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# Canaries in the Coal Mine: The Chronicallly Ill in Managed Care

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# CANARIES IN THE COAL MINE: THE CHRONICALLY ILL IN MANAGED CARE

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**IF HEALTH FINANCE IS THE QUESTION,** managed care must be the answer. As government and employers seek a model of health care finance that contains cost while offering acceptable quality, they turn as one to managed care.[1] Working the most dramatic changes to Medicare and Medicaid since their crea-

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[1] Managed care organizations (MCOs), for purposes of this Article, include health maintenance organizations (HMOs), preferred provider organizations, (PPOs), provider sponsored organizations, (PSOs), and point of service plans (POSs). *See* Eric R. Wagner, *Types of Managed Care Organizations, in* ESSENTIALS OF MANAGED HEALTH CARE, 37, 37-40 (Peter R. Kongstvedt ed., 2d ed. 1997). What unifies these disparate entities for present purposes is a central feature of their organizational structure, by which incentives and restrictions work to reduce the utilization of health care services by covered persons. This organizational feature was nicely stated recently by Professor Eaton:

> While there are different types of managed care organizations (MCOs), they share the common characteristic of integrating to some extent the payment and provider function. Cost are controlled through a complex web of agreements among payers, providers and patients. These agreements tend to advance the cost containment objective by limiting the patient's choice of physicians and hospitals, limiting provider compensation for services, and establishing financial incentives that discourage the use of expensive technologies and specialists. Thus, the managed care paradigm is one of vertical and horizontal integration rather than one of independent actors.

Thomas A. Eaton, *Adapting Old Rules for a New Paradigm,* 31 GA. L. REV. 367, 368 (1997) (focusing on how to apply principles formulated under a traditional fee-for-service health plan to managed care). *See also* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting,* 22 AM. J. LAW & MED. 173, 174-76 (1996) (analyzing the effect of capitation, the payment of a per-month flat fee for a comprehensive array of care, and a central financial aspect of managed care, to the evolution of health care delivery systems).

tion in 1965,[2] the Balanced Budget Act of 1997[3] reconfigured those programs to shift beneficiaries from fee-for-service to managed care systems.[4] In addition, the Balanced Budget Act of 1997 created a new Title XXI of the Social Security Act, (State Children's Health Insurance Program), which extends health coverage to a broad range of uninsured children. This new program also permits states to provide covered services through managed care plans. This shift treats beneficiaries of those public programs more nearly like those receiving employment-based coverage,[5] who are now overwhelmingly subject to managed care.[6] The subject of this Article is a subset of the population – the chronically ill – that comes late to managed care.[7] Historically, managed care has ap-

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[2] *See* Social Security Act of 1965, Pub. L. No. 89-97, 79 Stat. 291 (codified as amended at 42 U.S.C. §§ 1395-1395ccc (1998)) (adding Medicare to the Social Security Act) *and* 42 U.S.C. 1396-1396v (adding Medicare to the Social Security Act).

[3] The Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered sections of the U.S. Code).

[4] *See* 42 U.S.C. §§ 1395 w-21 -28 (creating "Medicare+Choice" as Part C of Medicare) *and* § 1396u-2(a)(1)(A) (amending Medicaid to give states, for the first time, general license to "require an individual who is eligible under the State plan under this subchapter to enroll with a managed care entity as a condition of receiving such assistance").

In addition, the Balanced Budget Act of 1997 created a new Title XXI of the Social Security Act, P.L. 105-33, sections 2101-2110 (State Children's Health Insurance Program), which extends health coverage to a broad range of uninsured children. This new program also permits states to provide covered services through managed care plans. *See also* 42 U.S.C.A. § 1397aa (West Supp. 1998).

[5] *See* Kenneth E. Thorpe, *The Health System in Transition: Care, Cost, and Coverage*, 22 J. HEALTH POL. POL'Y & L. 339, 340 (1997) (exploring the health care system's change from a more passive model to a managed care system and analyzing the effect of growing competitive forces on patient care and costs of care).

[6] *See* Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan.-Feb. 1997, at 125, 125 (noting that, as of 1995, "[n]early three-quarters of U.S. workers with health insurance now receive that coverage through a health maintenance organization (HMO), a preferred provider organization (PPO), or a point-of-service plan"); Prospective Payment Assessment Comm'n, Medicare and the American Health Care System, 26 (1997) (noting that a 1996 survey of firms employing at least 200 workers found that 75% of employees with insurance were enrolled in managed care plans); Jinnet B. Fowles et al., *Taking Health Status Into Account When Setting Capitation Rates: A Comparison of Risk-Adjustment Methods*, 276 JAMA 1316, 1316 (1996) (stating that, by 1995, managed care covered approximately 71% of employees with employer-sponsored health insurance).

[7] Chronic illnesses, for present purposes, are "long-term conditions that encompass diseases, injuries with long sequelae, and prolonged structural, sensory, and communications abnormalities. They manifest themselves in physical or mental impairments, and they emerge both at birth and throughout the lifespan." Lewis G. Sandy & Rosemary Gibson, *Managed Care and Chronic Care: Challenges and Op-*

pealed to, and therefore has disproportionately enrolled, well members.[8] This is changing, as deep market penetration in the pri-

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*portunities, in* MANAGED CARE AND CHRONIC ILLNESS: CHALLENGES AND OPPORTUNITIES 8, 9 (Peter D. Fox & Teresa Fama eds. 1996). *See also* Bruce Jennings et al., *Ethical Challenges of Chronic Illness,* HASTINGS CENTER REP., supp. (Feb./Mar. 1988), at 1, 4, defining chronic illness as:

> [A] condition that lasts for a substantial period of time or has sequelae that are debilitating for a long period of time. It is also commonly defined as a condition that interferes with daily functioning for more than three months in a year, causes hospitalization for thirty days or more per year, or (at the time of diagnosis) is likely to do either of these.

*See also* Medical Payment Advisory Comm., Report to the Congress: Context for a Changing Medicare Program 143 (June 1998) (giving definitions and overviews for vulnerable populations in Medicare managed care) [hereinafter Context for a Changing Medicare Program]; JON B. CHRISTIANSON ET AL., RESTRUCTURING CHRONIC ILLNESS MANAGEMENT: BEST PRACTICES AND INNOVATIONS IN TEAM-BASED TREATMENT 3 (1998) (discussing attempts to develop more precise definitions of chronic illness); Catherine Hoffman et al., *Persons With Chronic Conditions: Their Prevalence and Costs,* 276 JAMA 1473, 1474 (1996) (estimating that "total costs projected to 1990 for people with chronic conditions amounted to $659 billion and stating that although concerns about the costs of chrome conditions, few studies about them have been performed). In short, the chronically ill have characteristics that provide managed care plans economic disincentives to enroll or treat. *See* Context for a Changing Medicare Program, *supra,* at 145 (detailing the relationship between the chronically ill and managed care organizations); Joseph Newhouse et al., *Risk Adjustment and Medicare: Taking A Closer Look,* HEALTH AFF., Sept.-Oct. 1997, at 26, 28 (discussing the access problems faced by chronically ill seeking to enroll in health plans).

[8] *See* Patricia Neuman et al., *Marketing HMOs to Medicare Beneficiaries,* HEALTH AFF., July-Aug. 1998, at 132, 138 (discussing how Medicare HMOs advertise to target healthy seniors); Bryan Dowd et al., *An Analysis of Selectivity Bias in Medicare AAPCC,* HEALTH CARE FINANCING REV., Spring 1996, at 35, 36-37; John M. Neff & Gerard Anderson, *Protecting Children With Chronic Illness in a Competitive Marketplace,* 274 JAMA 1866, 1867 (1995) (discussing the ways in which managed care plans influence and who will enroll in other health care plans and stating that "it is possible that some fully capitated managed care plans may try to discourage families of children with chronic illnesses from enrolling"); MEDICARE PAYMENT ADVISORY COMM., REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (Mar. 1998) (describing why risk adjustment is necessary under Medicare); PHYSICIAN PAYMENT REVIEW COMM., ANNUAL REPORT TO CONGRESS (1996) (Medicare enrollees); Gerald Riley *et al., Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994,* HEALTH CARE FINANCING REVIEW, Spring 1996, at 65 (finding that the Medicare payment formula for HMOs does not adequately adjust for the better health and consequent lower costs of HMO enrollees and discussing suggestions for improvement); Gail R. Wilensky & Louis F. Rossiter, *Patient Self-Selection in HMOs,* HEALTH AFF., Spring 1986, at 66, 68 (citing evidence of biased selection among HMOs). *But see* Teresa Fama et al., *Do HMOs Care for the Chronically Ill?,* HEALTH AFF., Spring 1995, at 234, 242 (reporting extensive data analysis and finding that those privately insured, noninstitutionalized persons under age sixty-five who are covered by HMOs are as likely to be chronically ill as those covered by indemnity insurance).

vate market,[9] and increasing use by Medicare[10] and Medicaid,[11] sweeps the chronically ill into managed care plans in large numbers.[12]

The thesis of this Article is twofold. First, the broadening of managed care's enrollment base poses problems for the chronically ill, for governmental and business payers, and for the well population. Most obviously, the chronically ill may be exposed to harm as they move into managed care. In addition, payers may experience a resurgence of health care costs if managed care fails to enroll or properly care for the chronically ill. Further, the well population, uneasy about the care offered by managed care, but unable to assess directly the promises of quality services offered by plans, can evaluate plans through the more intense experience of the chronically ill. In this sense, the chronically ill will serve as "canaries in the coal mine." Their treatment by MCOs is a bellwether of the care to be provided to wider society.

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[9] *See* Jensen et al., *supra* note 6, at 126 (noting that, as of 1995, 73% of Americans receiving health insurance through their employer were enrolled in managed care plans); Douglas R. Wholey et al., *HMO Market Structure and Performance: 1985-1995*, HEALTH AFF., Nov.-Dec. 1997, at 75, 77 (stating that HMO enrollment jumped from approximately 19 million members to approximately 58 million members from 1985 to 1995).

[10] *See* Medicare: HCFA Should Release Data To Aid Consumers, Prompt Better HMO Performance, GAO/HEHS-97-23 at 14 (October 1996) ("Between August 1994 and August 1996, enrollment in Medicare risk-contract health maintenance organizations (HMO) rose by over 80 percent (from 2.1 million to 3.8 million) . . ."). Risk-contract HMOs are those providing Medicare coverage pursuant to section 1876 of the Social Security Act. Risk contracts under that section will be phased out in favor of the financial arrangements in Medicare+Choice. *See* 42 U.S.C.A. § 1395mm(k) (West Supp. 1997).

[11] *See* Health Care Financing Administration, *National Summary of Medicaid Managed Care Programs and Enrollment* <http://www.hcfa.gov/medicaid/trends97.htm> (last modified Feb. 27, 1998) (showing that the proportion of Medicaid population enrolled in managed care has increased from 9.53% in 1991 to 47.82% percent in 1997); *see also* Colleen M. Grogan, *The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns*, 22 J. HEALTH POL. POL'Y & L. 815, 815 (1997) (discussing that the Medicaid managed care reform is about cost control, improving patient access, and addressing welfare concerns, and stating that "by January 1995 all states (except Alaska) had implemented some type of Medicaid managed care program").

[12] *See* Karen Kuhlthau et al., *Assessing Managed Care for Children with Chronic Conditions*, HEALTH AFF., July-Aug. 1998, at 42, 43 (reviewing how well the Health Plan Employer Data and Information Set (HEDIS) assesses care for chonically ill children in managed care covers an increasing number of children with chronic conditions); *see also* Sandy & Gibson, *supra* note 7, at 8 (examining Medicare and Medicaid's use of managed care for the chronically ill).

The secondary thesis is that the ability of managed care to provide appropriately for the chronically ill is the acid test for managed care's dominance of health care finance in the future. If managed care can smoothly move from a system of care for the basically well to one for all Americans, it can lay legitimate claim to dominance of health care finance. If it is unable to accommodate coverage of the large, growing, disproportionately needy and expensive chronically ill population, its social usefulness as an economic form will have reached a significant limit, and we will look elsewhere for a unifying model of health care finance, or agree that managed care can serve as a health finance system for only a portion of the population.

Health care costs for the chronically ill are higher – often dramatically higher – than those of persons with acute illnesses only.[13] And health care is also different in kind for this group, with an emphasis on "specialist care, supportive care, and non-medical social services."[14] Simply stated, what works – in terms of cost and quality – for the well may not work for the ill. If it does not, then society's reliance on managed care to solve our health financing problems is misplaced. Section I of this Article describes the assumed bargain that runs between society and commercial managed care plans, and describes a group increasingly touched by that bargain: the chronically ill. Section II then describes why we should be concerned by the fit between managed care and the chronically ill. Section III describes the efforts that have been, and might be, made to retrofit commercial managed care to accommodate the chronically ill, and evaluates the likelihood that such efforts will be successful. Section IV examines two avenues available should retrofitting commercial managed care to suit the needs of the chronically ill not succeed: centralization of the allocation of enrollees to MCOs, and employing mixed-model reimbursement,

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[13] *See* Hoffman et al., *supra* note 7, at 1476 (comparing $272.2 billion in costs for people with chronic conditions with $85.7 billion for people with acute conditions). *See also* Neff & Anderson, *supra* note 8, at 1867 (discussing the disproportionately higher costs of providing health care to chronically ill children); Sarah McCue Horwitz & Ruth E.K. Stein, *Health Maintenance Organizations vs Indemnity Insurance for Children with Chronic Illness*, 144 AM. J. DISEASES CHILDREN 581 (1990) (providing an account of the time and expense incurred by hospitals and families in caring for chronically ill children).

[14] Context for a Changing Medicare Program, *supra* note 7, at 145. *See infra* Section IV and text accompanying notes 236-41 (discussing care for the chronically ill).

with capitation and fee-for-service reimbursement coexisting for a sizable portion of the population.

## I. THE MANAGED CARE BARGAIN AND ITS INCREASING RELEVANCE TO THE CHRONICALLY ILL

### A. The Bargain

Managed care is ascendant because its perceived ability to coordinate treatment decision making, while applying economic incentives to modify provider and patient behavior, promises containment of health care costs without reduction in quality.[15] Delivering on this promise depends on minimal governmental regulation to prevent gross market failure, such as a precipitous tilt toward cost savings and away from quality.[16]

In a sense, insureds (or, more likely, others on their behalf) have made a wary bargain with managed care. The fee-for-service health care "system" presided over an unacceptable rate of medical inflation. After various formulations of centrally planned managed competition crashed and burned,[17] consumers found themselves

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[15] *See* Paul M. Ellwood & George D. Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083, 1083 (1996) (discussing the past, present, and future implications of managed health care on the quality of care); *see also* Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J. OF L. & MED. 399, 407-08 (1996) (describing the potentially beneficial effects of incentive payments on managed care, including reduction of unnecessary care and elimination of overcare); Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24, 37-38 (offering examples of managed care's superiority over fee-for-service systems).

[16] *See* Ezekiel J. Emanuel & Lee Goldman, *Protecting Patient Welfare in Managed Care: Six Safeguards*, 23 J. HEALTH POL. POL'Y & L. 635, 640 (1998) (discussing safeguards in the allocation of resources); Paul B. Ginsburg, *The Dynamics of Market-Level Change*, 22 J. HEALTH POL. POL'Y & L. 363, 376-79 (1997) (arguing that public policy has shaped change in health care even though no legislation has been imposed and explaining that state initiatives have been opposed "not only by health plans, but by purchasers, who are sensitive to restrictions on health plans' ability to contain costs"); Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 590 (1997) (discussing the need for legal accountability of MCOs to persons injured due to a failure of quality standards in order to maintain minimal government interference in the industry).

[17] *See* Sven Steinmo & Jon Watts, *It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL. POL'Y & L. 329, 330 (1995) (arguing that the failure to implement national health insurance in the United States can be attributed to institutional bias against comprehensive care); *see also* Hugh Heclo, *The Clinton Health Plan: Historical Perspective*, HEALTH AFF.,

(sometimes without being consulted[18]) in managed care plans regulated only lightly by government on the promise that the marketplace would police both cost and quality.[19] Whether managed care can live up to its end of the bargain in terms of the general, basically well population is the subject of dispute[20] and time and further study will tell.

As managed care finds itself serving the substantial minority of the population with chronic illness, both its cost saving and quality preserving abilities face challenges. The essence of the bargain with managed care depends on its treatment of moral hazard.[21] The fee-for-service system had been plagued famously with this phenomenon, in which those making spending decisions (chiefly physicians and patients) were not meaningfully answer-

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Spring 1995, at 86, 87 (discussing pre-Clinton attempts to achieve national health insurance, noting that, historically, most major social reform efforts have rarely succeeded).

[18] *See* Diane E. Hoffmann, *Emergency Care and Managed Care – A Dangerous Combination*, 72 WASH. L. REV. 315, 349 (1997) (relating how employers increasingly limit employees' choice of health insurance to a single plan); *see also* Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1045-47 (1996) (describing various methods employed unilaterally by employers to reduce costs).

[19] *See* Barry R. Furrow, *Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos*, 43 VILL. L. REV. 361, 396-97 (1998) (defining "accreditation" and discussing its benefits with respect to health care institutions); Paul M. Ellwood & Alain C. Enthoven, *"Responsible Choices": The Jackson Hole Group Plan for Health Reform*, HEALTH AFF., Summer 1995, at 38 (explaining the Jackson Hole Group's accountability system, which operates under a private umbrella organization composed of a broad range of participants).

[20] *See* Harold S. Luft, *Perspectives and Evidence on Efficiency in Managed Care Organizations, in* COMPETITIVE MANAGED CARE: THE EMERGING HEALTH CARE SYSTEM 30, 51-52 (John D. Wilkerson et al. eds., 1997) (discussing the difficulties of analyzing information on HMO and managed care performance, and indicating that rating their perforamnce is becoming more difficult); Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227 (1996) (discussing capitation as a form of managed care and its effect on different segments of the managed care population); Robert Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512 (1994) (comparing the health care utilization, expenditure, quality of care, and satisfaction since 1980 of enrollees in managed care and indemnity plans and concluding that, although several clear patterns of results existed, generalizations must be made with caution).

[21] *See* CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 80-88 (1988) quoting excerpts from PAUL JOSKOW, CONTROLLING HEALTH COSTS: THE ROLE OF GOVERNMENT REGULATION 20-31, 36-39 (1981) (describing the rational disinclination of insureds and their physicians to economize on health care if the patient has rich insurance with low cost-sharing).

able to those funding the coverage (chiefly government and employers) for their choices. Managed care seeks to end the inflationary effect of moral hazard by collocating much of the power to approve and direct treatment with the financial incentive to do so cost-effectively.[22]

As the cost of health care rose, apparently impervious to attempts by payers to intervene, then, managed care descended as *deus ex machina*. The bargain it offers to public and private payers is moderation of health care cost inflation and relief from direct responsibility for the formation, maintenance, and compensation of a seemingly unmanageable array of health care providers. In return, MCOs required the power to control their networks of providers and, in the case of the majority of MCOs that are for-profit, the opportunity to retain a portion of the realized cost savings. Payers, in other words, ship off their headaches of managing providers and of developing ever-more-intrusive methods of controlling costs.[23] The bargain could be characterized as a cynical one, in which payers, sensitive to public approbation and reluctant to take harsh steps to rein in health care costs, hired MCOs as intermediaries to do the dirty work. But there is a non-cynical explanation for the bargain.

When payers attempted to tame inflation with per-unit controls, they were hopelessly outflanked by providers' control over the description of those units of service (leading to, *e.g.*, "DRG creep" and "up-coding"[24]) and providers' control over the volume

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[22] *See* Eaton, *supra* note 1, at 368 (comparing cost-management in fee-for-service and managed care plans).

[23] *See* Matthew, *supra* note 18, at 1046 (discussing the fact that employers are purchasing managed care options in order to lower their premium rates, and thereby, their health insurance costs).

[24] "DRG creep" and "CPT creep" are related phenomena in which health care providers seek to maximize reimbursement in systems using per-unit or per-case payment. DRGs are diagnostic related groups, a designation of an inpatient case that forms a unit of care for hospital reimbursement purposes. CPT (Current Procedural Terminology) codes are designations of medical procedures used for many purposes, including physician reimbursement. Hospitals and physicians engage in DRG creep and CPT creep (or upcoding) when they represent hospital cases or procedures as relatively highly reimbursed cases or procedures, when they could or should be described as belonging in lesser categories. *See* Peter R. Kongstvedt, *Compensation of Primary Care Physicians in Open Panel Plans*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 1, at 135 (discussing problems associated with the use of unmanaged fee-for-service plans).

of services.[25] Price controls, then, often resulted in increases in volume, and therefore failed to contain costs.[26] But MCOs can control costs globally, through more thorough control of providers. MCOs achieve much of their cost saving not through direct rationing or explicit restrictions in services,[27] but by creating incentives for "down-stream" network providers to economize. These incentives arise through now well-understood payment mechanisms such as capitation and performance bonuses and withholds, and through "economic credentialing," by which providers' initial or continued membership in the MCOs' networks depends on an assessment of the "efficiency" of their practice habits.[28]

This flipping of providers' incentives to treat – turning a marginal medical procedure from an opportunity for gain to an opportunity for loss – promises to control medical inflation. But the bargain between payers and MCOs is for moderated cost *and* undiminished quality. In theory, MCOs are able to achieve the quality piece of the bargain through the same mechanism that allows price moderation: close control over provider networks.[29] And payers

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[25] *See* Peter D. Fox, *Applying Managed Care Techniques in Traditional Medicine*, HEALTH AFF., Sept.-Oct. 1997, at 44, 45 (discussing general aspects of managed care, such as its attempts "to maximize the value of the health care dollar" and to exclude from consideration "measures whose primary focus is price-per-unit service").

[26] *See id.* at 45 (stating that "the Federal government has had far greater success in controlling unit costs than in controlling utilization").

[27] Some explicit restrictions, of course, exist, such as limits on the pharmaceuticals to which a member may have access, or on the hospitals from which he may obtain service. *See* Barry R. Furrow, *Managed Care Organization and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 446-51 (1997) (illustrating restrictions on subscriber choices in cases where plaintiffs claimed that injuries resulted from the unwillingness of providers to pay for certain treatment options). In addition, the effect of financial incentives used by MCOs to control provider behavior appears indistinguishable in effect from rationing in some cases. *See id.* at 465-69 (discussing lawsuits based on the failure of cost-containment activities such as financial incentives directed toward physicians); *see also* John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 710-19 (1997) (characterizing the cost-saving control and pressure as subtle and overt, in addition to describing incidents and factors that have caused consumers to doubt the loyalty of care givers).

[28] *See* Blum, *supra* note 1, at 182-83 (evaluating the pros and cons of hospitals' use of economic variables in credentialing of physicians).

[29] *See* Alice G. Gosfield, *Who is Holding Whom Accountable for Quality?*, HEALTH AFF., May-June 1997, at 26, 36-37 (discussing the means used by health care plans to hold providers accountable, such as credentialing, selection, and termination of providers based on quality factors). *See generally* Pamela B. Siren & Glenn L. Laffel, *Quality Management in Managed Care*, *in* ESSENTIALS OF MANAGED HEALTH

(and consumers) can (again, in theory) monitor that quality efficiently, because each MCO provides a coherent set of services through an organized, testable set of providers, rendering it accountable by means of reporting and analysis by private and public quality analysis mechanisms.[30] So MCOs promise to reduce medical inflation, maintain quality, undertake the day-to-day network maintenance tasks, and to be accountable in their performance.

There is some evidence that payers' switch to managed care has netted them price moderation without measurable diminution in quality, at least with non-chronically ill populations. Therefore, payers can be seen as rationally and non-cynically buying into the bargain with managed care. They are "privatizing" their health coverage by handing over to MCOs broad responsibility for providing a defined set of health care services to a group of enrollees at a set price.[31]

Assume for present purposes that this stratagem is or can be successful for the first wave of the well, largely volunteer, managed care members.[32] Can the deal hold for the next wave of enrollees – the elderly and disabled? This group of enrollees poses significant problems for "privatized" managed care. These structural problems are embedded in the bargain itself, and the con-

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CARE, *supra* note 1, at 274-98 (1997) (describing various management methods undertaken by MCOs to control quality).

[30] *See* Barry R. Furrow, *supra* note 19, at 396-404 (discussing the private accreditation of health care institutions and the National Committee on Quality Assurance (NCQA) standards); *see also* Jacobi, *supra* note 27, at 766-70 (discussing "independent systems of quality evaluation").

[31] "Privatization" is the proper term for this phenomenon with public payers such as Medicare and Medicaid. Those programs eliminate the public function of network formation, maintenance, and compensation by contracting with MCOs on a capitated basis. For private payers, the more proper term for this ceding of function would be "contracting out."

[32] The day of meaningful consumer choice between managed care and non-managed care plans may soon be over, even in the private sector. As Donald Moran has recently observed;

> Up until a few years ago it was possible for most Americans to avoid managed care benefits options at only a modest incremental cost in terms of premiums and copayments. Within the past few years, however, the price differential between managed and unmanaged care options has risen, and many private employers are restructuring their health benefits to expose beneficiaries to the full incremental cost of selecting less-managed options. In this environment, plans find themselves enrolling a growing number of "involuntary recruits". . . .

Donald W. Moran, *Federal Regulation of Managed Care: An Impulse In Search Of A Theory?*, HEALTH AFF., Nov.-Dec. 1997, at 7, 14.

tinuing validity of the bargain may depend on the existence of solutions for these problems.

## B. The Chronically Ill

Medical and public health progress in this century has steadily advanced life expectancy, creating cures for previously fatal diseases, and reducing or ending threats of previously virulent infectious diseases.[33] As a result, Americans who in prior times would have died of acute conditions now increasingly survive and thrive, often living with long-term chronic conditions.[34] The chronically ill live with long-term, even permanent conditions such as cancer, cystic fibrosis, muscular dystrophy, spina bifida, and heart disease.[35]

The number of Americans with significant chronic illnesses is very large, and growing. Perhaps the most widely cited recent study of chronically ill Americans was published in 1995 by the Institute for Health and Aging at the University of California, San Francisco.[36] This study examined the results of several large surveys, and estimated the number of Americans with a significant

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[33] *See* Christine K. Cassel, *Issues of Age and Chronic Care: Another Argument for Health Care Reform*, 40 J. AM. GERIATRICS SOC'Y 404, 404 (1992) (stating that almost 80% of the population in the United States now survives past the age of 65).

[34] *See id.* at 404 (footnotes omitted):

> The successes of 20th century society and medicine have led to a shift from the predominance of acute illness to a predominance of chronic illness in all age groups. By preventing death from infectious diseases and postponing death from degenerative diseases such as coronary artery disease and stroke, the vast majority of premature deaths have been prevented, allowing almost 80% of the population in the United States to survive past the age of 65. This phenomenon accounts for the increasing life expectance of Americans and also for the increasing prevalence of chronic non-fatal diseases of old age such as arthritis, visual and hearing disorders, and dementia. On a smaller scale, but just as impressively, disabilities of childhood can now be survived, and many people now live their entire life span with major motor or cognitive disabilities. For example, we are seeing studies of the aging of persons with major spinal cord injury and paralysis. Children with severe sickle cell disease or cystic fibrosis are surviving, at least into young adulthood, but now with significant ongoing chronic disease and need for medical care. These survivors, both young and old, are products of a developed and aging society.

*Id.* (footnotes omitted).

[35] *See id.* (noting that medical advances and studies which result in increasing life expectancy are characteristics of an advanced civilization); Jennings et al, *supra* note 7, at 4 (noting that individuals with chronic illnesses vary widely in the severity and manageability of their impairments).

[36] Hoffman et al., *supra* note 7, at 1474.

chronic condition, which was defined as an impairment or a condition that "creates persistent and recurring health consequences, lasting for periods of years (not days or months)."[37] The study estimated that about 100 million Americans had at least one such chronic condition in 1995.[38] The authors noted that this estimate exceeded expectations, perhaps reflecting common confusion between the concepts of chronic illness and impairment – the latter being both the narrower category and the more frequent subject of data analysis.[39] The Institute for Health and Aging study went beyond those with impairments, also counting those "living normal lives" but under a threat of "recurrent exacerbations" such as elevated health care costs.[40] The Institute's choice of the broader definition seems entirely appropriate in light of its purpose. It was primarily interested not in the ability of disabled persons to undertake activities of daily living, but in the financial impact of a large and growing population of chronically ill on maintaining and reforming American health care finance.[41] Even if a more restrictive definition is applied, limiting the chronically ill to those with an "ongoing functional impairment," the number of chronically ill can be estimated at about forty million.[42] And the chronically ill span the age spectrum, as ten to thirty percent of children experience chronic illness to some degree, with ten percent dominating health expenditures, the majority of whom "have one or more severe chronic illnesses."[43]

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[37] *Id.* at 1474.

[38] *Id.* at 1477. *See* Christianson et al., *supra* note 7, at 1 (citing Institute for Health and Aging study).

[39] Hoffman et al., *supra* note 7, at 1477.

[40] *Id.*

[41] *See id.* at 1474:

> Successful cost containment will have to address the needs of this relatively small group with extreme medical needs. This realization has contributed in part to the emergence of managed care organizations as a dominant form of health insurance coverage .... Despite ... concerns about the costs of managing chronic conditions, there are few sources of data that allow us to weigh the overall economic and social impact of chronic conditions.

[42] *See* Sandy & Gibson, *supra* note 7, at 9 (citing the definition of "chronic illness" used by the Robert Wood Johnson Foundation when it made "improving services for people with chronic conditions" a major priority for the 1990s).

[43] Neff & Anderson, *supra* note 8, at 1866 (footnotes omitted) (providing examples of severe chronic illnesses). *See* Horwitz & Stein, *supra* note 13, at 581 ("[d]epending on the way in which chronic illness is defined, between 10% and 20% of U.S. children have some health impairment, and this percentage appears to have risen in recent years").

One significant aspect of chronic illness for present purposes is its association with high medical costs.[44] The Institute for Health and Aging study found that the annualized per capita direct health care costs[45] for the chronically ill were more than three times higher than those for persons experiencing only acute illness: in 1987, $3074 for those with chronic conditions, compared with $817 for those with only acute conditions.[46] Medicare data suggest that the cost of care for beneficiaries with chronic conditions is well over twice the average cost.[47] Analysis of data specific to children suggests that the annual health care costs for chronically ill children can range to five times that of well children.[48] This cost disparity leads to a dramatic skewing of health care cost distributions. For example, in a recent year, one state devoted over seventy percent of its children's Medicaid expenditures to ten percent of the enrolled children, with the remaining thirty percent of the resources spread over the remaining ninety percent of enrolled children.[49] Medicare's experience has been similar for many years, with about eleven percent of Medicare enrollees accounting for over seventy percent of program expenditures.[50] In short, the

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[44] Another is the very different health and social service requirements of the chronically ill. *See infra* Part IV, text accompanying notes 236-41 (describing the unique nature of chronic care, and distinguishing between the treatment goals and approaches of chronic care and acute care).

[45] Costs the authors included in direct health care costs were "hospital stays, physician and other health professional visits . . . prescribed medicines, and medical equipment and supplies." Hoffman et al., *supra* note 7, at 1475.

[46] *Id.* at 1476, Table 2. The difference grows even more dramatic when the per capita cost of those with at least two chronic conditions is contrasted with those with only acute conditions: $4672 vs. $817, in 1987. And the scale of difference remains similar across age classifications. *See id.* at Table 2.

[47] *See* Context for a Changing Medicare Program, *supra* note 7, at 145-48 (using the 1996 Medicare Current Beneficiary Survey (MCBS) conducted by the Health Care Financing Administration (HCFA), to illustrate the differences in cost and enrollment between vulnerable population members and managed care members in general).

[48] Neff & Anderson, *supra* note 8, at 1866 (providing examples of illnesses requiring substantial health care costs).

[49] *See id.* at 1867 (reporting the Washington State Medicaid program data from 1993).

[50] *See High-Cost Users of Medicare Services*, HEALTH CARE FINANCING REV.: MEDICARE & MEDICAID STAT. SUPP., 1996, at 32, 32.

> Medicare program spending is concentrated on a relatively small percentage of enrollees with serious medical problems. As a result, certain groups of beneficiaries account for a disproportionate share of Medicare program payments. In 1994, about 11 percent (4.1 million) of all Medicare enrollees had payments of $10,000 or more and accounted for 73 percent ($106.8

chronically ill have characteristics that provide managed care plans economic disincentives to enroll or treat.[51]

The percentage of those with chronic illness is certain to increase in the future as the population ages. "[B]oth the incidence and the prevalence of all types of chronic illness are positively correlated with increasing age, and rise to particularly high levels in the population over sixty-five."[52] And the American population is aging dramatically. The proportion of Americans over the age of sixty-five is expected to grow from one in eight in 1990 to one in five in 2030.[53] Severe as are the systemic problems presented by the chronically ill today, then, the stakes will only rise in the future.

## II. WHY THE TREATMENT OF THE CHRONICALLY ILL BY MCOs MATTERS

As the above describes, the number of Americans with at least one significant chronic illness is enormous and growing. And as the chronically ill move from fee-for-service to managed care financing,[54] they face the dual dangers of *excluding* and *stinting*. Both problems derive from the nature of the bargain between payers and MCOs, in which the incentive to overtreat is transformed to an incentive to undertreat, and the well patient, rather than the patient in need of a long course of expensive treatment, is the hot commodity. Managing risk, and avoiding it where possible, is central to the success of a managed care plan.

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billion) of all Medicare payments. This distribution of payments has remained stable during the past two decades.

*Id.*

[51] *See* Context for a Changing Medicare Program, *supra* note 7, at 145 (stating reasons why such health plans may not be the best sources of care for the chronically ill); *see also* Newhouse et al., *supra* note 7, at 28 (stating that "plans have incentives to configure themselves such that they will not appeal to bad risks," thus creating access problems for the chronically ill).

[52] Jennings et al., *supra* note 7, at 5.

[53] Hoffman et al., *supra* note 7, at 1478 (commenting on the projected increase of people with chronic conditions due to declining mortality and medical advances). *See* Christianson et al., *supra* note 7, at 1 ("On average, health care costs for individuals with chronic illnesses are three times the costs of the care delivered to others. As the United States's population ages over the next few decades, expenditures for chronic illness care are expected to increase dramatically from this already high level").

[54] *See supra* text accompanying notes 9-12 (explaining how market forces are moving chronically ill patients into managed care plans).

Actuarial assessment of risk is not new with managed care, but has long been central to the business of health insurance.[55] Crucial to the insurer's business judgment is his ability to determine whether the price offered for coverage of an individual or group comports with the expected cost of such coverage.[56] Where uniform prices are offered – that is, where the insurer cannot bargain for a higher premium in cases of higher expected cost – the insurer will, where permitted, prefer the good risk (the person or group with a lower expected cost) to the bad risk (the person or group with the higher expected cost).[57] Such incentives continue to exist when the form of health coverage moves to managed care. Indeed, because the risk assumed under modern, largely managed care-based health insurance is larger than ever (reflecting higher costs of health care), the incentives to pick and choose among potential insureds may be higher.[58] The economic incentive remains, of course, even when a plan is formally obligated to accept all qualified applicants – to eschew risk selection. In addition, modern MCOs seek to contain costs in large measure by taking advantage of their control over the financial incentives of their downstream providers to treat. Common mechanisms of provider reimbursement, such as capitation and financial incentives for utilization control,[59] are therefore capable of more effectively limiting care after a chronically ill person has enrolled.[60]

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[55] *See* KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY AND PUBLIC POLICY 64-69 (1986) (discussing the development of legal policy dealing with risk-assessment insurance classification).

[56] *See id.* at 67 (discussing how risk classification results in lower premiums for healthy insureds, thereby allowing the insurer to attract healthy, low-risk customers and consequently, maintain a high profit).

[57] *See generally id.* at 64-65 (discussing how insurers use both risk-assessment and risk distribution to eliminate the majority of high-risk customers and spread the cost of those who are not eliminated, thereby maintaining the lowest premium rates).

[58] *See* Richard G. Frank et al., *Solutions for Adverse Selection in Behavioral Health Care*, HEALTH CARE FINANCING REV., Spring 1997, at 109, 109-10 (discussing the adverse selection process, in which managed care companies attempt to eliminate costly high-risk members).

[59] *See supra* text accompanying notes 27-28.

[60] *See* Jonathan B. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL. POL'Y & L. 595, 615-16 (1997) (analyzing and comparing the various organizational types of HMOs). *See also* Frank et al., *supra* note 58, at 114 (asserting that HMOs use practices to limit the amount of care they must provide to patients with mental health or substance abuse problems); Linda F. Wolf & John K. Gorman, *New Directions and Developments in Managed Care Financing*, HEALTH CARE FINANCING REV., Spring 1996, at 1, 1-2 (discussing the limiting effects that capitation

Managed care plans can turn risk selection and organizational control to their advantage in two ways. First, they can engage in *excluding*, by which I mean the practice of avoiding enrollment or reenrollment of high-risk, otherwise-qualified persons. Although excluding is often prohibited, the incentives among plans to bend the rules where premium adjustment underreflects expected costs is enormous. The following example gives a sense of the scale of the incentives faced by plans. It describes Medicaid managed care reimbursement in one state, in which the only relevant premium adjustment was to pay a separate rate for disabled and non-disabled persons. Within those two categories, no premium adjustment was made to reflect the wide range of costs within the categories:

> Standard Medicaid practice is to pay plans a percentage (e.g., 95 percent) of the fee-for-service (FFS) average, adjusted in some States for age, gender, and region. For example, in Colorado in 1994, the FFS average for AFDC adults was $1,646 per year, and for recipients with disability, $4,763 per year. If a health plan were somehow able to attract members only from the one-fifth of AFDC adults who were least costly in 1993, the next year the plan could expect to make a profit on each enrollee of $963, or 59 percent of capitation . . . . Conversely, if the plan attracted members only from the most expensive one-fifth of AFDC adults, it would expect to lose $831 per enrollee, or one-half of the capitation. The potential profits and losses for recipients with disabilities are much larger, because of the higher costs involved and because of the much greater predictability. A plan attracting members only from the least expensive one-fifth of recipients with disability in 1993 would earn profits of $4,021 per member, or 84 percent of the capitation; a plan enrolling from the most expensive one-fifth would expect to lose $9,736 per member, or more than twice the capitation.[61]

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has on health care services utilization); Horwitz & Stein, *supra* note 13, at 581 (discussing successful methods HMOs use in limiting medical care expenditures).

[61] Richard Kronick et al., *Diagnostic Risk Adjustment for Medicaid: The Disability Payment System*, HEALTH CARE FINANCING REV., Spring 1996, at 7, 9 (describing "a system of diagnostic categories that Medicaid programs can use for adjusting capitation payments to health plans that enroll people with disability").

Not surprisingly, evidence suggests that plans have acted on the obvious, enormous financial incentives to enroll the healthier members of premium categories.[62] More subtly, plans can locate physicians or facilities more or less accessibly to a disabled population, avoid recruiting physicians with a loyal following among high-risk chronically ill potential enrollees, or interpose barriers to access to specialty care of particular interest to the chronically ill.[63] Where price is sufficiently divorced from cost, then, "it is not healthy for a plan's bottom line to have the reputation of having the best cancer service in town."[64]

The behavior of plans in excluding high-cost (including chronically ill) enrollees encompasses both risk selection (the avoidance by plans of the enrollment of an eligible person due to high expected cost of coverage) and dumping (the failure of plans to renew coverage, either overtly, or by discouraging the high-cost member's choice to renew). A closely related problem for the chronically ill is "stinting," the cost-avoiding behavior of managed care plans in which the chronically ill are denied necessary services.[65] Denial of medically necessary care is not, of course, new with managed care, as indemnity insurers and others have long had

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[62] *See id.* at 7-8 (discussing the necessity of risk adjustment for people with disabilities because "expenditures are not only skewed but also much more predictable than expenditures for the non-disabled population"). *See* Newman et al., *supra* note 8, at 138 (1998) ("Our research . . . finds that, in general, Medicare HMO ads appear to target physically sound and socially active seniors, but not beneficiaries in relatively poor health or beneficiaries who are under age sixty-five and disabled"); Joseph P. Newhouse, *Patients at Risk: Health Reform and Risk Adjustment,* HEALTH AFF., Spring 1994, at 132, 137 (discussing marketing practices including targeting healthy enrollees and offering "tie-ins," such as free health club memberships).

[63] *See* Context for a Changing Medicare Program, *supra* note 7, at 150-51 (discussing strategies that affect plan enrollment and the use of risk adjustment); *see also* Carol Lee & Deborah Rogal, ALPHA CENTER, RISK ADJUSTMENT: A KEY TO CHANGING INCENTIVES IN THE HEALTH INSURANCE MARKET 7 (1997) (discussing the selection methods used by insurers to attract people who are better health risks, despite insurance reforms designed to require insurers to accept risks they might otherwise have avoided); Newhouse et al., *supra* note 7, at 26, 28 (discussing the access problems, expensive efforts to attract good risks, and risk-adjustment deficits caused by the lack of adequate risk-adjustment).

[64] Newhouse et al., *supra* note 7, at 28.

[65] The term "stinting" is borrowed from Newhouse et al., *supra* note 7, at 27. Some MCO behavior could be regarded as either excluding or stinting, such as when an MCO refuses, on a sustained basis, to provide appropriate referrals to specialty care. The denial of such care is important independent of its effect in causing enrollees to exit (or, on the basis of a plan's reputation, not enrolling in) a plan, as individual enrollees are, through stinting, denied medically necessary, covered services. *See infra* text accompanying notes 72-74.

(and acted on) incentives to deny care.[66] The movement of high-utilizing chronically ill enrollees to managed care highlights the concern, however. As is described above, MCOs have both a greater incentive to reduce utilization and a wide array of organizational tools to do so.[67] The great paradox of the application of managed care principles to the chronically ill is that, while MCOs are programmatically capable of providing the coordination of primary and specialty medical care, nursing care, home care, and social services so needed by the chronically ill, they are financially structured to foster incentives to withhold just that care.[68] These cost-containing incentives may be felt with particular severity by the chronically ill, as utilization decisions may favor more familiar preventive and acute services over long-term chronic care.[69] For example, while early intervention and treatment may facilitate a rapid cure of acute conditions, and thereby save money for the plan, the chronically ill typically need *care* rather than *cure,* and

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[66] *See* Bedrick v. Travelers Insurance Company, 93 F.3d 149, 154 (4th Cir. 1996) (reversing an ERISA plan administrator's refusal, on medical necessity grounds, to provide physical therapy to a spastic quadriplegic infant); Zuckerbrod v. Phoenix Mutual Life Ins., 78 F.3d 46, 49 (2d Cir. 1995) (reversing ERISA plan administrator's refusal, on medical necessity grounds, to provide 24-hour private duty nursing); Weaver v. Reagen, 886 F.2d 194, 200 (8th Cir. 1989) (reversing, on statutory grounds, Missouri's Medicaid program's refusal to cover AZT as treatment of HIV disease). *See generally* Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes,* 26 SETON HALL L. REV. 1055 (1996) (using "content analysis" to analyze judicial holdings of health insurance coverage disputes).

[67] *See supra* text accompanying notes 23-31 (describing how MCOs control costs by creating incentives for providers to economize, through mechanisms such as capitation, performance bonuses, and economic credentialing).

[68] *See* Context for a Changing Medicare Program, *supra* note 7, at 144-45 (discussing the organizational structure of MCOs and the pros and cons of providing services, based on this structure, to the chronically ill); *see also* Horwitz & Stein, *supra* note 13, at 581 (discussing how HMOs depend on "low utilization of high-cost services for economic solvency"). *See generally infra* text accompanying notes 102-11 (discussing the irony that managed care plans, which are particularly suited to providing care to chronically ill patients, are designed to exclude them from coverage, or stint their coverage when included, in order to lower costs).

[69] *See* Kuhlthau et al., *supra* note 12, at 43 ("Managed care may improve comprehensiveness of care and coordination among providers of care for children with chronic conditions and their families. However, the cost control strategies associated with managed care may reduce access and quality for children with chronic conditions more than they do for children without such conditions") (footnote omitted).

the rapid provision of treatment therefore entails lesser fiscal payback.[70]

From the perspective of the chronically ill consumer, then, a move to a managed care system of finance poses the dual threats of excluding – by which a plan of choice may be more or less overtly unavailable, and stinting – by which a plan denies medically appropriate care. It is obvious that this behavior would be harmful to the chronically ill. By definition, excluding denies them access to plans, and stinting denies them access to appropriate care should they become members of plans. Should those who are not chronically ill – at least not yet[71] – care about whether the tendencies for excluding and stinting are realized? There are three reasons they should care. First, they should be guided by humanitarian impulses to care about the treatment of the chronically ill. Second, they should be concerned about the loss – in money and opportunity – visited on public and private plans by the disparate treatment of the chronically ill. And third, they should be concerned because poor health care for the chronically ill by MCOs provides a forecast of poor treatment of the non-chronically ill who will nevertheless inevitably require specialty or acute care at some point, and will depend on their plans to be there when the need arises. These three reasons to care are discussed in turn.

We should be concerned about the care of the chronically ill, first, for basic humanitarian reasons. It is simply wrong for the chronically ill, who face the personal and non-medical costs of addressing long-term conditions,[72] to in addition be badly treated

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[70] *See* Horwitz & Stein, *supra* note 13, at 581 (generally explaining how HMOs are not structured to provide cost-effective care to the chronically ill).

[71] *See* Jennings et al., *supra* note 7, at 5 (stating that "[c]hronic care for all who need it in an aging society will place enormous demands on an already exceedingly costly health care system. Now and in the future it may be said that virtually everyone will suffer from a chronic illness at some time during their lives").

[72] A concise description of this phenomenon is provided in Jennings et al., *supra* note 7, at 6.

> For the individual perhaps the most salient general feature of chronic illness is the transformation it causes in the texture of personal and social life. The person is thrust into unfamiliar and often inhospitable worlds – frequent hospital stays and encounters with highly complex, impersonal, and often frightening modes of acute medical treatment; prolonged and inconvenient regimens of medication, special exercise, and restricted diet; a continuing round of bureaucratic hassles with a disjointed system of medical and social service professionals and agencies; the daily prospect of sometimes disabling pain; the perpetual uncertainty that comes from the

by the MCO obliged to provide them with health care. This is a separate point from the more politically charged issue of entitlement to coverage.[73] This Article, notwithstanding Buchanan's quite properly impassioned plea to the contrary, does not examine the problems of the uninsured. The simple point here is that, once a class of persons has been promised defined health coverage by contract, employee benefit plan, or statute, the chronically ill members of that class should, like all other class members, be afforded the benefit of that bargain.[74]

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> intermittent flair-ups of debilitating symptoms and the occasional onslaught of an acute, life-threatening episode.

*Id.*

[73] Philospher Allen Buchanan takes to task the sort of article – perhaps including this one – in which the ethics of managed care are debated to the exclusion of the ethics of neglect by this nation's leadership of the 40 million or more with no health coverage *at all:*

> [T]he motivation for moving to managed care on the part of those whose efforts actually brought it about had nothing to do with addressing what might be called *the primary access problem.* By the primary access problem, I mean the fact that over 40 million people in the United States lack secure access to anything other than emergency care because they have no private health insurance and are not covered by any government program.
>
> ....
>
> Indeed, what is most remarkable about the vociferous popular debate about managed care – from an ethical point of view – is that the issue of access for the uninsured seems to have dropped off the public's radar screen entirely.

Allen Buchanan, *Managed Care: Rationing Without Justice, But Not Unjustly*, 23 J. HEALTH POL. POL'Y & L., 617, 620 (1998).

[74] *See* Loretta M. Kopelman & Michael G. Palumbo, *The U.S. Health Delivery System: Inefficient and Unfair to Children*, 23 AM J.L. & MED. 319, 322 (1997) (discussing David Hume's theory of distributive justice, based in part on his assumption of the presence of "limited benevolence," by which "most humans, when they are disinterested, had some limited concern for others"). In other words, we should care about bad health policy toward the chronically ill because we should care about the chronically ill. Society's concern in this regard should spring from the same humanitarian impulses that lay behind the broad public funding, through Medicaid and Medicare, for the permanently and totally disabled. *See* 42 U.S.C.A. §§ 1396a(a)(10)(A)(i)(V), 1396a(m)(1) (1992) (dealing with Medicaid, specifically the description of individuals covered and plans for medical assistance); 42 U.S.C.A. § 1395c (1992) (describing individuals qualified to receive Medicare funds), 42 U.S.C.A. § 1395(c) (West Supp. 1998) (describing hospital and medical expenses paid in the form of Medicare); *see also* Hoffman et al., *supra* note 7, at 1477 (stating that, while public funds covered over 40% of direct health care costs for persons with chronic conditions in 1987, they paid for less than 20% of costs for persons with acute conditions. But, while private insurance covered about 45% for persons with acute conditions, it paid only one-third of costs for persons with chronic conditions); Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213 (stating a broad social obligation to "reasonably accommodate" the disabled by offering them affirmative

The second reason for concern is the fiscal version of the first. The cost of treating the chronically ill is large, dwarfing the cost of providing preventive care or episodic acute care.[75] If managed care-based health financing is to fulfill its end of the bargain, it must provide high quality care to the chronically ill at a low cost[76] – a feat it has not demonstrated itself able to accomplish.[77] The cost, however, is not just large – it is also *predictable.* This feature raises its own set of concerns. "Privatization," for purposes of this discussion, has previously been described as the mechanism by which government or an employer cedes to an MCO the basic responsibilities of provider network formation, maintenance, and

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assistance unavailable to others). *See* 42 U.S.C. § 12112(b)(5)(A) (1998) (requiring employers to make reasonable workplace accommodations to an employee or applicant who is disabled). *See also* President's Statement on Signing the Americans With Disabilities Act of 1990, 26 WEEKLY COMP. PRES. DOC. 1165 (July 30, 1990) (recognizing the goal of the Americans With Disabilities Act as assisting the disabled to participate fully in society). This humanitarian impulse should be spurred by real empathy, if not self-interest, among the "temporarily able-bodied." *See* Jennings et al., *supra* note 7, at 5 (stating, "Now and in the future it may be said that virtually everyone will suffer from a chronic illness at some time during their lives").

This is not to suggest that MCOs should be compensated at less than a fair basis for the coverage. Indeed, it is critically important that financial arrangements not create a barrier to coverage for the chronically ill. *See infra* Part III (discussing regulatory steps needed to protect the clinicially ill). But once a governmental or employment-based program promises coverage, and an MCO accepts a deal to treat similarly for coverage purposes people with disparate health histories, all involved have accepted the price and ought to deliver equally to the well and the ill.

[75] *See* Hoffman et al., *supra* note 7, at 1476-77 (stating that "[w]hile 46% of persons reported chronic conditions, they accounted for 76% of the direct medical care costs in the United States in 1987").

[76] Relative to the cost of other forms of health care financing, that is. It would, of course, be unreasonable to expect managed care-based systems to eliminate the disparity in cost between the treatment of those with and without chronic illness. *See id.*, at 1478 (citing reasons such as per capita costs of those with chronic conditions being three times the costs of those without chronic conditions, high utilization rates, and declining mortality rates across the entire lifespan that make persons with chronic conditions less attractive to more comprehensive managed care programs).

[77] *See* Neff & Anderson, *supra* note 8, at 1869 (discussing the difficulties that managed care plans have in attempting to provide cost-effective health care to chronically ill children); Paul W. Newachek et al., *Children With Chronic Illness and Medicaid Managed Care,* 93 PEDIATRICS 497, 500 (1994) (describing the need for states to assess the effects of managed care on chronically ill children); Horwitz & Stein, *supra* note 13, at 586 (concluding from the author's study that the ability of HMOs to care for the chronically ill "may be more a myth than a panacea"); *but see* Edward H. Yelin et al., *Health Care Utilization and Outcomes Among Persons With Rheumatoid Arthritis in Fee-for-Service and Prepaid Group Practice Settings,* 276 JAMA 1048, 1052-53 (1996) (comparing the similarities in the health care services provided to chronically ill patients under fee-for-service and HMO health plans).

compensation.[78] MCOs are simply paid a per capita sum – often uniform, or nearly so[79] – and are entrusted[80] to balance appropriately tensions among the quality, cost, and access to care.[81] The cost of coverage for the chronically ill, however, is dramatically high, and predictably so. MCOs will therefore profit greatly from acting on this advanced notice of cost, accepting the nearly uniform rate, and predominantly enrolling the below-average risk. If acted upon, this understandable business inclination would subvert the bargain. MCOs often bargain to accept self-selecting members of a group of, *e.g.*, employees, or Medicaid or Medicare beneficiaries, in return for a per capita sum. When an MCO enters into such a deal, and then avoids enrolling the portion of the relevant population whose cost is likely to exceed the per capita rate, selecting predominantly those whose cost is likely to be below the per capita rate, the payer loses in two ways.

Initially, the payer is simply overcharged. It offered a rate based on the average expected cost of the entire group on the assumption that the risk profile of those enrolled by an MCO would more or less reflect that group-wide average. If the risk profile of those enrolled by the MCO, by virtue either of group members' self-selection or the MCO's manipulation of the enrollment process, drops significantly below the group's average, the MCO gains a windfall. That windfall is at the payer's expense if the payer permits group members to choose between an MCO and a form of coverage, such as self-insured fee-for-service, in which the payer is directly responsible for the medical costs of the residual members with above-average risk. The MCO would be skimming the cream, charging full price, and leaving the payer with the most costly cases.[82]

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[78] *See supra* text accompanying notes 23-31 (defining "privatization").

[79] *See* Dowd et al., *supra* note 8, at 35 (describing limited demographic adjustments in Medicare's capitation payments to HMOs); *see also* Nicholas A. Hanchak et al., *U.S. Healthcare's Quality-Based Compensation Model,* HEALTH CARE FINANCING REV. Spring 1996, at 143, 144 (describing limited demographic adjustments in private plan's subcapitation payments to primary care physicians).

[80] Not that the trust is complete, of course. *See infra* Part III.B (describing structural regulation of MCOs).

[81] *See* Randall S. Brown et al., *Do Health Maintenance Organizations Work for Medicare?,* HEALTH CARE FINANCING REV., Fall 1993, at 7-8 (evaluating whether HMO treatment of Medicare patients has actually decreased Medicare costs).

[82] Medicare beneficiaries, for example, are free to choose managed care coverage, other types of "privatized" plans, including managed care plans, or to remain in the traditional public fee-for-service system. *See* 42 U.S.C. § 1395w-21 (1998) (describing the eligibility, election, and enrollment rules for Medicare+Choice). While

But the payer loses in an additional, perhaps less obvious way. Cream-skimming not only deprives payers of the anticipated benefit of their bargains, but also deprives them of the opportunity to trim costs by shifting the health management of their expensive, chronically ill members to managed care. Along with its potential to harm the chronically ill, managed care holds the structural potential to provide care both more appropriately and more efficiently than fee-for-service care. Managed care can knit together disparate services needed by the chronically ill, creatively enhancing primary and home care services that are at the heart of chronic care.[83] And the capitated financing frequently used in managed care provides MCOs with the financial incentives to employ a wide range of medical and non-medical services, as such broad-spectrum services are often the least costly, as well as the most appropriate means of treating chronic illness.[84] Managed care, then, is structurally capable of providing the chronically ill with cost-efficient, effective care. But the tremendous cost of even economically covering the chronically ill,[85] and self-selection

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many states are moving toward managed care for Medicaid beneficiaries, some allow beneficiaries, and in particular the chronically ill, to opt for fee-for-service coverage, either at their own election, or if they can meet "opt out" requirements. The Federal government permits states to "require an individual who is eligible for medical assistance under the State plan . . . to enroll with a managed care entity as a condition of receiving such assistance . . . ." 42 U.S.C.A. § 1396u-2(a)(1)(A)(i) (West Supp. 1998). States' authority in this regard, however, is not unlimited. For example, a state may not require certain disabled children or children in foster care to enroll in a managed care entity. 42 U.S.C. 1396u-2(a)(2)(A). States could, however, presumably make managed care enrollment optional for such beneficiaries. Finally, many public employers and large private employers offer an array of health plans, and permit employees to choose from among those plans on an annual basis. *See* Henry T. Greely, *Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity*, 5 HEALTH MATRIX 37, 46-47 (1995) (stating that members of the California Public Employee Retirement System who live in Los Angeles and the San Francisco Bay Area may choose among more than ten different health plans); *see generally* Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 BYU L. REV. 1229, 1229-30 (explaining that § 106 of the Internal Revenue Cose subsidizes employee health benefits beyond what is necessary to accomplish the goals of affordable health care).

[83] *See* Sandy & Gibson, *supra* note 7, at 12-13 (discussing the features of managed care organizations that can improve the care of the chronically ill, including the flexibility to devote resources to home- and community-based services).

[84] *See id.* (explaining that managed care provides a capitated financing environment, creating a financial incentive to provide cost-effective care)

[85] *See* Hoffman et al., *supra* note 7, at 1476 (citing the cost of covering the chronically ill as being $272.2 billion in 1987).

among group members,[86] has prevented a migration of high-risk enrolles to managed care.[87] Therefore, biased selection, in which the chronically ill are not enrolled in managed care, may deprive payers of the cost-saving potential for lowering the cost of chronic care through managed care principles.

Medicare is the clearest example of this dual dilemma. As is more fully described below,[88] managed care has the apparent capacity to provide care to Medicare beneficiaries equivalent to, but at a significantly lower cost than, that available through the fee-for-service system.[89] However, Medicare has lost money on managed care, as it has paid premiums to MCOs loosely tied to historical average beneficiary costs in the fee-for-service system,[90] while participating MCOs have enrolled substantially below-average

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[86] *See* Wilensky & Rossiter, *supra* note 8, at 68 ("In general, there seem to be unique aspects patient self-selection for HMOs for which available studies are either inconclusive or indicate favorable selection for HMOs").

[87] *See id.* (noting that HMOs, on average, enroll low-risk patients). The effect is most clear at the initial enrollment stage. Over time, the risk profile of enrollees in managed care tend to move somewhat toward the average risk, although quite slowly. *See id.* at 69-71 (describing regression toward the mean suggesting that, over time, both lower and higher-than-average risks move toward the mean).

> New enrollees in the Medicare managed-care plans appear quite healthy, with costs that are about 35 percent below the Medicare fee-for-service average in the six months before enrollment. By contrast, beneficiaries disenrolling from managed-care plans had costs 60 percent higher than the Medicare fee-for-service average in the six months following disenrollment. The good health of new managed-care enrollees declines only slowly after enrollment, taking perhaps eight years to approach the level of the average Medicare fee-for-service beneficiary.

Medicare Payment Advisory Comm'n, *supra* note 8, at 27.

[88] *See* discussion *infra* and text accompanying notes 106-09 (explaining how MCOs are well-suited to provide cost-effective health care for the chronically ill).

[89] *See* Oberlander, *supra* note 60, at 610-11 (highlighting the costs and benefits of using a managed care approach to Medicare with regard to quality of care).

[90] *See* Dowd et al., *supra* note 8, at 36 (stating that HMO selectivity may raise overall Medicare costs); MEDICARE MANAGED CARE: GROWING ENROLLMENT ADDS URGENCY TO FIXING HMO PAYMENT PROBLEM, GAO/HEHS 96-21, at 3 (Nov. 8, 1995) (explaining the three-step process that HCFA uses to calculate the payment rate to HMOs for Medicare beneficiaries). Medicare does exact a five percent discount, and engages in some modest demographic adjustment to premiums. *See* Dowd et al., *supra* note 8, at 35. It overpays nevertheless. *See* Wolf & Gorman, *supra* note 60, at 2-3 (noting that capitation amounts paid to HMOs by Medicare may be too high since the HMO enrollees tend to be healthier than the average Medicare enrollee). *See infra* text accompanying notes 112-28 (discussing circumstances under which capitation rates encourage risk selection and the resulting search for adequate risk adjusters).

risks.[91] Simply stated, Medicare pays as though MCOs will enroll a broad spectrum of beneficiaries, from healthy to ill, while MCOs have overwhelmingly enrolled the healthy.[92] Medicare, therefore, takes a double hit: it overpays for those beneficiaries who elect managed care, and it is left with direct responsibility for the bulk of high-risk beneficiaries, who could, at least in theory, enjoy more appropriately coordinated care at a lower cost in a managed care system.[93]

The third reason for concern is a bit counterintuitive. MCOs, by design, reduce utilization. Consumers' unease with managed care stems from their lack of confidence that such reductions will be done in a manner that assures them of access to the care they need, when the need arises.[94] As the chronically ill need acute and specialty services much more frequently than the well, the chronically ill can serve as "canaries in the coal mine," as society monitors their treatment by MCOs for clues as to how the well will be treated. We value health coverage at least in part[95] because it promises us coverage for expensive, medically necessary acute care. Managed care plans, to a greater or lesser extent, restrict utilization and control the setting in which care is given. Consumers, then, are increasingly concerned that this management of their care not deprive them of *necessary* care, and that the care they are provided be of acceptably high quality.[96] By definition, the well

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[91] The Inspector General of the Department of Health and Human Services recently asserted that Medicare overpays in a different, more straight-forward way as well. The Inspector General reported that Medicare paid between 23.5 and 31.7% of the administrative expenses of Medicare-participating HMOs in recent years, while Medicare enrollees constituted only between 7.5 and 8.9% of the HMOs' enrollees. In one case, the Inspector General reported that a plan with 43% Medicare enrollees collected 127% of its administrative costs from Medicare. DEP'T OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GEN., ADMINISTRATIVE COSTS SUBMITTED BY RISK-BASED HEALTH MAINTENANCE ORGANIZATIONS ON THE ADJUSTED COMMUNITY RATE PROPOSALS ARE HIGHLY INFLATED 9 (1998).

[92] *See* Oberlander, *supra* note 60, at 606-07 (explaining the options and money-saving techniques that MCOs use to attract healthy members).

[93] *See id.* at 607 (showing the cost savings potential of managed care system for Medicare).

[94] *See* Moran, *supra* note 32, at 21 (showing that most Americans are skeptical about access to potentially needed health care services when it comes to managed care).

[95] We also value health care coverage for the access it provides for routine preventive care. This aspect of health coverage is not really "insurance" at all, but rather prepayment for expected, periodic costs.

[96] *See* Moran, *supra* note 32, at 20-21 (analyzing the prospects for workable federal regulation of managed care).

rarely need specialized or acute care; how, then, are they to judge whether a health plan will do the job correctly when the need arises? There are two developing forms of such assurance for consumers that offer some promise. These embryonic forms are direct government regulation of managed care,[97] and "market-based" regulation, through the measurement and public disclosure (often by private entities) of the quality of care offered by MCOs.[98] A common thread that runs through these emerging forms of consumer protection is the belief that the selective testing of MCOs for performance against quality measures will permit better government licensure enforcement on the one hand, and better information to support consumer choice on the other.[99] But the aspects of measured performance are dominated by primary care indicators, with a few acute care and, recently, chronic care indicators added.[100] The science of such measurement, while promising, remains confused. In the words of one leader in the field, "today's [MCO quality] measures are, to be blunt, expensive, incomplete, and distorting. And, unless great care is taken, they can easily be inaccurate and misleading."[101] Monitoring plan performance with current tools, then, is unlikely to inform consumers of their plans' ability to provide extensive acute or specialty care.

The chronically ill, in contrast with the run-of-the-mill MCO member, regularly needs a wide array of health interventions, ranging from the significant acute care procedure to routine, ongoing outpatient therapy. An assessment of the performance of a plan in providing treatment for the chronically ill, then, can provide in a concentrated form an indicator of the plan's ability to

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[97] *See id.* at 15-16 (noting that there are conflicting conclusions regarding the ability of the marketplace to regulate managed care in the absence of federal intervention); *see also* Judith G. Waxman & Geraldine Dallek, *Hit and Miss: State Managed Care Laws* <http://www.familiesusa.org/HIT1.HTM> (visited Mar. 10, 1999) (analyzing common problems experienced by managed care consumers and discussing recent consumer protections that have been enacted by state legislatures).

[98] *See* Furrow, *supra* note 19, at 396-404 (discussing private accreditation, specifically the merits of NCQA accreditation); *see also* Jacobi, *supra* note 27, at 766-73 (discussing various forms of quality assurance systems by private entities and government agencies).

[99] *See* Furrow, *supra* note 19, at 396-97 (discussing the benefits of private accreditation of health care institutions).

[100] *See* Kuhlthau et al., *supra* note 12, at 45 (discussing the weaknesses of methods used to assess managed care for children with chronic illnesses, specifically, the lack of descriptors of service that apply to children with chronic conditions).

[101] David M. Eddy, *Performance Measurement: Problems and Solutions*, HEALTH AFF., July-Aug. 1998, at 7, 16.

provide medically necessary care of an acceptably high quality. The high utilization of services by the chronically ill permit them to be sensitive barometers of the performance of a plan – to be "canaries in the coal mine." By closely monitoring the care a plan provides to the chronically ill, the broader community can reasonably infer the level of quality all members will receive when they need care. The ability of a plan to manage the care of a person with serious heart disease, brittle diabetes, or cystic fibrosis may provide a window on how the plan would treat a heart attack, a significant infection, or a cancer.

There are, then, three reasons we should care about how well the chronically ill fare under managed care. Our concern should spring from human concern for the proper care of the insured chronically ill; from a preference that payers, including state and federal government, receive the cost savings that form the basis of their bargain with MCOs; and from a desire to use MCOs' performance with the chronically ill to inform the general population of the MCOs' likely performance in providing high-quality specialty and acute care. The following section addresses the available and contemplated regulatory means available to secure the benefit of the managed care bargain for the coverage of the chronically ill. These regulatory measures are aimed at controlling or eliminating excluding and stinting behavior by MCOs. As the following section describes, however, regulatory measures may differ in the relative importance they assign to controlling excluding or stinting behavior. The difference may arise depending on which of the three reasons for concern motivate the regulatory impulse. For example, concern for payers' spending may result in great concern for excluding, because excluding so clearly cheats payers. On the other hand, concern for the chronically ill themselves, either on humanitarian grounds or as "testers" for the benefit of society, will place a relatively higher value on controlling stinting, as that behavior more clearly and immediately threatens consumer well-being. At any rate, an impressive armamentarium is amassed to regulate excluding and stinting; unfortunately, it is far from clear that these regulatory measures offer, alone or in combination, more than partial proof against these transgressions.

## III. SQUARING THE CIRCLE: PIECEMEAL REGULATORY STEPS TO PROTECT THE CHRONICALLY ILL

A system for the regulation[102] of managed care for the benefit of the chronically ill must respond to a central paradox. The paradox arises from the nature of MCOs as both financing (and therefore naturally risk-assessing) entities, and care giving entities.[103] The paradox is that the care giving aspect of managed care is capable of curing the discontinuous and fragmented provision of the care historically experience by the chronically ill, including overemphasis on institutional care.[104] At the same time, however, the financing aspect of managed care inclines plans and plan providers to exclude the chronically ill, and to stint on care delivery when they are enrolled.[105]

On the one hand, the organizational structure of MCOs seems ideally suited to provide the chronically ill the broad range of care they need in a well-planned fashion. First, MCOs central organization permits – indeed, enforces – a great deal of coordination among the varied providers the chronically ill must consult.[106] Second, "capitated financing allows reallocation of resources to

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[102] "Regulation" in this context refers to both public and private mechanisms to shape the behavior of MCOs. Many of the mechanisms described in this section, e.g., risk adjustment and quality measurement, are and will be practiced through private initiatives as well as through direct government intervention.

[103] *See* Buchanan, *supra* note 73, at 619 ("A managed care organization *combines* health care *insurance* and the *delivery* of a broad range of integrated health care services for *populations* of plan enrollees, financing the services *prospectively* from a predicted, limited budget").

[104] *See* Context for a Changing Medicare Program, *supra* note 7, at 144-45 (stating that the numerous advantages available to the chronically ill through an MCO); *see also* Horowitz & Stein, *supra* note 13, at 581 (explaining how HMOs could provide comprehensive medical services to chronically ill children, and also minimize institutional care and fragmented delivery systems); Sandy & Gibson, *supra* note 7, at 12-13 (describing how managed care systems have the capacity to "overcome the fragmentation of a poorly organized fee-for-service sector" while allowing resources to be devoted to home- and community-based services).

[105] *See* Context for a Changing Medicare Program, *supra* note 7, at 145 (showing that MCOs traditionally provide care through primary care physicians and this may present challenges to a MCO confronted with the special care, supportive care, and non-medical social services needs of a chronically ill member); *see also* Horwitz & Stein, *supra* note 13, at 581 (explaining how there is little economic incentive for HMOs to care for individuals wih chronic illnesses, due to the long-term nature of such conditions).

[106] *See* Sandy & Gibson, *supra* note 7, at 12 (discussing how "[e]ffective systems use multi-disciplinary teams to provide integrated care" to the chronically ill).

better meet the needs of persons with chronic conditions."[107] That is, MCOs can provide services creatively, without the constraints imposed by rigidly defined benefits limits. Third, to the extent less intensive care such as home care and social support is more cost-effective than institutional care, MCOs' treatment planning is not distorted toward expensive settings for care as are treatment plans generated in a fee for service environment.[108] And fourth, MCOs are commonly rich in primary care options, and are therefore likely to be institutionally suited to provide the types of care most frequently needed by the chronically ill.[109]

On the other hand, the financing system at the heart of managed care is at war with its care-giving potential when it comes to the chronically ill. In particular, the capitation rates offered to MCOs, in systems where the plan does not contract for the entire group, but rather self-selecting members of the group, may be sufficiently uneconomic to lead the plan to select against the chronically ill.[110] And when plans enroll the chronically ill, the financial incentives used by the plans may disincline the plan's providers from realizing the potential of the plan's network.[111]

Faced with this paradox, the regulatory system seeks to correct for the undesired aspects of managed care – excluding and stinting – without disabling MCOs from providing cost-effective, well-integrated care. In the following pages I outline several current or developing means of regulating managed care, and assess their ability to control excluding and stinting behavior.

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[107] *Id.* at 12.

[108] *See id.* at 12-13 (reviewing opportunities to use alternate care environments to efficiently care for the chronically ill).

[109] *See id.* at 13 (explaining how a system of "generalist physicians, nurse practitioners, and other health providers" is the most appropriate way to care for the chronically ill).

[110] *See* Context for a Changing Medicare Program, *supra* note 7, at 150-51 (discussing the economics of enrolling the chronically ill, and stating that, beginning in the year 2000, new risk adjustment methods will be used. These new methods will reflect the enrollee's health status in order to compensate for the current variations in individual beneficiaries' health care costs); Neff & Anderson, *supra* note 8, at 1867 (discussing Medicaid programs and explaining that "plans that attract proportionally more chronically ill children would need to raise their rates to remain financially solvent").

[111] *See* Blum, *supra* note 1, at 175-76 (discussing how, under capitation health care, the expansion of the plan may bring increased harm to patients and increased liability to individuals and the plan itself); *see also* Horwitz & Stein, *supra* note 13, at 581 (stating that "there is little incentive within HMOs for providers to care for those individuals who, because of their medical conditions, must constantly return for medical intervention or time-consuming supervision and support").

### A. Risk Adjustment

Capitation rates in systems where optional member enrollment can result in risk selection are usually average payment rates, pegged to experience under fee-for-service, moderated slightly by demographic characteristics. For example, Medicare's rate, known as AAPCC, for "adjusted average per capita cost," begins with a rate equal to 95 percent of the average regional fee-for-service for a Medicare patient.[112] The actual rate paid is adjusted by employing "30 cells: 5 age groups, 2 sex categories, and 3 institutional status groups (institutionalized, welfare recipient not institutionalized, and neither)."[113] While this demographic adjustment is intended to vary payment rates to correspond to an enrollee's actual health costs, the application of current demographic adjusters explains only "about 1 percent of the variance in actual spending."[114] As insurers will always benefit by accurately risk-selecting in light of the offered premium,[115] and as factors, such as the enrollee's prior year's utilization experience,[116] explaining at least a portion of the balance of the variation are readily (if not lawfully)[117] available to MCOs, there is at least a risk that they will act on that information.[118] In fact, risk selection clearly occurs, although the mechanism is not clear.[119] Risk adjustment as a correction to the tendency toward risk-selection has been examined for use in Medicare,[120] Medicaid,[121] and private insurance.[122]

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[112] *See* Dowd et al., *supra* note 8, at 35 (noting that the purpose of the AAPCC system is to adjust HMOs payment rates in accordance with demographics of enrollees).

[113] *Id.*

[114] *See* Newhouse et al., *supra* note 7, at 30.

[115] *See* ABRAHAM, *supra* note 55, at 11-12 (discussing the difference between risk neutrality and risk aversion in the relation between insurance and economic efficiency, and noting that risk-averse individuals will always pay more than their expected loss and, by satisfying this demand for protection, insurance can work to insure economic efficiency).

[116] *See* Newhouse et al., *supra* note 7, at 31 (describing an element of the estimation of the variance in expected spending from observations on actual spending).

[117] *See* 42 U.S.C. § 1395w-22(b)(1)(A) (1998) (stating that a Medicare+Choice organization "may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor . . .").

[118] *See* Newhouse et al., *supra* note 7, at 31-32 (noting that there will never be a perfect risk adjuster formula, but higher incentives to better adjust risk are needed).

[119] *See* Medicare Payment Advisory Comm'n, *supra* note 8, at 27 (noting that studies have repeatedly demonstrated that risk selection occurs under Medicare).

[120] *See* Leslie M. Greenwald et al., *Risk Adjustment for the Medicare Program: Lessons Learned from Research and Demonstrations*, 35 INQUIRY 193, 195-97 (1998)

"Risk adjustment is the process of setting capitation rates that reflect health status, paying plans more to care for ill beneficiaries and less to care for healthy ones."[123] To the extent the risk selection currently experienced in managed care is a function of excluding,[124] risk adjustment to narrow the gap between the offered price and the plans' actuarial judgments as to expected cost are seen as a critical means of narrowing the enrollment gap, particularly for the chronically ill.[125] Because future costs for this group;

> [A]re more predictable, health plans can more easily engage in risk selection, enrolling low cost beneficiaries as members and avoiding high costs ones. A plan has an incentive to avoid excelling in care for people with disabilities and chronic conditions for fear that developing a good

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(discussing research to develop risk adjusters for Medicare managed care payments); *see also* Jonathan P. Weiner et al., *Risk-Adjusted Medicare Capitation Rates Using Ambulatory and Inpatient Diagnoses,* HEALTH CARE FINANCING REV., Spring 1996, at 77, 97-98 (discussing diagnostic-based methodologies for calculating risk-adjusted capitated premiums for Medicare enrollees); Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem, GAO/HEHS 96-21, at 14 (Nov. 1995) (citing research evaluating 10 possible risk adjusters).

[121] *See* John Holahan et al., *Medicaid Managed Care in Thirteen States,* HEALTH AFF., May-June 1998, at 43, 57 (examining states that have adopted a form of Medicaid managed care, and the different manners in which some have been handling risk adjustment); *see also* Laura Tollen & Michael Rothman, *Case Study: Colorado Medicaid HMO Risk Adjustment,* 35 INQUIRY 154, 159-64 (1998) (examining the risk adjustments of the Colorado Medicaid HMO system and how they effect budgeting); Kronick et al., *supra* note 61, at 28-30 (discussing the use of diagnostic approaches to risk adjust capitated payment for Medicare and Medicaid beneficiaries).

[122] *See* Daniel L. Dunn, *Applications of Health Risk Adjustment: What Can Be Learned From Experience to Date?,* 35 INQUIRY 132, 137-39 (1998) (discussing the implementation of health status risk-adjusted payments by the Minneapolis Buyers Health Care Action Group); John Bertko & Sandra Hunt, *Case Study: The Health Insurance Plan of California,* 35 INQUIRY 148, 149-52 (1998) (addressing the impact of implementation of risk adjustment to the Health Insurance Plan of California); *see generally* Fowles et al., *supra* note 6, at 1316 (finding that adjusting capitation rates based on health status, rather than demographic measures, worked best to result in fair capitation payments to physicains).

[123] Medicare Payment Advisory Comm'n, *supra* note 8, at 27 (defining risk adjustment).

[124] Excluding, that is, by either explicitly refusing to enroll or re-enroll a high-risk person, or by declining to undertake program development that would make a plan more attractive to high-risk persons.

[125] *See* Context for a Changing Medicare Program, *supra* note 7, at 150 (stating that, without adjustments, MCOs will have strong incentives to select low-cost members).

> reputation in such care will lead to adverse selection as more such members enroll.[126]

The desire to solve this problem has driven a long search for accurate and fair risk adjusters.[127] Congress has provided new urgency to the search, requiring that Medicare report a risk adjustment methodology to Congress by March 1, 1999, and implement "a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by . . . January 1, 2000."[128]

Much work has been done to develop acceptable risk adjusters, although none has yet emerged as the "holy grail."[129] A very wide array of risk adjustment have been investigated and subjected to statistical scrutiny, a full discussion of which is beyond the scope of this Article.[130] The competing methodologies attempt to

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[126] *Id.* (Citations omitted).

[127] *See* Randall P. Ellis et al., *Diagnosis-Based Risk Adjustment for Medicare Capitation Payments,* HEALTH CARE FINANCING REV., Spring 1996, at 101, 101 (identifying numerous studies which indicate a preponderance of "cream skimming: with experimental HMO-Medicare enrollees).

[128] 42 U.S.C.A. § 1396w-23(a)(3) (West Supp. 1998) (directing how payments to Medicare+Choice organizations shall be made).

[129] *See* Oberlander, *supra* note 60, at 622 ("Some risk-adjustment models have attracted favorable interest, and it has been argued that the AAPCC can be fixed by adding history-of-illness variables. However, risk adjustment remains a 'holy grail': No risk-adjustment mechanism has successfully operated in practice, and Medicare's own experience does not provide much reason for optimism that the technical barriers can be easily overcome") (citations omitted).

[130] *See* Oberlander, *supra* note 60 (analyzing the advantages and disadvantages to using a managed care approach to Medicare); Newhouse et al., *supra* note 7 (discussing the lack of adequate risk adjustment and selection); Fowles et al., *supra* note 6, at 1316 (discussing the necessity of taking health status into account when setting capitation rates, to avoid penalizing physicians who treat the sicker segment of the population); Kronick et al., *supra* note 61 (describing different diagnostic categories that could be used by Medicaid programs to determine payments to health care plans enrolling disabled persons); Dowd et al., *supra* note 8 (examining the effect of AAPCC Medicare enrollees on HMOs); Leonard Gruenberg et al., *Improving the AAPCC With Health-Status Measures from the MCBS,* HEALTH CARE FINANCING REV., Spring 1996, at 59 (examining the use of multiple regression-based models to predict Medicare costs, incorporating demographic, diagnostic, perceived health, and disability variables); Weiner et al., *supra* note 120, (summarizing the strengths and complexity of various risk-adjuster models); Ellis et al., *supra* note 127 (developing, estimating, and evaluating risk-adjustment models which use diagnostic information from Medicare enrollees); *Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs,* GAO/HEHS-94-119 (Sept. 2, 1994) (studying the payment system used by Medicare's risk-contract program for HMOs and including recommendations to make the program more cost-effective). There are a number of works that provide greater information on the different models of risk adjustment

attain a closer correspondence between the premium paid and the cost experienced by adding factors such as a person's "single highest cost principal inpatient diagnosis";[131] the presence of one of a few specified disabling conditions;[132] a person's inpatient and outpatient diagnoses;[133] and an array of factors including "diagnostic characteristics, perceived health status and functional-impairment information."[134]

How much of an improvement do these models show? It appears that the most powerful of these mechanisms, applied prospectively – that is, to the next year's premium for the same person[135] – explains about nine percent of the variance, which is to say that it is about nine times as powerful a predictor of variance from the average as the AAPCC system in use in Medicare.[136] Is that enough? How powerful does a risk adjustment method have to be to trim the incentives to exclude? Complete prediction of cost variation is neither possible[137] nor necessary. First, the outright prohibitions against risk selection by MCOs in many settings[138] certainly have some effect on dampening the excluding behavior of MCOs.[139] And second, risk adjustors need only be as good, at the

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under consideration. *See, e.g.*, Frank et al., *supra* note 58, at 115 (considering "the potential for risk-adjusted premiums to attenuate selection incentives").

[131] *See* Ellis et al., *supra* note 127, at 105 (describing one variant of the diagnostic cost group – or DCG – model).

[132] *See* Brown et al., *supra* note 81, at 19-20. (discussing that, by adding one factor such as a history of cancer, heart disease, or stroke, to the adjusted average per capita cost (AAFCC) payment rate formula, the increased costs to the Health Care Financing Administration could be eliminated).

[133] *See* Weiner et al., *supra* note 120, at 78-79 (discussing the effects of hospital admissions and diagnoses on various risk-adjustment models).

[134] Gruenberg et al., *supra* note 130, at 62.

[135] *See infra* text accompanying notes 146-50 (discussing prospective versus retrospective adjustment).

[136] *See* Newhouse et al., *supra* note 7, at 35 (regarding the hierarchical coexisting conditions (HCCs) model as the most powerful mechanism for explaining variance prospectively).

[137] *See Risk Adjustment: How Far Have We Come?*, HEALTH CARE FINANCING & ORG. NEWS & PROGRESS (Robert Wood Johnson Foundation), July 1998, at 1 (citing Joseph P. Newhouse, speaking at a conference on risk adjustment, for the proposition that "a perfect retrospective risk adjustment method will always elude us.").

[138] *See* Newman et al., *supra* note 8, at 132-33 (describing prohibitions against the use of marketing materials by Medicare HMOs that attempt to select against the ill or disabled).

[139] *But see id.* at 138 (finding some current Medicare HMO materials misleading in this regard).

outer limit, as the plans' own ability to estimate risk variance.[140] Professor Newhouse, a most thoughtful and lucid commentator on this issue, has suggested a "lower bound" of appropriate predictive power as twenty to twenty-five percent of variation.[141] This range represents the amount of variation that can commonly be captured by considering two factors: the presence of a permanent significant condition such as a chronic illness, and the occurrence of an upward departure in the previous year from the expected experience (in light of the chronic illness).[142] This calculation is one that is within the power of a risk-selecting plan, and a risk adjustment methodology that captures this level of variation may "still" the impulse to risk select.[143] After all, if the goal is to prevent excluding behavior, payers need only match the predictive power of the plans. Some progress has been made. At least on paper, "a great deal of progress has been made toward shifting health care dollars around [through risk adjustment] in a way that makes the health care system more accessible to sicker, more vulnerable populations."[144]

The reference in the last quote to making the system "more accessible" is telling. For much of the thrust of research into risk adjustment is payer-driven, and focuses on limiting excluding, rather than stinting behavior.[145] In fact, the discussion and evalua-

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[140] *See* ABRAHAM, *supra* note 55, at 78 (explaining that plans will reach a point of diminished returns in risk assessment, where the cost of refining the assessment of the potential enrollee's risk exceeds the benefit to the plan of learning that which the more refined assessment would tell).

[141] Newhouse et al., *supra* note 7, at 30-31.

[142] *See id.*

[143] *See id.* at 31-32. Professor Newhouse remains agnostic on this point, concluding, "In short, a workable adjuster need not achieve the ideal. But how far from perfection will be sufficient is unknown." *Id.* at 32. The question can be answered, in all likelihood, only by experience, in which plan behavior, encouraged by risk adjusters, cautioned by prohibitions against risk selection, and limited by the plans' technical ability to exceed the predictive power of the risk adjuster. For this reason, Newhouse and others recommend implementation and testing of the methodologies now available, at least on a pilot basis. *Id.* at 37; *see also* Oberlander, *supra* note 60, at 622 (exploring the risk plans and possible alternate solutions).

[144] *Risk Adjustment: How Far Have We Come?*, *supra* note 137, at 1.

[145] *See* Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem, GAO/HEHS 96-21, at 9 ("Our review of studies on risk selection show that, because most HMOs benefit from favorable selection . . . Medicare has paid HMOs more than it would have paid for the same patients' care by fee-for-service providers."); *see also* Bryan Dowd et al., *supra* note 79, at 3 (noting that inadequate risk adjusters in Medicare result in "payment bias" and overpayment to HMOs).

tion of risk adjustment surfaces a tension between the desire on the one hand to control excluding behavior, thereby permitting payers to pay a fair premium, and the desire on the other hand to control stinting behavior, thereby permitting chronically ill patients to receive appropriate care. This tension is most clearly displayed in the debate over the relative merits of prospective and retrospective adjusters.

Prospective adjusters test for the presence of some of cost-sensitive demographic and diagnostic factors *in a past period or periods* to set a premium level for an enrollee.[146] Retrospective adjusters use diagnostic and treatment information for *the current year* to change, after the fact, the amount of the premium.[147] Prospective adjusters, then, are purely predictive, attempting to set in advance premium rates that will make well and ill persons sufficiently similar from a risk perspective to make them equally attractive to plans.[148] Retrospective adjusters, on the other hand, attempt to do more. They attempt to tie increased payment more closely to *actual* services rendered, thereby encouraging not just the enrollment, but the appropriate treatment of the chronically ill.[149] But this increased sensitivity comes at a cost. Permitting current year treatment to affect current year premium permits a plan to "game the system" by increasing care not simply for the benefit of the enrollee, but to increase the capitation amount.[150]

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[146] *See* Newhouse et al., *supra* note 7, at 34 (stating that the previous year's diagnostic information is usually used for prospective adjusters).

[147] *Id.* (defining "retrospective adjusters").

[148] *See id.* (defining "prospective adjuster" and providing an example of the information used for setting reimbursement). As Newhouse explains, if the goal is to avoid excluding, the risk adjustment mechanism need only do about as well at forecasting risk as could a plan's actuary. It need not be concerned with unforeseeable risk, because, by definition, such risk would not factor into a plan's individual risk analysis; "explaining random variation is not important for purposes of mitigating selection behavior." *Id.*

[149] *See* Medicare Patient Advisory Comm'n, 2 Report to Congress: Medicare Payment Policy 25 (March 1998) (explaining some of the differences between prosepective and concurrent risk adjustment by noting that "a high dependence of payment on service use may be a reflection of good performance of the risk adjuster. If variations in use of care are due mainly to variations in health status, then a high correlation of use and payment would be a desirable outcome of the risk-adjustment process").

[150] *See* Ellis et al., *supra* note 127, at 124-25 (comparing prospective and concurrent (current year) risk adjustment models); *see also* Medicare Payment Advisory Comm'n, *supra* note 149, at 25 (discussing how the use of concurrent risk adjustment results in a "closer match of payments and costs, but allows a much greater share of payment to depend on services actually performed by the plan").

In some ways, the tension between prospective and retrospective risk adjusters goes to the heart of the bargain between payers and MCOs. MCOs achieve price moderation in large part by accepting full control and responsibility for an enrollee's care in return for a fixed, prospective payment.[151] To the extent risk adjustment methods modify premiums based on actual treatment, and to the extent those modifications filter down to the payments that plans make to providers, the risk adjuster may blunt the impulse to stint on service. But it simultaneously, and apparently inevitably, varies from the central bargain of managed care, in which payers "privatize" control over the delivery of care in order to gain administrative efficiency and cost control.[152] Prospective risk adjustment seems true to the bargain, as it continues to pay a flat, once-and-for-all premium for all necessary care, leaving the judgments, and the financial ramifications of those judgments, for the plans. For better or worse, retrospective adjusters are a step away from the bargain, as payers and plans become jointly responsible for the ramifications of plans' treatment decisions.

In order to stay true to the bargain between payers and MCOs, then, and to better serve the dominant motive behind the movement toward risk adjustment (accurate pricing for the benefit of payers),[153] payers will likely select prospective adjusters. Risk adjustment, then, is unlikely to address plans' incentives to stint in any dramatic way. While more accurately set premiums will reduce plans' incentive to deny care as a subterfuge for encouraging an enrollee to switch to another plan,[154] it will not reduce plans' incentive, or that of their network providers subject to financial incentives to reduce utilization, to be overly conservative in any particular treatment setting. For prospective risk adjustment continues to treat each additional service to a member as a dead loss to the plan. Risk adjustment, then, is likely to respond to one of the reasons for concern about the treatment of the chronically ill by MCOS – the fiscal interests of payers – without significantly responding to the concerns for the appropriateness of the treatment

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[151] *See supra* text accompanying notes 15-32 (discussing the managed care role and organizations' relationships with payers).

[152] *See* Ellis et al., *supra* note 127, at 124 (noting the substantial administrative difficulties inherent in a retrospective system).

[153] *See* Newhouse et al., *supra* note 7, at 34-35 (discussing prospective adjusters in Medicare and managed care).

[154] *See* Newhouse, *supra* note 62, at 138 (noting that plans could, in the absence of adequate risk adjusters, "feign a certain amount of ignorance or simply be rude to potentially high-cost patients").

of the chronically ill, either for their own sake or as surrogates for the well population.

## B. Structural Regulation of MCOs

The bargain with managed care notwithstanding, federal and state governments are increasingly imposing regulatory restrictions on the behavior of MCOs.[155] These interventions into the management of MCOs have come about as a reaction to a broad range of "horror stories" of injuries or mistreatment allegedly suffered by consumers subject to managed health care.[156] The federal movement to regulate the behavior of managed care plans is apparent in the Balanced Budget Act of 1997, which, while extending the use of managed care for federal health programs, provided sets of explicit beneficiary protections for both Medicare[157] and Medicaid.[158] In addition, both the House of Representatives[159] and the Senate[160] of the 105th Congress passed bills (albeit, different bills) proposing to codify a "patient bill of rights" for some privately insured persons. And many states, not waiting for federal action, have adopted their own patient protection statutes aimed at various activities of MCOs.[161]

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[155] *See* Waxman & Dallek, *supra* note 97, at 2 (discussing state legislative attempts to provide solutions to the problems of managed care consumers); *see also* Moran, *supra* note 32, at 8-9 (looking into governmental regulations that use a managed care approach); Hoffmann, *supra* note 18, at 319-20 (discussing the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) and noting that 12 states have enacted legislation to eliminate the obstacles that MCOs have placed in the way of patients in need of emergency care); *Managed Care Regulations: States Respond to Complaints With Moves to Protect Consumers*, 23 ST. INITIATIVES IN HEALTH CARE REFORM 1, 1-3 (1997).

[156] *See* Moran, *supra* note 32, at 8-9 (looking into the impulse toward governmental regulations for managed care); *see also* Jacobi, *supra* note at 27, at 711-17 (describing several accounts of patients' mistreatment under managed health care).

[157] *See* 42 U.S.C. § 1395w-22 (1998) (establishing benefits and beneficiary protections under the Medicare+Choice program).

[158] *See* 42 U.S.C. § 1396u-2(b) (1998) (listing beneficiary protections such as "assuring coverage to emergency services," "protection of enrollee-provider communications," "grievance procedures," and "protecting enrollees against liability for payment").

[159] *See* Patient Protection Act of 1998. H.R. 4250, 105th Cong. (1998) (proposing a patient bill of rights which would "provide new patient protections under group health plans").

[160] *See* S. 2330, 105th Cong., 2d Sess. (1998) (proposing "to improve the access and choice of patients to quality affordable health care").

[161] *See* Waxman & Dallek, *supra* note 97, at 3-4 (discussing examples of consumer protection statutes that have been enacted to ensure adequate health coverage).

The proposed and enacted laws are aimed at a wide variety of variety of MCO activities. Some attempt, at least partially, to take away from MCOs the power to determine which treatments, and for what duration, are medically necessary. Some, for example, prescribe minimum hospital lengths of stay for patients undergoing childbirth or a mastectomy.[162] Others require MCOs to cover care (or at least stabilization) in an emergency department when a "reasonably prudent person" would regard the enrollee's condition to be such as to require emergency care.[163] Previously, plans had been the masters of determinations of a condition's emergency status, as they were of virtually all medical necessity decisions.[164]

Others set mandates and requirements interfering with the ability of MCOs to control the access of enrollees to specialists. Some, for example, require that women be afforded the option of designating an obstetrician/gynecologist rather than an internist or generalist, as their primary doctor.[165] Others require that plans

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[162] *See* 29 U.S.C. § 1185(a)(1)(A) (1998) (requiring ERISA plans to cover 48-hour hospital stay following normal vaginal delivery and 96-hour stays following cesarean delivery); TEX. REV. CIV. STAT. ANN. art. 21.52G(3)(a)(1) (West 1998) (requring health insurers to cover 48-hour hospital stays for mastectomies); TEX. REV. STAT. ANN. art. 21.54F(4)(a)(1)-(2) (West 1998) (establishing the 48/96 hour rule for post-childbirth hospital stays); N.C. GEN. STAT. § 58-3-168 (1997) (requires that the length of hospital stay following mastectomy be based on the "unique characteristics of each patient," and be determined by the treating physician); N.J. STAT. ANN. § 26:2J-4.15(a) (West 1998) (providing that, following modified radical mastectomy, an HMO must provide a 72-hour hospital stay, and a 48-hour stay following simple mastectomy); CAL. HEALTH & SAFETY CODE § 1367.62(a)(1) (West 1998) (establishing a 48/96 hour rule for post-childbirth hospital stays); 215 ILL. COMP. STAT. 5/356s (West 1998) (establishing a 48/96 hour rule for post-childbirth hospital stays).

[163] *See, e.g.*, 42 U.S.C.A. § 1395w-22(d)(3) (West Supp. 1998) (stating that Medicare+Choice plans must cover emergency evaluation and stabilization outside plan under a "prudent layperson" standard); 42 U.S.C.A. § 1396u-2(b)(2) (stating that Medicaid managed care plans must cover emergency evaluation and stabilization outside plan under "prudent layperson" standard); 1998 Cal. Legis. Serv. 1015 (West) *amending* CAL. HEALTH & SAFETY CODE § 1371.4 (West Supp. 1998) (stating that a health plan must cover emergency stabilization outside plan under "reasonable enrollee" standard); N.Y. INS. LAW § 4303(a)(2) (McKinney Supp. 1998) (hospital service corporations and health service corporations must cover emergency treatment under "prudent layperson" standard); N.C. GEN. STAT. § 58-3-190(a) (Supp. 1997) (health insurer must cover emergency screening and stabilization outside of plan under "prudent layperson" standard).

[164] *See* Hoffmann, *supra* note 18, at 327-29 (discussing preauthorization requirements for emergency and non-emergency care MCOs commonly used to procedurally limit access to care by enrollees).

[165] *See* S. 2330, 105th Cong., 2d Sess. § 723 (1998) (proposing that covered plans be required to permit direct access to OB/GYN services); H.R. 4250, 105th

permit some chronically ill members to gain direct access to certain specialty physicians, circumventing generally applicable plan rules requiring a referral by a primary care doctor.[166] Previously, plans subjected primary care physicians to protocols and financial incentives to control the referral of patients to specialty physicians as a central aspect of their cost containment efforts.[167]

Yet another set of proposed and enacted legislation mandates procedures for enrollees' disputes with their MCOs. Some, for example, require that plans permit external review of utilization and medical necessity disputes left unresolved by internal plan dispute resolution procedures. Some of these external review procedures are not binding on the plans, and are intended to serve an "advisory" function – although the failure of the plan to heed the advice may be reportable to a regulatory agency or the public.[168] Other procedures are binding on the plan, and require the plan to provide services to the enrollee consistent with any decision rendered by the external reviewing entity.[169] Previously, plans had carefully

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Cong. (1998) (planning to amend the Employee Retirement Income Security Act of 1974 by adding section 713 allowing a patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care); 1998 Ill. Legis. Serv. 90-741 (West) *amending* 215 ILL. COMP. STAT. 5/356r (West Supp. 1998) (requiring health plans to permit women to designate OB/GYNs as their primary care physicians); TEX. INS. CODE § 21.53D(4) (West Supp. 1998) (health plans required to permit direct access to OB/GYN services); CAL. HEALTH & SAFETY CODE § 1367.69(a) (West Supp. 1998) (requiring plans to include OB/GYNs as primary care physicians).

[166] *See* TEX. INS. CODE ANN. § 20A.09(a)(3)(D) (West Supp. 1998) (requiring HMOs to permit chronically ill member to apply to the plan to designate specialty physician as primary care physician).

[167] *See* Kongstvedt, *supra* note 24, at 121-22 (describing how excess funds in capitation pools are used to reward primary care physicians who make few patient referrals).

[168] *See* S. 2330, 105th Cong., 2d Sess., § 121(a) (1998) (proposing to amend § 503 of ERISA to require that plan permit non-binding external review of denial of services); N.J. STAT. ANN. § 26:2S-12 (West Supp. 1998) (creating a non-binding appeal process for denial of services by managed care plans).

[169] *See* 42 U.S.C.S. § 1395w-22(g) (Lexis Supp. 1998) (providing for binding external appeals from coverage decisions of Medicare+Choice plans); *see also* ARIZ. REV. STAT. ANN. §20-2537 (West Supp. 1997) (providing that a member may initiate a binding external independent review if a plan's agent denies the member's request for a covered service claim at both the informal and formal appeal levels); MO. ANN. STAT. § 376.1387 (West Supp. 1998) (requiring MCO directors to resolve grievances by enrollees over adverse determinations of covered services by any means not specifically prohibited by law, including through utilization of services of independent review organizations); CAL. HEALTH & SAFETY CODE § 1370.4 (West Supp. 1998) (providing the independent review process to examine the plan's coverage decisions regarding experimental or investigational therapies for enrollees).

controlled the grievance and dispute resolution processes, providing procedures within the plan, subject to decisions by plan employees, in order to maintain as much control over the dispute resolution process as possible.[170]

These regulatory measures are quite new, and time will tell how well they serve their intended ends. For present purposes, two questions should be asked: first, whether these regulatory measures are consistent with the bargain struck between payers (including government payers) and plans, and, second, whether these regulatory measures (or others like them) will likely succeed in moderating plans' inclination to exclude or stint.

The first question is essentially a political one. To the extent the bargain between payers and plans is literally that – a contract setting out terms, then, of course the contract is binding for its term. But the bargain at issue here is metaphorical, more akin to Rouseau's social compact than a purchase and sale agreement. Under those circumstances, whether and to what extent regulations should shape MCO behavior is properly in the hands of government, as political representative of broader society – one of the parties to the bargain. The bargain has always been subject to regulatory oversight,[171] although central to the bargain has been the movement of health care network formation, maintenance, and compensation away from government (and private payer) control, and delegating the task to entrepreneurial MCOs.[172] Although it is undeniable that injecting additional regulatory control over MCOs changes the bargain, and may reduce society's benefit therefrom,[173] it is a proper political question to ask whether broader so-

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[170] *See* Peter R. Kongstvedt, *Member Services and Consumer Affairs, in* ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 1, at 382-86 (discussing types of consumer complaints and grievances, while presenting the formal procedures enacted by health care plans to resolve them). There is, of course, a continuing dispute over the proper role of litigation in resolving disputes between plans and members. *See* Furrow, *supra* note 27, at 485-509 (analyzing theories of liability potentially available to injured patients for use against managed care organizations). That discussion is beyond the scope of this Article.

[171] *See* Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care,* HEALTH AFF., Nov.-Dec. 1997, at 26, 26 (discussing the necessary role of government regulation, along with market forces, in the development of an efficient and equitable health care system).

[172] *See generally id.* (discussing the fact that, although market forces control managed care costs, collective regulation is, to some extent, necessary for controlling against market failure).

[173] *See* Moran, *supra* note 32, at 16-17 (examining the potential effect that federal regulation of managed care has on society).

ciety prefers more costly, more heavily regulated managed care to the *status quo*.[174] And the recent "backlash" against managed care has been argued to constitute a public consensus for trimming the autonomy of MCOs in some way. Recent surveys have disclosed that approximately seventy-five percent of Americans support increased government regulation of managed care, although the number drops to fifty-two percent when the question is framed to acknowledge the likelihood that such regulation would raise costs.[175] These numbers are close enough to question the presence of a broad mandate for change. Moving from the general question to the specific, however, and considering regulatory measures one-by-one on their merits is both consistent with the bargain and the proper domain of legislatures.

The second question – whether the array of regulatory measures will curb excluding or stinting behavior – is harder to resolve. Initially, it should be noted that the vast majority of these measures (unlike risk adjustment measures discussed above) attempt to regulate stinting, not excluding behavior. There certainly are regulatory measures aimed at excluding – requirements that plans offer open enrollment and guarantee the issue of coverage for any qualified applicant are the clearest of these.[176] But most managed care regulations, and all of those described above, are aimed at plan behavior that would deny or limit care to an enrollee during the period of enrollment. While each of the regulations imposed on managed care will likely be evaluated in practice in years to come, there is reason to doubt the efficacy of these forms of regulation, which seek to divest plans of decisional authority in very explicit but narrow circumstances, often in reaction to the public's perception of specific abuses by MCOs.[177]

The reason for skepticism about the ultimate value of these structural regulations of MCOs is the very nature of MCOs. The nature of managed care plans is to change their structure and busi-

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[174] *See* Alain C. Enthoven & Sara J. Singer, *The Managed Care Backlash and The Task Force In California*, HEALTH AFF., July-Aug. 1998, at 95, 100 (suggesting that "Americans must reconcile their demand for lower cost with their demand for unlimited care").

[175] *See* Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., July-Aug. 1999, at 80, 83 (exploring cost dependent analysis of increased government intervention in MCOs) (West Supp. 1998).

[176] *See* 42 U.S.C.A. § 1395w-21(g) (West Supp. 1998) (imposing guaranteed issue and renewal requirements for plans participating in Medicare+Choice).

[177] *See* Moran, *supra* note 32, at 8-9 (decrying "body part *du jour*" legislation that is allegedly the result of cynical political reaction to anecdotal reports of abuses).

ness practices rapidly and continuously,[178] and regulators are likely to be always a step behind the latest business practice in this dynamic area.[179] In addition, piecemeal regulatory legislation adopted to respond to the latest horror story too often represents a facile response, and one not representing a thoughtful balancing of the costs of such interference with managed care. But the pace of change aside, the methods by which MCOs contain costs are simply too complex and subtle to be easily addressed by rigid regulations. In the context of managed care for one set of chronic conditions, mental health and substance abuse (MH/SA), the problem with regulation has been described as follows:

> The significance of the shift to managed care for MH/SA is that insurance contracts have become much more complicated and at the same time more remote from regulatory control. Managed care typically covers "medically necessary" care. Medical necessity and therefore de facto coverage for treatment of MH/SA conditions depends on a complex set of interrelationships involving the features of the benefit package, the structure of the provider network organized by the managed care organization, the financial incentives facing providers, and the administrative mechanisms put in place by the managed care organization to control utilization and quality of care.[180]

In other areas of treatment as well, "[t]he denial of necessary care is carried out through mechanisms that are often subtle and vary depending on the structure of the managed care plan."[181] The sub-

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[178] *See* Wagner, *supra* note 1, at 37 ("As a result of . . . recent changes, the descriptions of different types of managed care systems that follow provide only a guideline for determining the form of managed care organization that is observed. In many cases (or in most cases in some markets), the managed health care organization will be a hybrid of several specific types").

[179] *See* Lynn Etheredge, *Promarket Regulation: An SEC-FASB Model*, HEALTH AFF., Nov.-Dec. 1997, at 22 (noting that governmental agencies' "bureaucratic decision-making processes, requiring two to three years for major regulations, are slow compared with today's pace of market change"). In addition, piecemeal regulatory legislation adopted to respond to the latest horror story too often represents a facile response, and one not representing a thoughtful balancing of the costs of such interference with managed care. *See* Furrow, *supra* note 19, at 394-95 (explaining that legislation is often flawed by a rush to protect what is "politically charged," and not that which is a serious problem).

[180] Frank et al., *supra* note 58, at 113.

[181] Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, 31 GA. L. REV. 373, 386 (1997)

tle mechanisms include the financial pressures on providers imposed by capitation and withhold/bonus compensation plans, "physician profiling" or economic credentialing, by which providers' admission and retention in a network is dependent on adherence to a plan's philosophy of practice, and the use of practice guidelines to encourage physicians to practice more conservatively.[182]

In short, the practices most responsible for stinting behavior in MCOs are constantly evolving with marketplace innovations, and are either carried out through subtle, difficult-to-police enforcement methods, or are the natural result of the financial compensation methods that are at the heart of the managed care form. At some level, regulating MCOs to control stinting is a battle against human nature. MCOs prosper, after all, from aligning providers' economic incentives with the cost containment goals of the plan. Egregious misbehavior is and always will be the proper and sensible subject of regulatory control. But it may be unreasonable to expect structural regulation of managed care to provide suitable comprehensive protection of the medically needy from care denials in a system driven by incentives to conserve cost.

### C. Information Distribution and Private Accreditation

Risk adjustment is likely to do little to address problems with stinting, although it may eventually be an effective means to address excluding. And structural regulation, while effective in preventing the most extreme abuses, is unlikely to serve as proof against stinting. Can the recent move toward "market-based regulation" in the form of quality analysis and broad distribution of evaluative information be expected to protect the chronically ill from stinting behavior? Perhaps it can in the future, but not in the near term. The ability meaningfully to measure the performance of MCOs has not yet been realized, although progress is being made, and the lack of a well-functioning assessment system is not attributable to "lack of effort or brains, but the fact that performance measurement is just plain difficult."[183]

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(discussing methods that managed care providers use to discourage patients from utilizing the plan's medical services).

[182] *See* Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 27-31 (1996) (evaluating indirect pressures which influence physicians to keep care costs low, such as capitations, fee withhold arrangements, and physician profiling).

[183] Eddy, *supra* note 101, at 8.

Efforts to gather, analyze, and publish qualitative information about MCOs has advanced in recent years, largely through the efforts of the National Committee on Quality Assurance (NCQA)[184] and its use of the Health Plan Employer Data and Information Set (HEDIS).[185] Through NCQA and other organizations,[186] payers and consumers have access to information measuring plan performance, structure, and process in a variety of areas.[187] In theory, payers and consumers may use data-gathering and analytic activity as a partial correction of managed care market failures.[188] Specifically, access to plan data and analyses thereof can provide payers and consumers with information to enable them to assess competing plans, and to enforce quality, access, and cost standards through market power – by choosing to do business with plans that meet their needs and requirements.[189]

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[184] The National Committee on Quality Assurance (NCQA) "is a not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. [Its] mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decisions." *National Committee for Quality Assurance: An Overview,* <http://www.ncqa.org/overview3.htm> (visited Nov. 3, 1998). *See also* Furrow, *supra* note 19, at 400 (explaining the function of the NCQA).

NCQA is governed by a 23-member board of directors. The members appear to have the following affiliations: business and industry (6), provider (including, but not limited to, health plan) (11), labor union (2), consumer (3), and NCQA officer (1). *Board of Directors* <http://www.ncqa.org/board.htm> (last modified Apr. 6, 1998)

[185] The Health Plan Employer Data and Information Set (HEDIS) is a data base maintained by NCQA, and comprises a "set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to compare reliably the performance of managed health care plans." *HEDIS/Report Cards* <http://www.ncqa.org/hedis/30exsum.htm> (visited Nov. 3, 1998).

[186] *See* Eddy, *supra* note 101, at 20 (stating that various organizations, such as NCQA, have described criteria used in assessing performance measures).

[187] The latest iteration of HEDIS (HEDIS 3.0), for example, measures plan performance, structure, and process in eight areas: effectiveness of care, access/availability of care, member satisfaction, plan stability, use of services by members, costs, patient education, and plan organization. *HEDIS 3.0® Reporting and Testing Set Measures,* <http://www.ncqa.org/news/hedismeas.htm> (visited Nov. 3, 1998). *See also* Kuhlthau et al., *supra* note 12, at 44-48 (discussing the strengths and weaknesses of HEDIS 3.0).

[188] *See* Moran, *supra* note 32, at 11-15 (examining the theory of a managed care market and showing the most commonly cited defects: information asymmetries, health insurance, supplier-induced demand, and concerns about the uninsured).

[189] *See* Furrow, *supra* note 19, at 404-05 (discussing both the competitive and consumer benefits that the public release of hospital outcome and success rate information would provide).

The two closely related benefits consumers and payers hope to gain from the data-gathering and analytic efforts are access to data on performance, structure and process, and guidance from the informed judgments, in the form of ratings or accreditation, from detached observers and experts. The second is a shorthand version of the first. Should payers and consumers be disinclined or unable to examine for themselves the array of data reports appropriate to their assessment of plans according to their desires and needs, they could use the ratings or accreditation process as a proxy for individualized assessment. The ratings and accreditation process employs data generated from performance (including patient satisfaction), structure and process measures, applies an evaluative judgment of the implications of the data, and reports a simple (or simpler) result.[190] In other words, consumers and payers disinclined to examine and evaluate data themselves can accept the judgment of the NCQA, which reports on "full," "one-year," "provisional," or "denied" status of plans on accreditation, and accept that judgment as a rough indicator of the quality of a plan.[191]

The potentials and shortcomings of the assessment systems have been described elsewhere, and will not be rehearsed here.[192] An incomplete list of the difficulties faced by the current systems includes: the conceptual difficulty of identifying measurable factors indicative of quality health care; information systems problems in gathering an accurate, suitably large sample of data for each relevant factor; the presence of competing and inconsistent measurement tools; and the massive problem of digesting large amounts of data, and translating that data into a form comprehen-

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[190] *See id.* at 400-07 (describing the NCQA accreditation process).

[191] *Id.* at 401 (discussing the percentage of plans that receive full accreditation, one-year approval, provisional accreditation, or a denial).

[192] *See, e.g.*, Eddy, *supra* note 101 (discussing the lack of sufficient indicators available to measure performance of health plans, and offering possible solutions); Furrow, *supra* note 19 (discussing the function of private accreditation in the managed care industry); Jacobi, *supra* note 27 (analyzing the scope and shortcomings of health care assessment techniques); Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J. L. & MED. 37, 37 (1994) (defining outcomes assessment and outlining "the possible uses of outcomes assessment in creating and operating a reformed health care system, and key legal implications"); Maxwell J. Mehlman, *Assuring the Quality of Medical Care: The Impact of Outcome Measurement and Practice Standards*, 18 L. MED. & HEALTH CARE 368 (1990) (discussing concerns that the quality assurance systems are ineffective, unfair, and costly). *See also* AVEDIS DONABEDIAN, THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT (1980) (exploring the definition of quality and some basic approaches to its assessment).

sible to payers and consumers.[193] Two overriding non-technical problems also loom. First, it is unclear who will actually use the information produced, and in what fashion.[194] Second, the information generated will not be useful if the recipients, and particularly consumers, are not permitted the use the information to exert market pressure, by exercising choice in the selection of a plan.[195]

Were the above problems resolved, consumers and payers would be able to assess for themselves plans' performance in an array of areas relevant to their choice of a plan. Should information and analysis be available in a form accurately reflecting relevant plan performance, in a form accessible to payers and consumers, and should payers and consumers be empowered to act on the information received, these devices would serve as a very effective corrective to managed care market failures. Specifically, plans that stinted on care would be revealed, and to the extent that their stinting behavior was regarded as unacceptable, the plans would suffer loss of market share unless and until they corrected their behavior.

As conditional as this sounds, the likelihood that a data-based information and accreditation procedure useful to payers' and consumers' judgments on plan quality will be met in the foreseeable future seems akin to the likelihood of a harmonic convergence. First, a chronically ill person, by virtue of his health status, is often nearly overwhelmed by the many tasks and complications that fall to him in negotiating social service systems, diet and exercise requirements, health systems, in addition to abnormally high levels of pain and discomfort.[196] Second, the low frequency of many chronic illnesses make them difficult subjects of measurement across plans, and therefore unlikely to appear in consensus panels'

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[193] *See* Eddy, *supra* note 101, at 11-17 (listing difficulties faced by health plan assessment systems).

[194] *See* Robert S. Galvin, *Are Performance Measures Relevant?*, HEALTH AFF., July-Aug. 1998, at 29, 30 (explaining the need for performance measures in managed care health systems that more accurately reflect what physicians and patients want); *see also* Judith H. Hibbard et al., *Choosing a Health Plan: Do Large Employers Use the Data?*, HEALTH AFF., Nov.-Dec. 1997, at 172, 178-79 (discussing barriers to the efficient use of clinical quality information by purchasers).

[195] *See* Furrow, *supra* note 19, at 390 (explaining that the lack of information available regarding access to care and quality of care precludes consumers from making informed decisions about health care).

[196] *See* Jennings et al., *supra* note 7, at 6 (detailing common problems of people suffering from chronic illnesses).

determinations of factors for measurement.[197] Third, HEDIS, the dominant tool for measuring plan performance, fails to measure adequately plan performance for chronic care. In its current iteration, it

> [L]acks a method to define the population of children with chronic conditions beyond disability enrollment based on SSI criteria (which is collected only for the Medicaid population). In addition, HEDIS lacks specific structure, process, and outcomes measures for this population.[198]

Fourth, people with chronic conditions, and certainly those with particular chronic conditions, will never be able to rely on the accreditation process as will the well population. Those with childhood diabetes, for example, will be in a tiny minority,[199] and will see their more specific chronic care indicators washed out in a global assessment process. And fifth, the chronically ill may lack market power to use the information meaningfully. That is, they may be either too small a group, with idiosyncratic needs, for a plan to court,[200] or, unless much-improved risk adjustment methods truly make them as attractive a group of enrollees as the well population, plans may be willing to lose their patronage.[201]

In sum, the circle will be difficult to square. Public or private regulation to eliminate or minimize excluding and stinting behavior directed by MCOs at the chronically ill show some promise to help, but are unlikely to succeed in the foreseeable future. Risk adjustment, at best, is likely to control excluding behavior, to the benefit of payers as much as consumers. Structural regulation is

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[197] *See* Eddy, *supra* note 101, at 12 (pointing out that the low frequency of certain diseases is a natural problem which makes the use of population-based health plan assessment measures very difficult); *see also* Kuhlthau et al., *supra* note 12, at 43 (distinguishing health care of children with chronic conditions from that of adults, and the impact low-occurrence diseases have on monitoring such conditions).

[198] Kuhlthau et al., *supra* note 12, at 48. *See also* Elizabeth A. McGlynn, *Choosing Chronic Disease Measures for HEDIS: Conceptual Framework and Review of Seven Clinical Areas, in* MANAGED CARE AND CHRONIC ILLNESS: CHALLENGES AND OPPORTUNITIES, *supra* note 7, at 18 (discussing analysis produced for NCQA's steering committee considering adding chronic conditions to HEDIS).

[199] *See* Kuhlthau et al., *supra* note 12, at 43 (explaining how children with diabetes are only a small percentage of those children with chronic illnesses, and how this impacts on measurements of care).

[200] *See id.* (describing how some chronic diseases, such as diabetes, only affect a very small number of children).

[201] *See supra* text accompanying notes 112-28 (discussing risk selection and adjustment).

bound to be ineffective, as the very nature of managed care creates subtle incentives and works on innumerable and hidden decision points not readily addressed by rigid rules. And information distribution and accreditation processes are still in their infancy, and will, even when mature, be more likely to protect the well than the chronically ill. In light of these conclusions, the following section sets out some preliminary thoughts as to the proper social response to the inadequacy of the bargain as it applies to the chronically ill.

## IV. MOVING BEYOND MANAGED CARE FOR THE CHRONICALLY ILL

If, notwithstanding the measures described above, the circle cannot be squared, and the managed care bargain cannot be tinkered with to accommodate the interests of the chronically ill to avoid excluding and stinting behavior by MCOs, what can be done? One choice that is clearly not a possibility is to revert "to the *status quo ante* of, say, 1975."[202] The world of health care and health care finance has simply moved on; legislation simply attacking managed care probably "misses the evolution of health care that managed care represents. The point of many of these changes is to produce a sophisticated integrated team approach to care rather than focusing on the model of the virtuous and solitary physician."[203] It is in the interest of the chronically ill, after all, to move to a more integrated system of health care delivery, and away from the episodic, fragmented system of the "good old days."[204]

This section will examine two methods by which some commentators have proposed more fundamental adjustments to the managed care bargain than those discussed above. The two methods share a common interest in maintaining in managed care that which is good for the chronically ill while modifying that which threatens them. Managed care is the combination of health finance

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[202] *See* Moran, *supra* note 32, at 20 (showing problems with the current health care system, prospects for workable federal regulation, as well as concerns with the proposed federal regulatory solution).

[203] Furrow, *supra* note 19, at 395.

[204] *See* Christianson et al., *supra* note 7, at 18 (discussing the history of the treatment process included in caring for the chronically ill); *see also* Sandy & Gibson, *supra* note 7, at 12 (stating that managed care systems have the potential to overcome the fragmented effects of a poorly organized fee-for-service sector).

and health care delivery.[205] Both of the following models propose to preserve the ability of managed care to coordinate and organize a broad array of care. Both propose changes in the financing aspect of managed care. The first model proposes a centralization of the financing aspect of managed care, in which the Health Care Financing Administration (HCFA) acts as a meta-MCO. The second proposes that, for the chronically ill, reimbursement not be based solely on a fixed capitation or global premium, but rather on a mix of a capitation amount and additional per-service payments to reflect actual utilization. The first appears to vary too much from the beneficial aspects of the managed care bargain be engrafted onto it, and could not be undertaken without a substantial and conscious political change of heart, while the second appears to be a sensible accommodation of the tension in managed care treatment for the chronically ill, if one difficult to put into practice.

### A. Centralization of Financial Function: HCFA as an MCO

In an article drafted before the Balanced Budget Act of 1997 was enacted, Peter D. Fox bemoaned the fact that Medicare would remain a "fee-for-service system for the foreseeable future."[206] He, like many other analysts, believes that "[m]anaged care offers the potential for reducing utilization," and that, by employing managed care, Medicare could avoid the threatened evil of benefit or reimbursement reductions.[207] Forecasting no appreciable shift in Medicare to managed care, he made an interesting proposal. Without quite saying so explicitly, he suggested that, if Mohammed would not go to the mountain, the mountain should come to Mohammed: Medicare should become a meta-MCO. He suggested that Medicare cease acting as merely a financing entity, and begin acting as a health program[208] – integrating, as do MCOs, the financing and care delivery functions.

I approach the issues from a slightly different direction than does Fox. I believe, for instance, that with the creation of a managed care infrastructure in Medicare by the addition of Medi-

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[205] *See* Eaton, *supra* note 1, at 368 (discussing how managed care's cost-cutting focus requires an adaptation of legal policies that were created under the fee-for-service system).

[206] Peter D. Fox, *Applying Managed Care Techniques In Traditional Medicare*, HEALTH AFF., Sept.-Oct. 1997, at 44, 45.

[207] *Id.* at 45.

[208] *See id.* at 51 (stating that this would require a shift in timing regarding how Medicare functions).

care+Choice,[209] future Congresses will be tempted to create substantial financial incentives to move more Medicare beneficiaries into managed care. In addition, my primary concern in the Article is not conserving payers' resources (although this is a genuinely important goal), but ensuring appropriate care for the chronically ill. Fox's modest proposal nevertheless offers an intriguing model for escaping the pressures managed care places on the chronically ill.

Fox begins by explaining why it is difficult for HCFA to mimic the nimble, ever-changing management style that characterizes MCOs. He points out that Medicare's very size (it insures one-third or more of the patients seen by many providers)[210] and its political accountability limit its ability to act decisively in provider network formation, maintenance, and payment.[211] As a governmental agency, its actions give rise to due process rights, and its contracting, personnel and rulemaking tasks must comply with various "sunshine act" requirements.[212] Perhaps most tellingly, Medicare must make rules through notice and comment rulemaking, requiring it to have a lead time measured not in days but in years.[213]

While Fox accurately captures the institutional limitations of HCFA, he may overstate the institutional merits of MCOs. Since Fox's analysis, many MCOs have fallen upon hard times.[214] In recent years, escalating competitive pressures have led MCOs to compete on the basis of price,[215] and their attempts to expand market share seem to have overwhelmed their broader sense of fiscal

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[209] *See* 42 U.S.C.A. §§ 1395w-21 to -28 (West Supp. 1997) (creating and defining the Medicare+Choice program).

[210] Fox, *supra* note 206, at 46 (noting, additionally, that the percentage may be greater than 50% in some specialists' practices).

[211] *Id.* (stating that, due to Medicare's size, the tendency of the government is to focus its attention on extreme outliers in the program, thus reducing its ability to influence practice norms).

[212] *See id.* (explaining that many decisions made by private plans are made privately and are judgmental, contrasting justified public decisions by government agencies).

[213] *See id.* (stating that "[g]overnment agencies are often slow in making decisions because of their size and organization").

[214] *See* Michele Bitoun Blecher, *Burned on the Street*, HOSP. & HEALTH NETWORKS, Mar. 5, 1998, at 23 (reporting the financial woes of Oxford Health Plans and other MCOs due to the decline of their stock on Wall Street).

[215] *See* Hoffmann, *supra* note 18, at 324-29 (explaining the means managed care plans use to lower costs so that they can compete on the basis of price).

prudence.[216] The moves of the largely for-profit, entrepreneurial managed care business these days often seems driven as much by the judgments of investment bankers and venture capitalists as by health systems administrators.[217] And even old, large, stable not-for-profit MCOs have experienced grave financial setbacks, and are facing the prospect of either seeking large premium increases, or dramatically cutting costs.[218] Hard times may force a revision of the almost automatic preference for private business over the reviled government bureaucrat.

After acknowledging the barriers to governmental action, Fox proposes that HCFA take steps to effect programmatic changes in Medicare. With respect to physicians and other professionals, he proposes that HCFA act as a PPO, creating select panels based on practice style and economic examination of utilization – in other words, HCFA should engage in economic credentialing.[219] In addition, HCFA should institute utilization controls, such as precertification and concurrent review, and should use primary care physicians as gatekeepers.[220] And it should fund separately population-based health education and case management for the chronically ill and frail elderly population.[221] These last measures would permit access to services, such as social services and housing support, that

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[216] *See* Blecher, *supra* note 214 (discussing the challenges that MCOs have faced in recent years, and their responses to competitive pressures).

[217] *See id.; see also* Jan Greene, *Starting Up the Upstarts,* HOSP. & HEALTH NETWORKS, Dec. 20, 1997, at 16, 18 (discussing how venture capitalists and other investors are becoming interested in managed care, and how these investors are affecting the development of managed care companies).

[218] *See* Richard Haugh, *Kaiser's Squeeze Play,* HOSP. & HEALTH NETWORKS, May 5, 1998, at 37-38 (discussing possible actions by Kaiser Permanente to reach economic stability after a multi-million dollar loss in 1997).

[219] *See* Fox, *supra* note 25, at 48-49 (explaining how improving provider profiling, conducting utilization studies, and developing PPO arrangements can improve Medicare, and suggesting that "HCFA could use practice profiles to identify efficient physicians and negotiate agreements with those willing to accept rates below those of Medicare or those who volunteer to cooperate with selected utilization management requirements"). *See supra* text accompanying notes 27-28 (discussing economic credentialing).

[220] *See* Fox, *supra* note 25, at 50 (describing how prior authorization of selected high-cost services can achieve savings, and discussing how a gate-keeping method would offer the advantages of achievement of savings through practices such as case management fee compensation to physicians for social service contacts).

[221] *See id.* at 52-53 (discussing the need for Medicare to fund local agencies to conduct secondary and tertiary prevention programs for the chronically ill and the elderly).

are both beyond the scope of the defined-benefit Medicare program, and absolutely essential to the populations Fox identifies.[222]

What Fox envisions is a one-tier shift from the current "privatized" vision of Medicare managed care. In current Medicare managed care, HCFA gives over to commercial MCOs the provider network formation, maintenance, and compensation tasks, and the MCOs in turn arrange, through subcapitation and other downstream financing mechanisms, for the delivery of care as appropriate.[223] Fox proposes retaining the provider network formation, maintenance, and compensation tasks within HCFA, with HCFA then acting not "as a financing [but as] a health program," aggressively and actively managing the entire spectrum of providers, as well as the care of Medicare enrollees, after the fashion of a commercial MCO.

The reinvention of HCFA as a meta-MCO would provide an opportunity to infuse the organizational coherence of managed care with the patient orientation and sensibility of a public health agency. It goes without saying that the result could be a disaster – failed experiments in big government are not difficult to find – but it need not be. If such a step were to succeed, HCFA would have at its disposal all of the tools of modern health care finance, including capitation, partial capitation, case management, and global fees to apply as the needs of a class of enrollees suggested. The provider credentialing process could be financial acuity, leavened by concern for quality and service; the selection of payment methodologies could vary not merely according to market pressure, but according to public policy concerns.

But this vision is unlikely to be realized in the near term. First, Congress seems to have chosen the road of "privatization" of network formation, maintenance, and compensation in the Balanced Budget Act of 1997.[224] This experiment in privatizing Medi-

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[222] *See id.* at 53 (discussing functions that local community agencies could perform to proactively reduce costs, such as conducting home assessments, developing support groups, and moving volunteer programs). *See* Christianson et al., *supra* note 7, at 16-17 (arguing that an essential aspect of managing chronic illness is providing social services).

[223] *See supra* text accompanying notes 15-32 (describing the "privatization" of Medicare through managed care); *see also* Latham, *supra* note 15, at 402-03 (discussing general techniques of how managed care plans reimburse their physician providers).

[224] *See* 42 U.S.C.A. §§ 1395w-21 to -28 (creating Medicare+Choice); 42 U.S.C.A. § 1396u-2(a)(1)(A) (granting states authority to condition Medicaid entitlement on managed care enrollment).

care and Medicaid financing has not yet run its course, and it is unlikely that Congress will veer away before testing is complete. Second, Fox's vision would inevitably sound of "big government," although it is not clear on its face that it would make government any bigger than it already is. As Fox points out, HCFA's attempts to engage in precisely the same aggressive network maintenance activities routinely employed in the private sector would likely result in a firestorm of protest, as some physicians, hospitals, and other providers would seek recourse in the political arena for their disappointment at being excluded from HCFA's PPO-style select network.[225] And solutions to health financing that sound in big government were not well-received during the 1993-94 exercise in considering national health system overhaul.[226] Therefore, reinvention of HCFA seems not to be in the cards.

### B. Partial Capitation and Mixed Systems

That piecemeal regulation cannot vouchsafe the safety of the chronically ill need not signal that managed care should be abandoned as a health financing mechanism. Indeed, as Professor Furrow suggests, "the evolution of health care that managed care represents" may now be too firmly entrenched in the culture of health care delivery to pretend that abandoning it is an option.[227] Indeed, the coordination and team-oriented care that is an aspect of many managed care organizations is potentially of great benefit to the chronically ill. It is the finance, and not the care delivery aspects of managed care, that raises concerns for the chronically ill, and several commentators have suggested that modifying the financial relations between plans and caregivers, but not the relationships *among* caregivers, may be a suitable method of accommodating the needs of the chronically ill to managed care. The incentives that might work well with enrollees who use primary care mostly as preventive care, and acute care only rarely, seem to run aground with patients who demonstrably require a high-utilization practice

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[225] *See* Fox, *supra* note 25, at 46 (discussing problems likely to be encountered if Medicare were to adopt a managed care form of organization).

[226] *See* THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS 133-72 (1996) (discussing the backlash against big government which occurred in 1994 as a result of proposed health security legislation); Steinmo & Watts, *supra* note 17, at 330 (arguing that the comprehensive national health care reform was not passed due to the political structure and "institutional context" being biased against comprehensive reform).

[227] Furrow, *supra* note 19, at 395 (discussing the flaws of state insurance regulation with respect to MCOs).

style, such as the chronically ill. The remedial concept, then, is to maintain managed care's financial incentives for the non-chronically ill, modify or jettison them for the chronically ill, and maintain for all enrollees the central coordination of care. While MCOs use a wide array of financial incentives, they uniformly, and rather indiscriminately, encourage a reduction in services.[228] Incentives can take the form of capitation, which itself can be structured to transfer more or less risk to the provider. For example, a physician can accept risk only for the services within her area of practice, or for all physician services, necessitating her contracting with a range of other physicians to provide needed care.[229] Alternatively, providers can be paid on a fee-for-service basis, but also be subject to "withholds" or bonuses.[230] That is, providers can expect a certain amount of payment for each service, but that amount (by the end of an accounting period) can vary dramatically depending on the provider's performance against a range of standards, including the level of service utilization experienced by the plan.[231]

These payment methods create incentives for providers to think creatively about the cost-effectiveness of various treatment options, to bargain more aggressively with suppliers, and economize on overhead.[232] But, as one commentator has observed,

> In the short term, a physician confronting a patient does not have the options of inventing a new form of cost-effective preventive treatment, negotiating a lower price for drugs, or firing a nurse. In that setting, given a choice of several plausible diagnostic or treatment options, the physician facing direct financial incentives will have some incentive to choose the least expensive option.[233]

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[228] *See generally* Kongstvedt, *supra* note 24, at 115-36 (detailing permutations of capitation and withhold/bonus arrangements).

[229] *See* Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 57-58 (1996) (describing direct financial incentives used in managed care, specifically discussing the capitated system's effect on and risk to the physician).

[230] *See id.* at 58-59 (describing bonuses and illustrating how withholds operate with an example based on Stanfored University's triple option plan).

[231] *See id.* at 57 (explaining how salaried physicians' incentives may differ from those of physicians under the capitated system).

[232] *See id.* at 69-70 (describing the means providers can use to lower the cost of caring for patients).

[233] *Id.* at 71.

In the general population, this impulse to economize on a treatment-by-treatment basis is sometimes moderated by knowledge that such conduct is penny wise and pound foolish: providing the appropriate treatment in a timely fashion can often forestall the need for more expensive treatment in the future.[234] This is not as commonly true for the chronically ill, for whom preventive, or even curative care cannot diminish the need for ongoing care and services.[235] The incentive created in managed care reimbursement policies, then, present a grave threat to the chronically ill.

But the coordinated care orientation of managed care, by reducing incentives for institutional care and encouraging cooperation and communication among providers, seems well-suited to chronic care.[236] Some with chronic conditions can, with proper treatment, experience "marked functional improvement, and in some instances, cure."[237] For a very large number of the chronically ill, however, extensive care is necessary to improve or maintain function.[238] Treatment goals in such circumstances are quite different than those for acute illness:

> For the increasingly large numbers of individuals suffering from chronic but non-terminal illnesses which cause functional impairment, "curing" is not possible, but "caring" includes extensive assessment and treatment aimed at maximizing quality of life on functional terms.
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> . . .
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> The clinical approach to chronic disease emphasizes functional assessment and functional goals of therapy . . . . Helping the patient requires understanding the interactions of often multiple chronic disorders, psychological dynam-

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[234] *See id.* at 73 (explaining how good treatment often saves the capitated physician money in the long run by using the example of stroke prevention and vaccinations). *See also* Horwitz & Stein, *supra* note 13, at 581 (explaining how HMOs could offer the coordinated care and preventative services needed by chronically ill children, presumably lowering health care costs in the future).

[235] *See* Horwitz & Stein, *supra* note 13, at 581 (discussing some of the specialized and ongoing services required by chronically ill children).

[236] *See id.* (discussing how HMOs can efficiently "provide improved coordinated care for those with complex conditions").

[237] Neff & Anderson, *supra* note 8, at 1866 (explaining that those illnesses may require high expenditures initially and some increased level of expenditures throughout the child's life).

[238] *See id.*

ics, and social support systems in order to assess areas of potential intervention and improvement.[239]

Essential to the successful treatment of chronic illness is sustained and flexible management, "a greater breadth of resources and a larger number of individuals than the treatment for most acute problems," and coordination with family members and social service providers.[240] The main differences between acute care and chronic care, then, is that the latter requires:

- a focus on relief of symptoms rather than cure;
- the imperative of patient participation in the care process ("patient empowerment");
- active roles for significant others, mostly immediate family;
- unclear boundaries among providers and between traditional medical services and the social services delivery system; and
- technical quality and patient (as well as family) satisfaction being more interdependent than for acute care.[241]

How, then, can the paradox of managed care be resolved,[242] in light of the likely partial failure of incremental regulation? Two strategies are now employed, on very small scales, in which the provider coordination function of managed care is maintained, but the nature of the financial relationships between payer and plan or the plan and its providers is altered. The first is "partial capitation," in which the payer's capitation rate or the plan's subcapitation rate to a provider is only a part of the payment for services. The basic capitation amount under such a scheme is supplemented either through a reinsurance plan, where fee-for-service payments begin after costs have reached a threshold level, or through a "blending" of capitation and fee-for-service payments from the

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[239] Cassel, *supra* note 33, at 408 (discussing the quality of life as a treatment goal).

[240] Christianson et al., *supra* note 7, at 17 (discussing the essential components of managing chronic illness).

[241] Peter D. Fox & Teresa Fama, *Managed Care and Chronic Illness: An Overview, in* MANAGED CARE AND CHRONIC ILLNESS: CHALLENGES AND OPPORTUNITIES, *supra* note 7, at 6. *See generally* Ronnie Grower et al., *Case Management: Meeting the Needs of Chronically Ill Patients in an HMO, in* MANAGED CARE AND CHRONIC ILLNESS: CHALLENGES AND OPPORTUNITIES, *supra* note 7, at 73-92 (providing examples of organizational attempts to provide coordinated managed cares services for the chronically ill in managed care settings).

[242] *See supra* text accompanying notes 103-11 (discussing the paradox of MCOs as both financing entities and caregiving entities).

first provision of services.[243] In the case of reinsurance, the payment for care for chronically ill enrollees would be increased when the cost of care becomes quite high, after which each additional treatment is paid for at a fee-for-service rate. In the case of blended payments, the payment would be partially by capitation, for example, fifty percent of the projected cost. Each patient encounter, however, would result in some fee-for-service payment, calculated at a percentage, for example, fifty percent, of the full fee for service rate. The result of this blending would be to share risk smoothly between the payer and the provider, maintaining an incentive to control cost, but moderating that incentive by ensuring higher payments for cases requiring more intense treatment.[244]

The second alteration of the financial aspects of managed care is the "carve out" of a group, such as the chronically ill, from the general pool, and the assignment of a greatly enhanced capitation rate, often coupled with expanded service coverage. This method is a distant cousin to risk adjustment, in that it attempts to maintain capitation as the form of payment, but is binary in a way that risk adjustment is not. That is, either an enrollee is in the general risk pool, and is subject to the general covered services and the general capitation rate, or he is in an entirely different plan, engineered in both coverage and capitation to reflect the enrollee's very different needs.[245] An example of this "carve out" methodology is the Program for All-Inclusive Care for the Elderly (PACE), a joint Medicare-Medicaid managed care program.[246] The program provides an extensive, flexibly defined array of community and social services to the frail elderly, who are sufficiently ill otherwise to qualify for nursing home level of care, in order to permit them to remain in

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[243] *See* Oberlander, *supra* note 60, at 624 (explaining the possibilities of incorporating a growing managed care system with the existing Medicare); Medicare Payment Advisory Comm'n, *supra* note 8, at 34-35 (describing partial capitation as an alternative approach to risk sharing under Medicare).

[244] *See* Medicare Payment Advisory Comm'n, *supra* note 8, at 34-35 (arguing that partial capitation is a more "economically neutral" approach to sharing risk); Newhouse et al., *supra* note 7, at 38-39 (discussing the benefits and important drawback to a payment scheme blending adjusted captitated payments and traditional program payments).

[245] *See* Context for a Changing Medicare Program, *supra* note 7, at 150 (discussing the use of "specialized managed care organizations" and "carve-outs" as innovative ways to care for beneficiaries with disabilities and chronic illnesses).

[246] *See* Medicare Payment Advisory Comm'n, *supra* note 149, at 111-20 (describing how the PACE program was "designed to keep frail elders out of nursing homes and to reduce their use of inpatient care by providing primary, preventative, and institutional care").

the community and out of institutions.[247] Both Medicare and Medicaid pay a capitation rate, and together the amount is quite high – ranging from $2,629 to $5,865 per month, depending on the location of the program.[248] The program is voluntary, and its goal is to extend social and community services to permit the enrollee to stay out of a nursing home, serving the personal goal of the enrollee and the fiscal interests of the two health programs. And although the program is comprised of small demonstration sites, and results are therefore tentative, it appears to have been successful on both scores.[249] The Balanced Budget Act of 1997 changed the status of the PACE program from experimental to permanent,[250] and it allowed for further demonstration projects to test rate adjustments, such as blended, reinsured, and carved-out rates for chronically ill Medicare enrollees.[251]

Both the partial capitation and carve-out adjustments to managed care change the managed care bargain in a relatively dramatic way. They reinject the payer into a much more active role in the payment and service delivery process. Blended and capitation rates require that the payer return to the tasks, ceded to MCOs under pure managed care, of maintaining encounter data and paying per-service reimbursement.[252] And carve-out systems such as PACE have yet to be fully evaluated for cost-effectiveness; certainly, there is grave risk of selection problems, at least to the extent the program remains binary (the enrollee is either in PACE, with its very generous capitation rate, or is thrown back into traditional

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[247] *See id.* at 113 (detailing some of the services from which enrollees benefit, "such as social services, nutrition counseling, extended personal care, home-delivered meals, transportation, and respite care").

[248] *See id.* at 116 (tabulating the capitation rates that Medicare and Medicaid pay in the 12 PACE sites). For persons clinically eligible for PACE who are eligible for Medicare but not Medicaid, there is a premium charged to the enrollee as a substitute for the Medicaid payment. *See id.*

[249] *See* Robert L. Kane et al., *Variation in State Spending for Long-Term Care: Factors Associated with More Balanced Systems*, 23 J. HEALTH POL. POL'Y & L. 363, 386-87 (1998) (discussing PACE and how management of long-term care can lower costs and facilitate the desire of the elderly to remain in their homes as they grow frail).

[250] 42 U.S.C. § 1395eee.

[251] *See* 42 U.S.C. § 1395 6-1 (describing the Medicare Coordinated Care Demonstration Project that is designed to decrease expenditures under Title XVIII of the Social Security Act for health care services provided to chronically ill consumers).

[252] *See* Newhouse et al., *supra* note 7, at 38-39 (explaining that moving to a "blended payment would require collecting and coding encounter data for each person").

Medicare and Medicaid).[253] That being said, neither seems to present too much of a break from the pure "privatization" mode of managed care finance to prevent its implementation.

The success of such halfway measures may signal an opportunity to reconsider Fox's proposal to remake HCFA as a meta-MCO.[254] After all, with the reinjection of payers into the business of maintaining encounter data, evaluating severity of illness, and coordinating program design, the blended rate and carve-out adjustments are Fox's proposal writ small. The intermediate proposals exist on a continuum between "pure" managed care, where all network creation, maintenance, and compensation tasks are privatized, and Fox's vision of HCFA acting as a huge PPO. Should troubles with the chronically ill in nearly pure managed care arise in great numbers, and should experiments with mixed-model systems meet with success, then the natural result will be, and should be, a move away from privatized managed care, and toward a system in which government (for public or public and private insureds) acts as the health program, forming maintaining, and compensating providers in managed care fashion.

## V. CONCLUSION

Managed care can be dangerous for the chronically ill. Some managed care plans feature highly coordinated services with a strong primary care orientation – a very helpful innovation for the chronically ill. Managed care's reliance on capitation and other utilization-control techniques, however, could harm this large and growing population segment. Managed care's treatment structure is, at least in this respect, at war with its innovative financing methods. The cost-saving mechanisms that have thrust managed care into the health financing spotlight have and will inevitably encourage plans to attempt to exclude the chronically ill, or to withhold necessary treatment when they are enrolled.

The chronically ill, on the other hand, can be dangerous for managed care. The social bargain that managed care promises to meet is to constrain medical inflation while maintaining quality. It has built a track record (and market share) through disproportionately enrolling well members. The social bargain does not, how-

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[253] *See* Medicare Payment Advisory Comm'n, *supra* note 149, at 118-19 (noting that HCFA has yet to analyze the economic results of the PACE program, and discussing how an appropriate base payment rate needs to be established).

[254] *See supra* Part IV A.

ever, contemplate cherry picking in the long run. If public or private regulation cannot control the tendency of MCOs toward excluding and stinting behavior toward the chronically ill, managed care will be marginalized as a health financing mechanism in the future. The Balanced Budget Act of 1997 forces confrontation with this conflict. Its resolution may shape American health care for decades to come.