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FOREWORD

MANAGED CARE—WORK IN PROGRESS OR STALLED EXPERIMENT?

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The core of this Symposium on managed care is a pair of articles that consider the manageability of health care in two of the most difficult contexts that health plans can expect to encounter: the treatment of mental illness[1] and decisionmaking with respect to terminally ill patients.[2] These two areas highlight, perhaps more dramatically than any other areas of medical care, not only how difficult it is, but also how painful it can be, to allocate resources rationally to health care uses.[3] Although both articles demonstrate the immense challenge facing managed care organizations ("MCOs") and the attendant opportunities for error or abuse, neither of them finds clear evidence of serious, systematic failings by the managed care industry—even in the difficult areas they canvass. At the same time, however, in neither area—nor anywhere else in managed care, for that matter—can it be concluded that all is well.

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1. *See* Jesse A. Goldner, *Managed Care and Mental Health: Clinical Perspectives and Legal Realities*, 35 HOUS. L. REV. 1437 (1999).

2. *See* Alan Meisel, *Managed Care, Autonomy, and Decision-Making at the End of Life*, 35 HOUS. L. REV. 1393 (1999).

3. *See* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 3-6 (1997) (discussing the emotionally charged debate that surrounds the allocation of resources for health care).

Instead, it appears in all four articles in the Symposium, and also in other recent work,[4] that MCOs have not yet completed the task of discovering and implementing effective, sensitive techniques for putting resources to their best uses in addressing personal health needs. Even to optimists, managed health care is still only a work in progress.[5]

But is managed care *really* making progress toward the goal of efficiently allocating resources to health care uses? Unfortunately, as this Symposium is being published, most health plans seem to have suspended active searches for new solutions to the difficult organizational, incentive, and information problems that bedevil health care decisionmaking. Certainly, managed care has improved the quality of care in important respects, has substantially reduced the cost of care, and has generally given consumers better value for the money they spend on health services. But the overall performance of the managed care industry has largely disappointed those observers who expected competing health plans aggressively to organize providers in ambitious collaborative efforts to improve quality and achieve real efficiency in health care spending.[6]

Among the many factors that have sapped or frustrated the industry's innovative energies and impulses are: the sheer difficulty of managing physicians and changing their behavior; employers' desire to offer their workers only a few, mainstream options for health coverage; consumers' inability to see the cost savings from managed care and their limited opportunities to compare benefits and costs in purchasing a health plan; excessive prescription of health plans' methods and obligations by government and by the courts; and health plans' fear of triggering even more draconian laws enacted by legislators populistically feeding off of public fears about managed care. But whatever the precise reasons for the industry's loss of reformist

4. *See, e.g.*, WALTER A. ZELMAN & ROBERT A. BERENSON, THE MANAGED CARE BLUES AND HOW TO CURE THEM xv (1998) (criticizing managed care for its failure to improve the quality of medical care).

5. *Cf.* Paul M. Ellwood, Jr. & George D. Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083 (1996).

6. A number of observers have noted departures from earlier expectations. *See, e.g.*, Robert A. Berenson, *Beyond Competition*, HEALTH AFF., Mar.-Apr. 1997, at 171, 171 ("Health care markets have not evolved [as the logic of managed competition suggests]."); Lynn Etheredge et al., *What Is Driving Health System Change?*, HEALTH AFF., Winter 1996, at 93, 95-96 ("Only a few companies thus far are actively managing clinical care quality through improved disease management"; "easy savings mean that health plans could prosper without having to take on more challenging issues.").

zeal,[7] innovation in managed care today seems largely confined to the formation of so-called provider-sponsored organizations ("PSOs").[8] To the extent that this movement is merely a response to the invitation to form PSOs that the federal government issued in the Balanced Budget Act of 1997,[9] it confirms the observation that today's health plans have little taste or capacity for spontaneous, independent action. It remains to be seen whether, despite all the obstacles to real innovation, PSOs will eventually put managed care back on a progressive path.

In addition to falling short in closely integrating providers to deliver coordinated, higher-quality care at lower cost, managed care plans have also generally failed to offer consumers a meaningful range of choices with respect to the nature, cost, and quality of the protection they can purchase.[10] Indeed, managed care plans have never accepted the idea that they should offer an array of explicitly differentiated products reflecting different trade-offs between quality and cost. Despite early hopes that managed care would convert health care into a true consumer good that consumers could purchase in competitive markets in accordance with their ability or willingness to pay,[11] health plans have made virtually no effort to manage care pursuant to contractual commitments reflecting the differing preferences of

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7. Fuller explanations are found in: Berenson, *supra* note 6; Etheredge et al., *supra* note 6; and Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, HEALTH AFF., May-June 1997, at 134.

8. *See* Allan Fine, *Creating a Vision and Goals, in* PROVIDER SPONSORED ORGANIZATIONS: EMERGING OPPORTUNITIES FOR GROWTH 7, 7 (Allan Fine & Colleen E. Dowd eds., 1998) (defining PSOs as "public or private entities consisting of a provider or group of affiliated providers organized to deliver under contract a spectrum of health care services to purchasers"). For a discussion of the differences between PSOs and managed care organizations, see *id.* at 7-8.

9. Pub. L. No. 105-33, § 4001, 1997 U.S.C.C.A.N. (111 Stat.) 251, 276 (to be codified at 42 U.S.C. § 1395w-21) (authorizing Medicare benefits to be paid to PSOs).

10. *See generally* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995) (arguing the need for expanding the range of options through better and more diverse managed care contracts); *see also* Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, *in* AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 87, 94 (Robert B. Helms ed., 1993) (noting the failure of health insurers "to facilitate the exercise of meaningful choice by consumers"). To be sure, some differences do exist between health plans. But all plans promise to finance all "medically necessary" care, hold out their physicians as independent practitioners answerable to the patient under conventional non-contractual standards, and represent that any economizing comes without risk.

11. Characterizing health care as a consumer good, while offensive to some observers, does not preclude society from also classifying it as a "merit" good, consumption of which is publicly subsidized to prevent its distribution solely according to ability to pay.

consumers as revealed by their purchasing decisions.[12] Instead, virtually all care is still governed by professional standards that have never had their implicit cost/benefit ratios validated, either as a matter of public policy or in the marketplace.[13] In this fundamental respect, managed health care may be viewed as a major public-policy disappointment. Indeed, if managed care does not ensure consumers real choices with respect to how and how much to spend on health care, one of the main justifications for preserving private financing of health care disappears, possibly inviting reconsideration of the desirability of public financing with its generally lower administrative costs.[14]

Rather than offering consumers real corporate health care in significantly differentiated packages, today's health plans have taken a more conventional path. Most plans have reverted to serving, essentially, as third-party payers merely financing care decided upon, for the most part, by physicians under professional standards.[15] Few plans actively organize the delivery of services or accept responsibility for the quality of care.[16] Indeed, managed care today usually means little more than selective contracting and capitation. By selective contracting, health plans can exercise purchasing power that insurers lacked in the fee-for-service era, squeezing providers' incomes by threatening exclusion from contracting networks. They can also impose compensation arrangements that transfer financial risks to providers, effectively delegating to them responsibility for rationalizing spending and controlling costs.

Thus, most health care is now being actively managed, if at all, not by health plans or professional agents they engage to assist them, but by independent providers, provider groups, and

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12. *See generally* HAVIGHURST, *supra* note 10, at 117-53 (describing inadequacy of contracts in use in health care today).

13. *See id.* at 92-117 (describing the inefficiency of professional standards as legal norms); *see also* HALL, *supra* note 3, at 66-67 (discussing the courts' hostility to insurers' attempts to interfere in clinical discretion, especially if the decision is based on cost-benefit tradeoffs).

14. *See* Havighurst, *supra* note 10, at 88 (arguing that private financing of health care may not be worth preserving if it does not offer consumers a meaningful range of choice).

15. *See* ZELMAN & BERENSON, *supra* note 4, at 12 ("[T]he most recent trends suggest that . . . managed care plans may wind up watering down their products to such a degree that the potential for real coordination and cost and quality control may be lost. Today much of managed care—with expanding networks of physicians and groups, easier access to specialists, and in some situations, less intrusive utilization review—is beginning to look and act ominously like the old fee-for-service system, only with lower provider [reimbursement] rates.").

16. Refer to notes 6, 10 *supra*.

PSOs under various risk-bearing arrangements.[17] By entrusting the performance of their general contracts with subscribers to independent subcontractors, health plans surrender most of their ability to control the nature and content of the care that subscribers receive. Thus, health plans, as general contractors, are in a poor position to ensure performance of their contracts and cannot easily be held accountable when patients fail to get the services for which they paid. Perhaps the most hopeful prospect for renewed progress in managed care today is the possibility that PSOs, instead of serving only as subcontractors, will enter into direct contracts with employers and consumers, undertaking at least some obligations that are determined by contract rather than by vague and variable professional standards.

The managed care industry currently appears to be innovating only collectively in an effort to shore up its collapsing public image,[18] not competitively to improve services to consumers. Individual health plans, for their part, are mostly waiting to see what government will do to channel the industry's further development. Indeed, for some time, the main mission of most health plans has been compliance with proliferating government regulations (a daunting task in itself), not pursuit of new and better ways to give consumers appropriate value for the money they choose to spend on health services. Already encrusted with regulatory burdens at every level, the industry appears ready to accept still another set of public prescriptions in the hope that new government action will give it some relief from the storm of criticism it has endured.[19] In the political struggle

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17. Explicit rationing by utilization managers has proved cumbersome, controversial, and legally risky, causing health plans to rely more and more on rationing sub silentio by providers "at the bedside" under the influence of capitation and other economic incentives on the one hand and, presumably, of professional standards and legal requirements on the other. *See* HALL, *supra* note 3, at 184-92 (discussing the controversy surrounding financial incentives). Health plans still engage in some explicit rationing of experimental treatments, which by definition are not yet governed by a professional standard. *See* HAVIGHURST, *supra* note 10, at 132-35 (describing health plans' coverage of experimental treatments).

18. For a statement in support of a collective initiative by the American Association of Health Plans ("AAHP"), see David A. Jones, *'Putting Patients First': A Philosophy in Practice*, HEALTH AFF., Nov.-Dec. 1997, at 115. *See also* Clark C. Havighurst, *'Putting Patients First': Promise or Smoke Screen?*, HEALTH AFF., Nov.-Dec. 1997, at 123, 125 (critiquing the AAHP effort and describing it as "a smoke screen behind which managed care organizations can continue to evade real accountability for the care that their enrollees actually receive"); Karen Ignagni, *Covering a Breaking Revolution: The Media and Managed Care*, HEALTH AFF., Jan.-Feb. 1998, at 26, 30-33 (presenting strategies for managed health care plans to promote positive media coverage).

19. *See* Laurie McGinley, *Managed-Care Industry Body May Back Right to*

over the so-called "Patient's Bill of Rights,"[20] the industry strongly opposes only those proposals that would make its members legally liable for personal injuries whenever their utilization management systems or their physicians slip up.[21] Another layer of regulation promises only to freeze the industry more securely in its present form, with much of its promise still unfulfilled.

Because health plans have largely halted work on the unfinished project of aggressively reorganizing and actively managing the delivery of care in the interest of consumers, managed care should probably be viewed today as a stalled experiment rather than as a hope-inspiring work in progress. The managed care revolution, which once promised to empower consumers in a dynamic health care marketplace, is therefore, at best, still only a half-baked affair to which new heat must somehow be applied if its products are finally to be palatable. How to apply that heat, whether through new regulatory prescriptions,[22] through market-strengthening disclosure requirements,[23] or through new accountability in the courts,[24] is the crucial question in American health policy in the late 1990s.

Appeal Denials of Treatment, WALL ST. J., Jan. 20, 1999, at B6 (noting that some managed-care organizations see acceptance of third-party review of treatment decisions as a way to allay consumer and congressional concerns); *see also* Donald W. Moran, *Federal Regulation of Managed Care: An Impulse in Search of a Theory?*, HEALTH AFF., Nov.-Dec. 1997, at 7, 9 (reporting a growing consensus from the managed care industry that federal regulation may not be bad).

20. *See generally* ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES (visited Jan. 17, 1999) <http://www.hcqualitycommission.gov/cborr>. Many items from the Commission's proposed "Bill of Rights" have been incorporated in proposed legislation.

21. For one AAHP official's statement of the industry's case against various kinds of legal liability, see generally Karen Ignagni, *Risk Without Reward: Health Plan Liability Would Increase Lawsuits and Costs, Wouldn't Help Patients*, MOD. HEALTHCARE, Aug. 1998, at 25.

22. *See* Moran, *supra* note 19, at 10-16 (commenting at length on "the impulse toward federal regulation of the managed care industry" and questioning the rationale for same); Etheredge et al., *supra* note 6, at 97 (observing that legislators are being called upon to enact regulations to address the managed care industry's shortcomings).

23. Among the regulatory reforms that the industry is willing to accept, either as requirements for accreditation or as government regulatory standards, is increased disclosure of quality-related information. *See* Norman Daniels & James Sabin, *The Ethics of Accountability in Managed Care Reform*, HEALTH AFF., Sept.-Oct. 1998, at 50, 51 & n.1 (revealing that the National Committee for Quality Assurance, which includes representatives from the managed care industry, supports the "robust disclosure of relevant information about health plan benefits and performance"). It remains to be seen whether information alone, given consumers' inability to digest it and the complexity of the trade-offs involved, will make things more than marginally better in either the political arena or the

Given the managed care industry's current disinterest in creative innovation, it would probably have been fruitless for the contributors to this Symposium to concentrate on advising health plans constructively on how to improve their ability to manage care in the interest of consumers. In any event, the authors have mostly focused on identifying problems that have surfaced under the various management strategies that MCOs have tried to date and on shaping a legal environment to discipline the system as it stands today and is likely to operate for the indefinite future. For the most part, the authors accept the conventional view of health plans as adversaries of patients in need of care and focus their analysis on the role of physicians caught in the middle of this conflict.[25] A dominant theme in this Symposium is the tension between the professionalism of physicians and the financial incentives that managed care plans employ to influence physician decisions.[26] Within this largely conventional

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economic marketplace. Although quality-related information can be expected to induce health plans to strive to score well on whatever criteria are implicit in the rating system, it is not necessarily an adequate substitute either for contracts that specify with more particularity what consumers can expect to receive or for expanded legal accountability of health plans when poor outcomes are achieved.

24. The leading proposals would remove employee health plans' immunity from suit for personal injuries allegedly caused by errors in determining coverage. *See, e.g.*, Access to Quality Care Act of 1999, H.R. 216, 106th Cong., § 302 (proposing the amendment of ERISA to allow for most personal injury causes of action under state law against group health plan insurers, though prohibiting suits against the insured party's employers). For proposals to make health plans vicariously liable for negligence and other torts of plan physicians, see Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587 (1997); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159, 166-69 (1997) (detailing the potential benefits of enterprise liability); *see also* CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 1180-1266 (2d ed. 1998) (including and discussing materials related to health plan liability).

25. Although health plans are usually characterized as anything but the patient's friend in health care transactions, they can also be viewed as agents appointed ex ante by premium payers to oversee spending of a common fund. Although the plan may seem to be an enemy of the patient when an issue arises ex post, it is in some respects just as much the patient's agent (in charge of cost control) as is the physician. *See* HAVIGHURST, *supra* note 10, at 176-78 (discussing "the health plan contract as a covenant among subscribers"). Despite the theoretical validity of this conceptualization, bifurcation of responsibilities creates large problems of legitimacy for health plans in the real world—problems that could be surmounted in some measure if integration of financing and delivery were more complete and if the entities with which consumers contract for care were legally responsible not only for the cost of care but also for delivering it and ensuring its quality.

26. This tension, which is heightened by the bifurcation of responsibilities observed in note 25 *supra*, would be ameliorated by fully integrating physicians into health plans, thereby overriding the old professional paradigm of health care based on the shibboleth that corporations do not practice medicine, only doctors do. *See* Havighurst, *supra* note 24, at 611-21 ("One result [of the persistence of old

framework, the authors provide many valuable insights. Such insights are essential if MCOs are ever to complete their work in progress.

But there is also room, it seems, for more radical thinking and for more radical measures that will finally legitimize managed care in the eyes of the consuming and voting public. To this observer, such legitimacy will come only when health plans are legally accountable not only for the cost of care but also for its quality. Making health plans vicariously liable for the negligence and other professional failings of physicians (*e.g.*, failures to inform a patient about treatment or diagnostic options or to bring essential facts about the patient to the attention of utilization managers) would go far toward finally aligning the interests and obligations of health plans and physicians.[27] Although the tort system is admittedly not very good at bringing bad medical practice and system failures to light,[28] adoption of automatic vicarious liability would push health plans to stand behind their work and give them a needed new incentive to complete the managed care revolution.[29] Today's health plans richly deserve the skepticism they have generated. Only when they assume both operational and legal responsibility for the quality of care will they finally deserve the public's trust.

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paradigms] is an unnecessarily high degree of tension between MCOs, charged by consumers with controlling costs, and physicians, who can claim to be exclusively accountable to patients for the quality of care.").

27. *See* Havighurst, *supra* note 24, at 629-34, 640-43 (discussing how holding health plans vicariously liable for negligence and other torts of physicians who are part of the plan could "turn MCOs into something they do not appear to be today—reasonably trustworthy purveyors of corporate medical care").

28. *See* PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 61-76 (1993) (summarizing a study by Harvard University researchers showing surprising incongruence between the universe of patient injuries attributable to negligence and malpractice claims filed).

29. Discussions of how to ensure quality in health care have come to focus less on assigning blame to individuals and more on so-called "continuous quality improvement" and "total quality management." *See generally* TROYEN A. BRENNAN & DONALD BERWICK, NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE 297-333 (1996). Making health plans vicariously liable for physician torts, while preserving traditional professional responsibility, would put the financial burden on the entity best positioned to identify and remedy quality problems.