Care Consumer Protection Act of 1995); Medicare Health Quality Act of 1995, S. Res. 1024, 104th Cong., 1st Sess., § 4, 5 (1995); Health Care Quality and Fairness Act of 1995, S. Res. 609, 104th Cong., 1st Sess., § 301 (setting standards for internal reviews and section 406 creating an independent appeals process). Section 1851(E)(d) of the Clinton Medicare Proposal requires that each organization provide review by an external contractor if an enrollee is not satisfied with an appeals decision made by the organization. Two petitions for a ballot initiative in California are proposing the 1996 Patient Protection Act and the 1996 Health Care Patient Protection Act. Both would prevent HMOs from denying care recommended by a patient's treating physician, unless the denial is based on a physical examination by a qualified professional. *See* 2 Managed Care Rep. (BNA) No. 20 (Mar. 6, 1996), at 222. *See also* COALITION FOR CONSUMER PROTECTION AND QUALITY IN HEALTH CARE REFORM, WHITE PAPER ON CONSUMER DUE PROCESS PROTECTION (Nov. 30, 1993).

Certain bills would assist consumers in the grievance process. For example, California Assembly Bill 454 allows providers to assist HMO members present grievances to the Department of Corporations. California Senate Bill 689 authorizes the Department of Corporations to establish a toll-free telephone complaint line funded by assessments on the MCOs themselves.

Proposed regulations in New Jersey add grievance procedures standards. *See* N.J.A.C. § 8:38 (Supp. 1996). These regulations are discussed also in *New Jersey Proposed Rewrite of HMO Rules; Closer State Scrutiny Required*, 4 Health Law Rep. (BNA) No. 46, at 1751-52 (November 30, 1995).

101 LAUREN DAME & SIDNEY M. WOLFE, SERIOUS PROBLEMS FOR OLDER AMERICANS IN HEALTH MAINTENANCE ORGANIZATIONS (Public Citizen's Health Research Group).

California has recently enacted a statute that creates a toll-free line for consumers to file grievances and complaints against HMOs and empowers the Department of Corporations to fine HMOs that do not respond to grievances promptly. *See generally* Cal. Senate Bill 454 and Senate Bill 445 signed by Governor Pete Wilson on Oct. 12, 1995; *supra* note 101 and accompanying text.

exhaust the complainant and slow or limit access to courts. Even grievance procedures that use independent reviewers have limitations.[102] To bring an appeal, the consumer must know that he or she has either been denied a service or received poor quality of care; believe that the MCO has acted improperly; be hopeful that filing a grievance may provide a remedy; have the time and resources to pursue the matter; and think it worth the cost of doing so.[103] These conditions are often absent for those who are ill, poor, or who lack education.[104]

Individual consumers are rarely in a strong enough position to

---

102 The classic case establishing administrative due process rights is Goldberg v. Kelly, 397 U.S. 254 (1970). *See also* PHILIP J. COOPER, PUBLIC LAW AND PUBLIC ADMINISTRATION App. A (2d ed. 1988) (providing an historical narrative of the appeals process and the plaintiffs life in *Goldberg v. Kelly* showing the toll it takes to pursue an appeal); JERRY L. MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE (1985); JERRY L. MASHAW, BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS (1983).

Such due process problems may also arise in arbitration in the private sector too. Indeed, a recent lawsuit claimed that Kaiser Permananente intentionally used its process of binding arbitration for settling malpractice claims in a way that delayed resolution until the claimant husband passed away. *See* Michael A. Hiltzik & David R. Olmos, *"Kaiser Justice" System's Fairness is Questioned*, L.A. TIMES, August 30, 1995, at A1. A California trial court found the arbitration system "unconscionable" and "corrupt . . . in general." *See id.* The Court of Appeals found that the trial court's finding of fraud and unconscionability were not supported by substantial evidence. The court also noted that Kaiser should not be held to a fiduciary standard when negotiating and administering the arbitration provisions of its service agreement and that Kaiser was free to act in its own business interest. *See* Engalla v. Permanente Medical Group, 37 Cal. App. 3d 497, 501-02 (Ct. App.), *review granted* 905 P. 2d 416 (Cal. 1995).

103 *See* JOEL F. HANDLER, THE CONDITIONS OF DISCRETION: AUTONOMY, COMMUNITY, BUREAUCRACY (1986); Judith H. Hibbard & Edward C. Weeks, *Consumerism in Health Care: Prevalence and Predictors*, 25 MED. CARE 1019 (1987); Jane Kolodinsky, *Complaints, Redress, and Subsequent Purchases of Medical Services by Dissatisfied Consumers*, 16 J. CONSUMER POL'Y 193 (1993); Sally Lloyd-Bostock & Linda Mulcahy, *The Social Psychology of Making and Responding to Hospital Complaints: An Account Model of Complaint Processes*, 16 L. & POL'Y 123 (1994).

See also Arthur Best & Alan R. Andreasen, *Consumer Response to Unsatisfactory Purchases: A Survey of Perceiving Defects, Voicing Complaints, and Obtaining Redress*, 11 L. & SOC'Y REV. 701 (1977); Jagdip Singh, *Determinants of Consumers' Decisions to Seek Third Party Redress: An Empirical Study of Dissatisfied Patients*, 23 J. CONSUMER AFF. 329 (1989).

104 Few Medicare beneficiaries are aware of the process of filing complaints. *See The Beneficiary Complaint Process of the Medicare Peer Review Organization*, Inspector Gen. HHS No. OEI-01-93-00250 (1995). For an analysis of the problems consumers face in bringing grievances in health care and other areas, see, e.g., Hibbard & Weeks, *supra* note 69, at 1030 (finding that those who are at greatest risk for using services and incurring costs are the least prepared to behave as critical consumers); Kolodinsky, *supra* note 104, at 210 (finding that educated consumers, even when dissatisfied with health care service providers, complain infrequently and that the complaints of women and the elderly, in particular, tend to fall on deaf ears); Sally Lloyd-Bostock & Linda Mulcahy, *The Social Psychology of Making and Responding to Hospital Complaints: An Account Model of Complaint Processes*, 16 L. & POL'Y 123 (1994); Best & Andreasen,

challenge producers. They do not control the funds for purchasing services they receive—leverage that might make providers heed their complaints. Third-party payers pay the bills and providers are more apt to cater to their interests.[105]

Moreover, consumers are typically locked into their MCOs for the short run, which fosters dependency, especially in Medicaid where fee-for-service or point-of-service plans are not options. Subscribers can disenroll, but only once a year under most private sector plans.[106] Patients depend on physicians and their MCOs for services. Complaining may jeopardize the relationship or subject the complainer to reprisals.[107]

Another limitation of grievance procedures concerns their impact on other consumers. MCO grievance panels, unlike courts, do not create binding precedents and do not have to justify their decisions. Appeals may resolve a complaint but do not require MCOs to change practices or help consumers with similar problems. Individual remedies sometimes appease the dissatisfaction that could lead individuals to organize for broader change.[108] Therefore, grievance procedures, ironically, might preserve the status quo.

To be sure, however, it is usually better to have due process rights, consumer information, and choice of providers than not: some consumers will make good use of these opportunities. Though not the usual case, sometimes individuals with grievances can change organizational policy, and consumers who shop prudently may affect provider behavior. To be able to go outside the provider network when an organization does not provide good quality care is an escape valve. Nevertheless, consumers who lack

---

supra note 104 (finding that a large number of consumer problems exist and that many are never presented as complaints); Singh, *supra* note 104.

105 Purchasing cooperatives can use their clout for the benefit of their employees, *see* Helen H. Schauffler & T. Rodriguez, *Exercising Purchasing Power for Preventive Care*, 15 HEALTH AFF. 73 (1996). Still, there is no certainty that all firms will act in the interest of employees when making purchasing decisions.

See also 3 DON D. LESCOHIER, HISTORY OF LABOR IN THE UNITED STATES, 1896-1932, 489-514 (1935) (describing the employers campaign to liquidate labor's advantage gained prior to World War I). *See also generally* MARY BEARD, A SHORT HISTORY OF THE AMERICAN LABOR MOVEMENT v (1924) (providing a brief history of the American labor movement from American independence to the 1920s).

106 An exception is the current Medicar risk contract program that allows Medicare beneficiaries to disenroll within 30 days. However, the Seven Year Balanced Budget Act would allow for disenrollment only once a year.

107 Health Care Quality and Fairness Act of 1995, S. Res. 609, § 406(d); Medicare Managed Care Health Care Quality Act of 1995. S. Res. 1024, § 4 (v).

108 *See generally* Irving Goffman, *On Cooling the Mark Out*, 15 PSYCHIATRY 451 (1952).

the support of advisers, advocates, or organizations face substantial obstacles which make many protection measures—despite their potential benefit—much less effective.

V. THE NEED TO ORGANIZE CONSUMERS' INTERESTS

In the last two decades, the United States consumer movement has been in retreat.[109] Concerns over health care, particularly managed care, may lead to its resurgence.[110] If this occurs, policymakers and advocates should look to problems consumers faced in other fields and the ways in which they were addressed. There are likely to be common issues and experiences that can provide useful lessons.[111]

One important lesson is that consumers fare less well when they face organized producers as individuals rather than as organized groups. When policy or markets affect consumer issues, producers often have their livelihood at stake, whereas an individual consumer's interest in such issues is often episodic or limited. Producers are a relatively small group; consumers are numerous, spread over a wide area, and most often do not know each other.[112] Producers have more ample resources, which consumers lack. These differences make it much harder for consumers than for producers to organize and protect their interests.[113]

In managed care, too, the disparity between producers and

---

109 *See generally* MICHAEL PERTSCHUK, REVOLT AGAINST REGULATION: THE RISE AND PAUSE OF THE CONSUMER MOVEMENT (1982). For a more developed discussion of the need for and prospect of organized consumer advocacy, see Marc A. Rodwin, *Consumer Protection and Managed Care: The Limitations of Reform Proposals and the Need for Organized Consumer Advocacy*, 15 HEALTH AFF. No. 3 (1996).

110 *See* Thomas W. Malone & Barbara Paul, *The Consumer Movement Takes Hold in Medical Care*, 94 HEALTH AFF. 268 (1991).

111 For a general overview of consumer movements, see DAVID A. AAKER & GEORGE S. DAY, A GUIDE TO CONSUMERISM, CONSUMERISM: SEARCH FOR THE CONSUMER INTEREST (1978); ALAN R. ANDREASEN, THE DISADVANTAGED CONSUMER (1975); ARDITH MANEY & LOREE BYKERK, CONSUMER POLITICS: PROTECTING PUBLIC INTERESTS ON CAPITOL HILL (1994).

112 *See* JAMES Q. WILSON, THE POLITICS OF REGULATION (1980) (Chapter 10).

113 For discussion of the difficulties consumers have in organizing to advance their collective interests, see generally, STUART CHASE & F. SCHLINK, YOUR MONEY'S WORTH: A STUDY IN THE WASTE OF THE CONSUMER'S DOLLAR (1927); JESSIE V. COLES, THE CONSUMER-BUYER AND THE MARKET (1938).

The difficulties consumers have in organizing explains, in part, why it is more difficult for consumers than producers to effectively lobby for legislation that promotes their interests. *See* PAUL J. FELDSTEIN, THE POLITICS OF HEALTH LEGISLATION (1988). For a discussion of the decline and rise of the power of business in influencing American public policy, see DAVID VOGEL, FLUCTUATING FORTUNES: THE POLITICAL POWER OF BUSINESS IN AMERICA (1989).

consumers is great. Third-party payers, MCOs, hospitals, physicians, and other medical personnel all have the benefit of organizations to advance their interests. Unorganized, those who receive medical services lack the means to assert their purchasing power or make their voice heard collectively.

The lack of funded, institutionalized organizational advocacy for consumers within MCOs places them at a competitive disadvantage compared with other key constituencies. One way to address this problem is to create institutions that help consumers organize or pool resources, expertise, purchasing power, information, or professional assistance.[114] Medical consumerism has been most effective where there has been organized advocacy—as in the womens' health movement and the disability rights movement—and when people with a common illness, such as AIDS, breast cancer, or polio, have organized to voice their concerns. The near absence of proposals that promote organized advocacy for consumers of managed care is striking.[115]

---

114 Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. & MED. 147-67 (1994). Representing consumer interests has frequently been unsuccessful. For a discussion of problems in representing consumers in health care, see James A. Morone & Theodore R. Marmor, *Representing Consumer Interests: The Case of American Health Planning*, 91 ETHICS 431 (1981); *see also* JAMES A. MORONE, THE DEMOCRATIC WISH: POPULAR PARTICIPATION AND THE LIMITS OF AMERICAN GOVERNMENT (1990); Charles W. Anderson, *Political Design and the Representation of Interests*, 10 COMP. POL. STUD. 127 (1977).

For a discussion of self-help strategies, see Irving K. Zola, *Helping One Another: A Speculative History of the Self-Help Movement*, 60 ARCH. PHYS. MED. REHABILITATION 452 (1979).

For a discussion of the limitations of a rights-based approach to social change and the politics of mobilization, see GERALD N. ROSENBERG, THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? (1991); MICHAEL W. MCCANN, RIGHTS AT WORK: PAY EQUITY REFORM AND THE POLITICS OF LEGAL MOBILIZATION (1994).

115 For a discussion of the need for patients to have advocates work on their behalf and for a proposal for the creation of a new profession of patient advocates, *see generally* Max Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WIDENER TOPICS L. 299 (1996); George J. Annas & Joseph M. Healey, Jr., *The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context*, 27 VAND. L. REV. 243 (1974).

Some other scholars have examined the value of group representation. For a discussion of an organized advocacy in Wisconsin, see Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 105 (1994); Louise Trubek, *Making Managed Competition a Social Arena: Strategies for Action*, 60 BROOK. L. REV. 275 (1994); Rand E. Rosenblatt, *On Access to Justice, Discrimination and Health Care Reform*, Testimony before Health and Environment Subcommittee, Energy and Commerce Committee (Feb. 14, 1994); Sylvia A. Law, *A Right to Health Care That Cannot Be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771 (1994).

For an example of consumer involvement drawn from community health centers, see, George Sparer, et al., *Consumer Participation in OEO-Assisted Neighborhood Health*

There are several ways to promote advocacy. One which may soon be tested in a trial project is noteworthy. The Medicare Beneficiaries' Defense Fund (MBDF) is seeking to organize seniors within a community and to work on their behalf.[116] The MBDF would serve as an institutional patient advocate: an ombudsman to evaluate the performance of MCOs, to respond to telephone queries, and to report on the kinds of problems members experience in different MCOs. MBDF will seek funds from subscribers, initially selling its services to unions for their members and to firms for their retired employees. It also expects to market its services through organizations that provide financial services to the general public.

Although some MCOs might shun working with MBDF or similar advocacy groups, others will not, for there would be benefits: a likely increase in enrollment from members or individuals they already advise; the potential for improved quality of care and patient satisfaction; and the publicity about MCOs concerned with the consumer's perspective.

The American Medical Association and other groups have proposed physician-owned MCOs, and physician groups and medical societies have started several such organizations.[117] Likewise, consumers can also protect their interests through cooperatively owned MCOs. Despite the use of consumer cooperatives in other areas and a couple of examples of cooperative HMOs, consumer advocates have hardly discussed the idea.[118] The main example,

---

Centers, 60 AM. J. PUB. HEALTH 1091 (1970); *see also* Arthur Best & Bernard L. Brown, *Governmental Facilitation of Consumerism: A Proposal for Consumer Action Groups*, 50 TEMP. L.Q. 253 (1977).

116 Interview with Diane Archer, Executive Director, Medicare Beneficiaries Defense Fund (June 1995).

117 *See* Edward Hirschfeld, *The Case for Physician Direction in Health Plans*, 3 ANNALS HEALTH L. 81 (1994); Brian McCormick, *HMO Sale Boosts Physicians Pay, Threaten Control*, 38 AM. MED. NEWS, Dec. 12, 1994, at 4. Brian McCormick, *Laws Thwart Physician Networks*, 38 AM. MED. NEWS. September 4, 1995, at 1, 42; Arnold A. Relman, *Medical Practice under the Clinton Reform—Avoiding Domination by Business*, 329 NEW ENG. J. MED. 1574 (1993); Adam Yarmolinski, *Supporting the Patient*, 322 NEW ENG. J. MED. 602 (1995).

A report based on data of SMG Marketing Group and the Group Health Association of America indicates that about 6% of group practices have ownership interests in MCO. *See* AMERICAN MEDICAL ASSOCIATION, MANAGED CARE AND THE MARKET: A SUMMARY OF NATIONAL TRENDS AFFECTING PHYSICIANS (1995). It is likely that the HMOs and PPOs owned have a small market share so that the percentage of consumers who are covered under such physician-owned MCOs is probably much smaller than the 6% figure might lead one to suspect.

118 Group Health Association of Washington, D.C., was the other main example. It had financial problems and was purchased by Humana in 1994. For a history of the

Group Health Cooperative of Puget Sound, was founded in 1947 and has become a major MCO in Seattle. However, today many individuals are enrolled through their employers without representation rights as cooperative members.

Cooperative ownership or governance is one means to make MCO policies responsive to the consumers. Cooperative ownership might also reduce administrative costs by eliminating profits for shareholders or exorbitant salaries for managers, thereby making possible reduced premiums or better services.

Alliances with employer purchasing groups are another way to promote consumer interests. Many employers have formed purchasing cooperatives to bargain with MCOs about what they will pay and receive.[119] Controlling employer expenditure is a key aim, but getting good value (quality care) is also important.

Purchasing cooperatives have the resources to monitor MCOs. Because they can deliver or withdraw their employees, they also have economic clout. They typically get data on medical care quality, organizational policies and practices, and negotiate the terms under which whey will pay MCOs.[120] They can use their clout to promote consumer interests. The Pacific Business Group on Health (PBGH), for example, has pushed MCOs to increase preventive health programs.[121] PBGH has required that plans target specific preventive services and provide data on how many members received these services. Managed care plans can lose up to 2% of their premiums for all the PBGH's members if their performance falls short of the year's goals. The poorer the performance, the more money is forfeited.[122]

---

cooperative, see EDWARD D. BERKOWITZ & WENDY WOLFF, GROUP HEALTH ASSOCIATION: A PORTRAIT OF A HEALTH MAINTENANCE ORGANIZATION (1988).

For a discussion of how communities might create their own standards for medical care using cooperatives, see EZEKIEL EMMANUEL, THE ENDS OF HUMAN LIFE (1991); Robert Sommer, *Consciences in the Marketplace: The Role of Cooperatives in Consumer Protection*, 47 J. SOC. ISSUES 135 (1991). Ralph Nader started a group called "Buyer's Up" in the Washington, D.C./Baltimore area in the 1980s. Buyer's Up negotiated discounts for heating fuel for consumers. *See generally* Ralph Nader, *Consumerism Through Group Activity*, 8 MOBIUS 12 (1989).

[119] General Accounting Office, *Access to Health Insurance: Public and Private Employers' Experience with Purchasing Cooperatives*, No. GAO/HEHS-94-142 (1994).

[120] Such purchasing cooperatives are taking on functions traditionally viewed as regulatory functions of government. Purchasers of medical care have found that contract requirements and specifications are akin to regulation. *See* JON B. CHRISTIANSON & DIANNE G. HILLMAN, HEALTH CARE FOR THE INDIGENT AND COMPETITIVE CONTRACTS: THE ARIZONA EXPERIENCE (1986).

[121] *See* Schauffler & Rodriguez, *supra* note 106.

[122] The Pacific Business Group also provides financial incentives for firms to report data on prevention programs where it has not previously been available, such as smok-

Purchasing cooperatives act for their employees informally.[123] The actions of employers may diverge from the interests of employees.[124] The history of labor-management conflicts attests to that.[125] Nevertheless, there can be alliances and purchasing cooperatives may become one of them if labor and consumer groups assert their interests.

There is also the prospect of consumer alliances with physician groups. Many consumer protection bills recently introduced in state and federal legislatures were drafted and backed by coalitions of consumers and physicians. These bills seek expanded choice of providers for patients—goals that serve the interests of consumers and physicians alike. They also promote due process rights for consumers who believe they have been improperly denied services and physicians who think they have been unfairly deselected. Consumer-physician alliances might also jointly own MCOs or pool resources for advocacy within MCOs.

Such alliances, however, have risks. Physicians have conflicts of interest and incentives to act in ways that do not promote patients' interests.[126] For example, physician-owned networks have lobbied for exemptions from financial reserve requirements and many bills drafted by consumer-physician coalitions would require MCOs to accept services from any willing provider and allow patients to choose from among them.[127] Such clauses impair the ability of MCOs to control quality or costs and have galvanized the

---

ing cessation rates. Once a plan shows that it can collect reliable data, the Pacific Business Group negotiates with the plan to set performance targets and the managed care plan is then offered incentives to meet the targets.

123 The issue of consumer representation for purchasing cooperatives is discussed by Walter Zelman in the context of the Clinton Administration health reform proposal. *See* Walter Zelman, *Who Should Govern the Purchasing Cooperatives?*, 21 HEALTH AFF. 49 (Supp. 1993).

124 Businesses may, for example, be more interested in reducing their health expenditures than in improving the quality of the care their employees receive. A survey of MCOs by Foster Higgins finds that many attribute their success to their ability to compete on price rather than quality. *See* Ron Winslow, *In Health Care, Low Cost Beats High Quality*, WALL ST. J., Jan. 18, 1994, at B1, B12.

125 As the history of labor law shows, the interests of employers and employees often differ. Moreover, even if employers want to act in the interest of their employees, the employer's conception of what these interests are may differ from the employee's. *See generally* MARY TITTER BEARD, A SHORT HISTORY OF THE AMERICAN LABOR MOVEMENT (1969); BUREAU OF LABOR STATISTICS, BRIEF HISTORY OF THE AMERICAN LABOR MOVEMENT (1976); JOHN R. COMMONS, HISTORY OF LABOR IN THE UNITED STATES (1935); SELIG PERLMAN, A THEORY OF THE LABOR MOVEMENT (1949).

126 MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993); Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604 (1995).

127 For a survey of "any willing provider" laws, see Physician Payment Review Com-

managed care industry's opposition. The result: the jeopardy of consumer protection legislation for a plank that helps doctors more than consumers. On some issues, consumers will have common interests with physicians rather than management but, on other issues, the reverse will be true. And consumer interests may sometimes be more closely aligned with employers or purchasers.

It is unlikely that consumer organizations or alliances will be sufficient to protect consumers. Governmental agencies have an important role to play in setting standards, monitoring compliance and penalizing illegal conduct. When scandals begin to mount, the public is likely to call for government intervention and for the rebuilding of a new regulatory system to replace the one we are currently dismantling. But a new and perhaps even better system of governmental oversight is likely to be created if consumer organizations help to promote it, and if once in place, consumer organizations will be needed to monitor governmental performance.

---

mission, Annual Report to Congress, Appendix D. *State Responses to Provider and Consumer Concerns About Managed Care* (Physician Payment Review Commission 1995).