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Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos Pain Management and Provider Liability

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REGULATING THE MANAGED CARE REVOLUTION: PRIVATE ACCREDITATION AND A NEW SYSTEM ETHOS

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"[T]he notion that some sort of automatic, self-regulating marketlike structure can be established that will substitute for public management and yet achieve public objectives is a fantasy: powdered unicorn horn."[1]

I. INTRODUCTION

AMERICA spends considerably more per capita on health care than do other industrialized countries.[2] The good news is that the rate of growth of health expenditures continues to drop.[3] In 1996, national

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1. Robert Evans, *Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform*, 22 J. HEALTH POL. POL'Y & L. 427, 462 (1997).

2. *See id.* at 451-52. ("[A] large proportion of the difference in per capita expenditures between the United States and all other countries of the [Organization for Economic Cooperation and Development] was a result of higher relative prices of health care in the United States."); *see also* George J. Annas & Frances H. Miller, *The Empire of Death: How Culture and Ecomonics Affect Informed Consent in the U.S., the U.K. and Japan*, 20 AM. J.L. & MED. 357, 377 (1994) (stating that "[i]t is not a coincidence that the U.S., which treats health care as a market good, spends far more money on the health sector than does any other country in the world" and that "[t]hree years ago, the U.S. spent 131 percent more per capita on health care than did Japan, and almost 200 percent more than did the U.K."); Sylvia F. Kleinman & John Glasel, *The Clinton Health Plan: We Deserved Better*, 21 N.Y.U. REV. L. & SOC. CHANGE 241, 241 (1994-1995) ("As a share of Gross Domestic Product (GDP) and on a per capita basis, America's health costs greatly exceed those of other nations."); Dana Priest, *The Road to Health Care Reform*, WASH. POST, Jan. 26, 1993, at 12 (stating that "the United States spends more per capita on health care than any other country"); Stephen Zuckerman & Jade Hadley, *Clinton's Cost Controls Can Work*, WASH. POST, Nov. 7, 1993, at C7 (noting that United States spent 14.3% of GDP on health care in 1993, although no other industrialized nation spent more than 10%).

3. *See* Kenneth E. Thorpe, *The Health System in Transition: Care, Cost, and Coverage*, 22 J. HEALTH POL. POL'Y & L. 339, 350 (1997) (stating that most major surveys in employee benefit context have concluded that growth in total spending per employee has slowed substantially and that "[t]he broadest examination of health care expenditures . . . results reveal a . . . downward trend in health care spending over the past couple of years"); *see also* Katherine R. Levit et al., *Health Care Spending in 1994: Slowest in Decades*, 15 HEALTH AFF. 130, 130-33 (1996) (noting slow rate growth of health expenditures); Charles D. Weller, *The Next Generation After PSOS: Self-Insured Patient Choice Organizations for Medicare*, 9 HEALTH L. 21, 24 (1997) (noting decline in rate of growth of health care costs since 1990 and that health care increases were "slowest in decades").

health expenditures increased only 4.4%, the slowest growth since 1960.[4] The growth rate between 1993 and 1996 averaged five percent, in contrast to the 11.7% average growth between 1966 and 1993.[5]

As private employers, states and the federal government have lowered the rate of increase in health care costs, managed care continues to reshape the practice of medicine in the United States.[6] Managed care organizations (MCOs) have provided the basic framework for American health care delivery because of their success in slowing health care cost inflation.[7] Managed care has achieved this slowdown by extracting a discount from physicians, who often reduced their fees from forty percent to seventy percent to be part of managed care networks, and by reducing hospitalization rates and lengths of stay.[8] State Medicaid agencies are converting to managed care, with capitated plans accounting for up to seventy percent of the market. Medicare is also moving toward managed care.[9]

Managed care is rapidly supplanting fee-for-service (FFS) medicine all over the country.[10] Physician practices, group practices, hospitals, other health care organizations and now insurers are consolidating by combining into systems.[11] Some systems are integrated, with salaried physicians and their own hospitals, while others engage in extensive contractual ar-

4. Katherine R. Levit et al., *National Health Spending Trends in 1996*, 17 HEALTH AFF. 35, 36 (1998) (stating that growth rate was lowest in four decades).

5. *See id.* (citing statistics from Health Care Financing Administration, Office of Actuary, National Health Statistics Group).

6. *See* Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 421 (1997) (discussing more comprehensively lowered rate of increase and noting significant role played by managed care organizations (MCOs)).

7. *See* Timothy N. Troy, *Does Managed Care Work?*, 6 MANAGED HEALTHCARE 21, 25 (1996) (discussing effectiveness to date of MCOs in retarding growth of health care costs). In 1994, national health care costs rose just 6.4%, in contrast to an average increase in health care costs of 14.6% per year from 1980 to 1985 and 12.6% from 1985 to 1990. *See id.*

8. *See id.* (discussing methods by which managed care has reduced rate of growth in health care costs).

9. Bruce E. Landon et al., *Quality Management by State Medicaid Agencies Converting to Managed Care*, 279 JAMA 211, 211 (1998) (discussing movement of government agencies toward managed care); Joseph White, *Which 'Managed Care' For Medicare?*, 16 HEALTH AFF. 73, 79-80 (1997) (noting Medicare's movement towards managed care and analyzing various managed care options available for Medicare).

10. *See* John K. Iglehart, *The American Health Care System: Managed Care*, 327 NEW ENG. J. MED. 742, 742-47 (1992) (discussing potential benefits of managed care). The escalation in medical spending by both the Medicare program and private health insurers led to an intensified focus on managing health care costs. *See* Furrow, *supra* note 6, at 422 & n.4 (discussing Medicare move to managed care). Traditional fee-for-service (FFS) insurance that pays medical charges without question has declined sharply over the past few years. *See id.* (noting that only 22% of people covered for health benefits by Aetna Life and Casualty in 1990 were eligible for traditional care as opposed to 64% in 1988).

11. *See* Furrow, *supra* note 6, at 422 & n.4 (discussing trend toward consolidation and resulting medical provider systems).

rangements to achieve integration.[12] Medical groups are also consolidating into physician practice management organizations.[13] Nearly eighty-five percent of insured working Americans now receive coverage through a managed care plan, such as a health maintenance organization (HMO), a preferred provider organization (PPO) or a point-of-service plan.[14]

The history and theory of managed care promise cost-effective quality services to large populations.[15] Yet, managed care also creates risks for patients as a rapidly expanding market leads organizations to employ pernicious strategies to compete for subscribers. Consumers fear that they will receive substandard care, be denied access to needed specialists and the best hospitals and end up worse off as a result of managed care economizing.[16] Some of this consumer anxiety is grounded in legitimate fears of

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12. *See id.* (discussing types of consolidated systems); Michael A. Morrisey et al., *Managed Care and Physician/Hospital Integration*, 15 HEALTH AFF. 62, 65 (1996) (discussing integration, but noting that such integration should not be overstated, because current evidence demonstrates that many such integrated delivery systems are relatively simple physician-hospital organizations and less than 25% of all hospitals have developed such systems).

13. *See* James C. Robinson, *Consolidation of Medical Groups into Physician Practice Management Organizations*, 279 JAMA 144, 144-49 (1998) (discussing trend); William S. Painter, *New Trends in Medical Practice Compensation Transitioning from "Eat What You Kill"*, SB51 A.L.I.-A.B.A. 633, 670 (1997) (discussing consolidation trend). One commentator noted that

> [w]hether as the result of the impact of managed care or because physicians recognize the need to be able to access larger amounts of capital and develop stronger management teams, there is a significant trend toward medical practice consolidation. Often, the consolidating organization may be a hospital system, but increasingly independent physician medical groups are combining to form larger, single specialty and multispecialty organizations.

Id.

14. *See* Ron Winslow, *Health-Care Inflation Kept in Check Last Year*, WALL ST. J., Jan. 20, 1998, at B1 ("[T]he annual Mercer-Foster Higgens survey [of 1997], a widely followed barometer of employer health costs . . . found that 85% of American workers with health insurance now belong to some kind of managed-care plan, up from 52% in just four years."); *see also* Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, 16 HEALTH AFF. 125, 125 (1997) (noting that 75% of American employers in both small and large firms alike receive health care coverage through managed care plan).

15. Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 HEALTH AFF. 7, 18 (1997) (discussing goal of managed care).

16. *See* GEORGE ANDERS, HEALTH AGAINST WEALTH: HMOS AND THE BREAKDOWN OF MEDICAL TRUST 9-32 (1996) (discussing disadvantages of managed care and setting forth number of examples of bad health maintenance organization (HMO) care). This book obviously represents a backlash against what the public fears is the predatory cost-cutting strategies of such organizations. For a critique of the book, see Robert J. Samuelson, Book Review, N. Y. TIMES, Nov. 24, 1996, at 13.

For a study of access to care in HMOs as compared with traditional insurance plans, see Tami Mark & Curt Mueller, *Access to Care in HMOs and Traditional Insurance Plans*, 15 HEALTH AFF. 81, 86 (1996). Mark and Mueller concluded that HMOs and traditional plans offer a trade-off between financial and administrative barriers. *See id.* (comparing HMOs with traditional plans). HMO enrollees were more likely than their counterparts in traditional plans to have had a medical visit,

excessive cost-cutting by market-driven plans. Some of the anxiety is based on a typically American desire to get all health care that is marginally beneficial, whatever the cost, so long as somebody else absorbs it.

Managed care begins with an assumption that only cost-effective care should be given, to minimize the total resources consumed by health care expenditures for the employer, employee or citizen receiving government financed care. Some of the critique of managed care is derived from this misalignment of perspective. Some subscribers will indeed be harmed at the margins by denial of care that in hindsight would have been effective despite its small probability of success when viewed over a large population.[17] The goal is to reduce this level of harm to the smallest level possible. The level of patient harm is likely to decrease as managed care reduces use of diagnostic tests, drug prescriptions, use of specialists and particularly hospitalization. Reduction of intensive medical interventions reduces the risks of injury from the side effects of medical treatment.[18] We must also worry, however, about the risks of underutilization in managed care, as well as problems of adverse selection, access and treatment of the poor.

MCOs—a hybrid of insurance, cost control mechanisms and medical delivery—can make decisions that harm patients.[19] Patients can be harmed by limits on access to specialty care, limits on access to hospitalization, poor drug choices and delayed diagnosis.[20] Given the variation in MCOs and their quality assurance activities, consumer protection constraints are needed just as in any market system with many players with economic power. The aggressive promotion of quality should be the primary goal of MCOs.

Managed care is an important development in the American health care system, with the potential to rationalize the delivery of care in ways

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and they had more medical visits and shorter waits in their provider's office. *See id.* at 81-87. They were more likely, however, to report having unmet health care needs. *See id.*

17. Some marginally useful care must be foregone to reduce health care costs. *See* Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418, 418-21 (1990) (comparing gatekeeper physicians with rationing of health care); David M. Eddy, *What Care Is "Essential"? What Services are "Basic"?*, 265 JAMA 782, 782-86 (1991) (discussing problems in determining what is or is not essential care); William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220, 224 (1987) (arguing for rationing with "cutting back on care that has lowest expected value"); William B. Schwartz & Paul L. Joskow, *Medical Efficacy Versus Economic Efficiency: A Conflict in Values*, 299 NEW ENG. J. MED. 1462, 1462 (1978) (discussing loss of additional care in cost-cutting efforts of managed care).

18. *See* P. Franks et al., *Sounding Board: Gatekeeping Revisited—Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 426 (1992) (discussing merits of protecting patients from risks of overtreatment).

19. *See* ANDERS, *supra* note 16, at 226-43 (discussing disadvantages of managed care).

20. *See id.* (illustrating HMO horror stories).

that FFS medicine coupled with indemnity insurance could not.[21] Can market competition between large MCOs eliminate the worst excesses of the system by forcing MCOs to compete on the basis of quality? At present, cost competition drives the marketing of these organizations to employers and large groups.[22] The question posed by this Article is whether private accreditation can force competition among competing plans on quality criteria, influencing both corporate purchasers of health care and consumers to choose based on quality.

Part II of this Article provides an overview of the principles of managed care and how these principles affect the efforts to reduce costs and to improve outcomes.[23] Part III discusses the current state of managed care and some of the major issues facing the managed care industry including reduction in physician's income and autonomy, the lack of conclusive evidence as to the benefits and risks involved in managed care, the struggle to define managerial power within MCOs and poor integration of service.[24] Part IV suggests some strategies for quality regulation in managed care.[25] Part V reviews the merits of the National Committee on Quality Assurance (NCQA).[26] Finally, Part VI concludes with some thoughts on the evolution of MCOs.[27]

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21. *See* Barry R. Furrow, *Incentivising Medical Practice: What (If Anything) Happens to Professionalism*, 1 WIDENER L. SYMP. J. 1, 3 (1996) (noting that MCOs claim to provide less expensive care without sacrificing quality); *see also* HAROLD S. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE 386-406 (1981) (discussing both known and unknown qualities of HMOs); PAUL T. MENZEL, MEDICAL COSTS, MORAL CHOICES: A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA 144-48 (1983) (approving of managed care model as ethical based on availability of choice and implied consent); Clark C. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716, 718-24 (1970) (discussing managed care generally); Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505, 1505 (1984) (discussing results and concluding that style of medicine in prepaid group practices is much less "hospital-intensive" and less expensive).

22. Clark C. Havighurst, *Prospective Self Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1806 (1992). Even Havighurst, long a forceful advocate of the merits of market competition in health care delivery, is less than sanguine about its benefits in the present market. *See id.* He writes about "interconnected practical, legal, and cultural obstacles to private choice." *Id.*

23. For a discussion of the principles of managed care, see *infra* notes 28-61 and accompanying text. This author has altered his structure somewhat, but portions of Part II are abstracted from a previous article. *See* Furrow, *supra* note 6, at 419.

24. For a discussion of the current state of managed care, see *infra* notes 62-148 and accompanying text.

25. For a discussion of strategies for quality regulation in managed care, see *infra* notes 149-205 and accompanying text.

26. For a discussion of the merits of NCQA private accreditation, see *infra* notes 206-36 and accompanying text.

27. For the conclusion of this Article, see *infra* notes 237-38 and accompanying text.

II. THE PRINCIPLES OF MANAGED CARE: WAITS

Wellness for Members
Appropriateness of Treatment
Integration of Services
Transfer of Financial Risk
Security of Coverage

The principles of managed care and integrated systems date back to the previous century.[28] The modern model of managed care is derived from five fundamental principles: (1) a focus on wellness and prevention; (2) a drive for "appropriate" treatments, meaning the most cost-effective care; (3) integration of services; (4) transfer of financial risk from insurer to provider to the greatest extent possible; and (5) security of access to health care for the consumer-employee at a fixed price.[29]

In the 1800s, businesses such as railroads, sugar plantations and lumbering companies wanted to attract immigrant labor and retain it, often in isolated locations in an undeveloped United States.[30] The provision of health services was an important way of attracting new labor and reducing labor turnover. Throughout the 1800s, various immigrant groups and their employers pioneered capitated health care and organized delivery of services.[31] Three of the major organizing principles that underpin managed care were visible early: (1) security to the employee that all necessary care would be provided so long as the employment status continued;[32] (2) financial risk-bearing by employers and providers, through salary as the mode of payment instead of FFS;[33] and (3) a focus on prevention or well-

28. *See* Emily Friedman, *Capitation, Integration and Managed Care*, 257 JAMA 957, 957 (1996) ("The roots of managed care, capitation, and integration can be traced to the funeral and benevolent societies that immigrants set up to cover death expenses in the 1800s.").

29. *See, e.g.*, Harrell v. Total Health Care, Inc., 781 S.W.2d 58, 61 (Mo. 1989) (en banc) ("People are concerned both about the cost and the unpredictability of medical expenses. [An HMO plan] would allow a person to fix the cost of physicians' services."). Thus, even the courts have acknowledged the comfort provided by coverage of all health expenses during a fixed period provided by the managed care coverage.

30. *See* Friedman, *supra* note 28, at 957 (describing beginnings of managed care systems).

31. *See id.* (stating view that these arrangements were designed to "recruit[ ] people to work in isolated areas, such as sugar and pineapple plantations in Hawaii; lumber camps in Michigan, Wisconsin, and Washington State; mines on the iron ranges of northern Minnesota; and railroads just about anywhere").

32. *See id.* at 958 (noting examples). One commentator noted that

> [m]ine owners in Lehigh, Pa., provided physician and hospital services to employees for 75 cents a month. The Northern Pacific Benevolent Association, formed in 1882 in Minnesota, owned five hospitals and several clinics and employed dozens of physicians from Minnesota to Washington State; it provided services to railroad employees until the mid 1960s.

Id.

33. *See id.* (noting as example that "[i]n 1914, Henry Ford founded his 'poor man's hospital' . . . by acquiring the financially troubled . . . Detroit (Mich.) Gen-

ness in many of the programs, as part of business goals of maintaining a healthy workforce and as a way of reducing the costs of chronic illnesses to the plan.[34]

The use of capitation by the modern MCO, and its focus on cost-effective treatment, has a more modern derivation in the HMO movement of the 1970s. During this period, the Medicare and Medicaid programs were facing rapidly growing costs, while critics noted that American health care was badly maldistributed, limiting access by the poor and rural residents, and was inefficiently administered and inferior in many of its delivery components.[35] The country was perceived to face a national crisis in health care in 1970, driven by escalating costs of FFS medicine.[36] The theory that the financing system should reward health maintenance through prepayment for comprehensive care became popular.[37] As both federal and state governments incorporated this strategy into their health care policies, HMO enrollment began to increase more rapidly, with the number of HMO plans growing from 175 in 1976 to more than 650 in 1987.[38]

The term "managed care" now encompasses a continuum of plans—ranging from plans that require little more than preauthorization of patient hospitalization to staff model HMOs—that focus on utilization and

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eral Hospital . . . [which,] when it opened in 1915, . . . was dedicated to then new concept of a 'full-time' staff of physicians . . . a salaried medical staff to pursue the hospital's research and teaching missions as well as patient care").

34. *See id.* at 957-58 (noting as example that "Oliver Mining Co. in north central Minnesota (later U.S. Steel) provided extensive visiting nurse services to keep workers and their families healthy and out of the hospital").

35. *See id.* at 958 (discussing problems associated with health care delivery).

36. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 381 (1982) ("The 1970s opened with ominous declarations of a crisis in health care.").

37. *See id.* at 395 (discussing origins of comprehensive care). The Nixon administrators from the Department of Health, Education and Welfare consulted with Paul M. Ellwood, Jr., a Minnesota physician, founder of Interstudy, and advocate of the restructuring of financial incentives in the private medical sector. *See id.* at 396 (summarizing Ellwood's health maintenance proposal). Because Ellwood's health maintenance strategy was viewed as self-regulating—not needing a new federal bureaucracy to manage it—it appealed to a Republican administration hostile to big government. *See id.* at 395-96 (discussing proposal's popularity with Republicans). President Nixon adopted this HMO strategy as a cornerstone of his new national health policy, as did then Governors Ronald Reagan and Nelson Rockefeller for their states. *See id.* Congress passed the Health Maintenance Organization Act of 1973 ("1973 HMO Act"), 42 U.S.C. §§ 300e to 300e-14a (1994), which required employers to offer at least one qualifying HMO as an alternative to conventional insurance in their health benefit plans, if a qualifying HMO was in the vicinity. *See* STARR, *supra* note 37, at 395-96. The 1973 HMO Act unfortunately created regulatory barriers to HMOs that hampered their growth. *See id.* at 405-15 (noting that law called for low subsidies and high requirements). By 1976, however, momentum toward HMO growth increased as Congress amended the law to increase federal aid to HMOs. *See id.* at 415.

38. *See* Lynn R. Gruber et al., *From Movement to Industry: The Growth of HMOs*, 7 HEALTH AFF. 197, 199 (1988) ("Essentially the amendments liberalized requirements for federal qualification and created widespread industry acceptance of the federal qualification distinction.").

price of services.[39] The dominant goal for an MCO has become the reduction of health care costs and maximization of value to both patient and payer.[40] An MCO is a reimbursement framework combined with a health care delivery system, an approach to the delivery of health care services that contrasts with FFS medicine.[41] Managed care is usually distinguished from traditional indemnity plans by the existence of a single entity responsible for integrating and coordinating the financing and delivery of services that were once scattered between providers and payers.[42] This entity provides comprehensive health care services to an enrolled membership for a fixed per capita fee, thus becoming both an insurer and a provider of medical care. This risk-bearing is then distributed downstream to physician providers through capitation contracts.[43] MCOs have a contractual obligation to provide care and must arrange for facilities and physicians to give that care.[44]

MCOs are governed by both state and federal law.[45] Federal policy is based on the assumption that MCOs deliver medical care at a total annual

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39. *See* ROBERT G. SHOULDICE, INTRODUCTION TO MANAGED CARE: HEALTH MAINTENANCE ORGANIZATIONS, PROFOUND PROVIDER ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS 2 (1991) (introducing concept of managed care and discussing various types of managed care plans); *see also* DONALD K. FREEBORN & CLYDE R. POPE, PROMISE AND PERFORMANCE IN MANAGED CARE: THE PREPAID GROUP PRACTICE MODEL 5 (1994) (same).

40. *See* PETER D. FOX, OVERVIEW OF MANAGED CARE TRENDS, THE INSIDER'S GUIDE TO MANAGED CARE: A LEGAL AND OPERATIONAL ROADMAP 1 (1990) (discussing goal of managed care and growth, evaluation and possible side effects of managed care).

41. *See id.*

42. *See* SHOULDICE, *supra* note 40, at 13 ("The HMO concept combines a financing mechanism and a delivery system under the control and direction of a single management entity."); Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75, 76 (1993) (discussing differences between managed care plans and traditional health insurance).

43. The prevalence of capitation as a mode of payment may be somewhat overstated in the literature. Most hospital and physician contracts with HMOs use discounts, fee caps and per diems rather than capitation. *See* Allen L. Hillman et al., *Contractual Arrangements Between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools*, 30 MED. CARE 136, 139 (1992) (discussing various allocations of risk depending on managerial organization of HMO).

44. *See* FREEBORN & POPE, *supra* note 40, at 53 (discussing contractual duties of HMOs). In the words of Freeborn and Pope:

> HMOs have a contractual responsibility to provide or arrange for the facilities and physicians through which their members receive care. When people join an HMO, they are not just buying health insurance. They are buying access to a health care system and have a contractual right to medically necessary services.

Id.

45. *See* 42 U.S.C. § 300(c) (1994) (regulating blood supply for treatment of hemophilia). States are rapidly producing regulations that govern both financial solvency and quality concerns for MCOs. *See, e.g.*, 40 PA. CONS. STAT. ANN. §§ 1551-1567 (West 1992) (discussing 1973 HMO Act and its purpose "to permit and encourage the formation and regulation of health maintenance organizations").

cost per person substantially lower than non-MCO health care plans.[46] Early studies found that MCOs cost from ten percent to forty percent less than FFS plans,[47] admitted patients to hospitals forty percent less often than do fee for service plans,[48] and used forty percent fewer hospital days.[49] Costs of outpatient care are typically cut in half when a patient sees a primary care physician first.[50] Differences in utilization of discretionary surgery by MCO and non-MCO plans have been particularly large because surgery under MCO care is less frequent, thereby lowering overall program costs.[51] MCOs thus provide real cost savings, attributable in part to the incentives created by per capita fixed fees to keep within an annual budget.[52] Despite uncertainity about the cost savings over the long run, MCOs are now an essential tool for employers concerned about health care costs, and they have become a cornerstone of federal policy for the Medicare and Medicaid systems.[53]

Integration of services has become a major goal of those who study the American health care system. Truly integrated care has enormous potential both to reduce costs and to improve outcomes. One example is the treatment of asthma. In the past decade, the ideal pattern of care for a child with asthma has changed dramatically.. The modern approach places devices and treatments in the home that were available only in an emergency room ten years ago.[54] A parent of a child with asthma today can, with training, perform simple pulmonary-function tests, administer

46. *See* Troy, *supra* note 7, at 25 (discussing HMO's success in delivering health care at reduced per capita expense).

47. *See* LUFT, *supra* note 21, at 74 (discussing early studies concluding that HMOs enable lower costs); Manning et al., *supra* note 21, at 1507 (same).

48. *See* Manning et al., *supra* note 21, at 1507 (discussing fact that HMOs have lower rate of hospital admittance than do FFS plans).

49. *See* GROUP HEALTH ASS'N OF AM., HMO INDUSTRY PROFILE: UTILIZATION PATTERNS 1 (1988) (detailing study of HMO utilization patterns complied with data of contributing insurance plans); Manning et al., *supra* note 21, at 1507 (discussing findings).

50. *See* Christopher B. Forrest & Barbara Starfield, *The Effect of First-Contact Care with Primary Care Clinicians on Ambulatory Health Care Expenditures*, 43 J. FAM. PRAC. 40, 40 (1996) (attributing cost savings to lower payments for primary care physician services, less resource-intensive practice styles of generalists compared with specialists, lower severity of illness and lower reimbursement for established rather than new patients).

51. *See* Jack Zwanziger & Glenn A. Melnick, *Can Managed Care Plans Control Health Care Costs?*, 15 HEALTH AFF. 196, 196 (1996) (noting that managed care plans have succeeded in their primary mission to slow growth of health care costs).

52. *See id.*

53. *See* Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461 (1994) (superceding state law, establishing comprehensive regulatory authority over employee welfare and pension benefit plans and extending authority to include plans that provide medical, surgical or hospital care benefits to plan participants).

54. *See* Gary R. Fleisher, *Management of Asthma*, 8 PEDIATRIC EMERGENCY CARE 167, 167 (1992) (noting instances when hospitalization is necessary in treatment of asthma).

therapy with a nebulizer and adjust types and doses of medication—all without leaving home. Better outcomes are the result.[55]

This new, modern pattern of asthma care is difficult to establish in a fragmented cottage industry with fragmented reimbursement. The doctor may be paid for visits, the pharmacist for filling prescriptions and the hospital for emergency room services. Few health plans, however, teach a mother to measure peak expiratory flow at home, visit the house to look for offending allergens or deliver and set up the nebulizer machine. Few incentives exist to design this new pattern of care, to craft contracts with companies supplying the home nebulizers or to develop programs to train patients in self-care. Managing asthma properly today requires a shift in thinking from selling separate services to designing and managing a system of integrated care.

Aggregating payment for all the care of a defined population makes integration and innovation both easier and more cost-effective. Resources can be transferred among providers of care so that the costs of an innovation such as home outreach for asthma patients can be offset by gains in reduced visits or hospital use. Capitation, properly designed, can clarify areas of interdependence and encourage cooperation, thereby improving the quality of care.

A second example is an integrated treatment approach for chronically ill elderly patients.[56] HMOs could implement both effective prevention and comprehensive rehabilitiation as a systematic approach to managing common geriatric symptoms.[57] Longer visits between patient and doctor could promote continuity of care and compliance with treatments, reducing system costs while improving outcomes.[58]

The organization paid by capitation must be able to redesign its care system for capitation to be an effective incentive. Providing capitated pay-

55. FAMILY MEDICINE: PRINCIPLES AND PRACTICE 403 (Robert B. Taylor ed., Springer-Verlag 1988) (noting that episode of asthma will often respond to "home or outpatient treatment with a beta agonist given orally with a nebulizer").

56. *See* Nicole Lurie et al., *The Effects of Capitation on Health and Functional Status of the Medicaid Elderly: A Randomized Trial*, 120 ANNALS INTERNAL MED. 506, 506 (1994) (concluding that there is no evidence of harmful effects of enrolling elderly patients in prepaid plans).

57. James R. Webster, Jr. & Joseph Feinglass, *Stroke Patients, "Managed Care," and Distributive Justice*, 278 JAMA 161, 162 (1997) (noting that because HMOs are comprised of integrated teams of health professionals that can be targeted toward defined populations of chronically ill elderly patients, "HMOs are ideally positioned to institute systematic approaches to managing common geriatric syndromes").

58. *See* Linda J. Weiss & Jan Blustein, *Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of HealthCare by Older Americans*, 86 AM. J. PUB. HEALTH 1742, 1746 (1996) (concluding that longer duration of tie between physicians and patient was "associated with substantially lower costs of inpatient and outpatient care and with a lower risk of hospitalizations"); *see also* Sheldon Greenfield et al., *Expanding Patient Involvement in Care: Effects on Patient Outcomes*, 102 ANNALS INTERNAL MED. 520, 526 (1985) (finding that patients who regularly interacted with physicians reported improvement in functional ability).

ment to too small an entity, such as an individual physician, is not productive. The individual physicians lack the leverage or capability to change the system and have little choice but to spend less within the current system. Few doctors working alone could patch together all the elements of a thoroughly modern program of asthma care. At the other extreme, applying capitation to too large an entity would also be a mistake. On a sufficiently large scale, performance becomes too loosely connected to rewards, and change becomes too difficult and bureaucratic.

One solution might be scorecards that hold systems accountable for their covered populations. These scorecards would include financial, access, quality and outcome criteria. Community-wide health status measures such as infant mortality, preventable mortality and morbidity, immunization rates and population-based measures of health and well-being could be included.[59]

The problem with such an integrated approach is that market success in the managed care market is at present only loosely connected to quality. Plans with poor reputations continue to grow; employer demands for fewer plans covering broader markets increase market pressures that favor size over past performance. This pressure to grow is motivated more by the desire to exert market power than the ability to provide quality care or to invest in internal systems. Studies have concluded that intensified competition has created a need for workable quality of care measures.[60] Such information is a necessary precondition to a strong link between market success and a reputation for quality patient care. Private accreditation through the NCQA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a powerful force promoting systematic study of medical outcomes and transmission of this information to the consumer. Such accreditation also helps to resist the pressure of consolidating markets and the temptations to cut corners inherent in this consolidation.[61]

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59. *See* Stephen M. Shortell et al., *The New World of Managed Care: Creating Organized Delivery Systems*, 15 HEALTH AFF. 46, 62 (1996) (noting that availability of measures is limited, but that some progress has been made).

60. *See Facts About the Joint Commission on Accreditation of Healthcare Organizations* (visited Mar. 10, 1996) <http://www.jcaho.org/about_jc/mh_frm.htm> ("The mission of the Joint Commission on Accreditation of Healthcare Organizations is to improve the quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in health care organizations."); *see also* WALTER A. ZELMAN, THE CHANGING HEALTHCARE MARKETPLACE 61 (1996) ("According to the Mathematica survey while utilization and cost measures are invoked most frequently, significant percentages of managed care plans (especially HMOs) are employing measures of quality (46%), and consumer surveys (36%), as well as a variety of other measures.").

61. *See* Nancy M. Kane et al., *Markets and Plan Performance: Private Summary Report on Case Studies of IPA and Network HMOs* (visited Apr. 1, 1998) <http://www.cmwf.org/health_care/konerpt.html> (noting that competitive pressure on HMOs is function of drive to control larger market segment and is not related to internal system requirement).

III. THE CURRENT STATE OF MANAGED CARE: CRIMP

Capitation
Reduction in Physician Income and Autonomy
Inconclusive Evidence as to Benefits and Risks
Managerial Power
Poor Integration of Services

MCOs are most commonly represented by HMOs, which include group models, network models and independent practice associations (IPAs).[62] Other organizations include PPOs, exclusive provider organizations, utilization review organizations and even hospitals.[63] While a staff model HMO will have a central location for practice, other models involve physicians and dentists in their own offices, providing care to subscribers under contract to the MCO.[64]

The models do not have great conceptual value in evaluating quality, because most plans now engage in multiple kinds of contracting arrangements. Commentators have noted that "even within a 'pure' HMO model, financial and clinical management arrangements and performance can vary so greatly that results that show an average of highly variable arrangements and performance may have little value."[65] Therefore, it becomes difficult to make facile comparisons of different forms of MCOs.

A. *Capitation*

Capitation is the engine that powers current managed care organizational practice.[66] Because the risk is shifted from insurers to providers,

62. *See* Gary Scott Davis, *Introduction to Managed Health Care Primer, in* THE INSIDER'S GUIDE TO MANAGED CARE: A LEGAL AND OPERATIONAL ROADMAP 1 (1990) (discussing variations in managed care throughout United States).

63. *See generally* Randall S. Brown & Jerrold Hill, DOES MODEL TYPE PLAY A ROLE IN THE EXTENT OF HMO EFFECTIVENESS IN CONTROLLING THE UTILIZATION OF SERVICES? (1993). Although MCOs vary substantially in their structure, there is little evidence at present that different structures make a significant difference in the utilization of health care services. *See generally id.*

64. *See* Jay M. Howard, *The Aftermath of HMO Insolvency: Considerations for Providers*, 4 ANNALS HEALTH L. 87, 90 (1995). HMOs are usually classified into four categories based on their relationship with medical care providers: staff model HMOs that directly employ physicians to provide medical care; group model HMOs that contract with an independent, multi-specialty corporation or partnership of physicians to delivery care; network HMOs that contract with a number of groups of physicians who also may serve patients not belonging to the HMO; and in the individual practice association model, the IPA and HMOs that contract and the IPA, in turn, contracts with individual physicians to provide care in their own offices. *See id.*

65. Miller & Luft, *supra* note 15, at 19.

66. *See* Thomas S. Bodenheimer & Kevin Grumbach, *Capitation or Decapitation: Keeping Your Head in Changing Times*, 276 JAMA 1025, 1025 (1996) (noting that in metropolitan areas with high HMO enrollment, capitation is method of paying primary care physician for 63% of enrollees). In general terms, "[c]apitation means payment 'by the head.'" *Id.* Under a capitation system, primary care physi-

insurers are not exposed to the same kinds of financial risks they were with FFS medicine.[67] A capitated reimbursement scheme has three features: "defined services for a specified time period are provided through an agreed-on prepayment; payment is tied to the care of a particular patient; and the provider, in accepting the capitation, agrees to be at risk for costs exceeding the capitation amount."[68] Approximately six percent of the U.S. population is now in a fully capitated plan for all services.[69] Within HMOs, capitation is the leading form of physician reimbursement, with

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cians are paid a set fee per month for each enrollee who has selected that physician as their primary care physician. If the primary care physician's cost for the month (for treating enrollees) is less that the capitation amount, the balance is kept by the physician as profit. If, however, the physician's monthly cost for treating enrollees exceeds the capitation amount, the HMO pays no additional fees and the loss is born by the primary care physician. Because the HMO is not required to pay any additional fees under a system of capitation, the burden of risk is effectively shifted from the insurer to the health care provider. The realignment of objective, by participating health care providers under a system of capitation fosters a collaborative approach to patient care, rather than an adversarial approach. *See id.* at 1028-30 (explaining advantages of cooperative risk-sharing in capitation); Peter Boland, *The Power and Potential of Capitation*, MANAGED CARE Q., Winter 1997, at 1, 4 (noting that capitation, through risk shifting, facilitates redefining of business relationships and financial incentives among participants). This collaborative approach advances one of the goals of capitation, namely, to provide better care to more people at less cost. *See* Bodenheimer & Grumbach, *supra*, at 1026 (discussing benefit of system in which cost is uniform); Maurice Penner, *How HMOs Assess Medical Groups and IPAs*, MANAGED CARE Q., Spring 1997, at 1, 1 (noting that before capitating physican organization, HMOs make evaluation to ensure that physician organization is capable of managing risk while maintaining high level of member satisfaction).

67. *See* Bodenheimer & Grumbach, *supra* note 66, at 1026 (noting that shift of risk from insurer to providers means insurers have little to fear from members getting sick); Anthony F. Lehman, *Capitation Payment and Mental Health Care: A Review of the Opportunities and Risks*, 38 HOSP. & COMMUNITY PSYCHIATRY 31, 32 (1987) (noting that capitation requires health care provider to bear risk that patient "will require more services than capitation revenues will cover").

68. David Mechanic, *Strategies for Integrating Public Mental Health Services*, 42 HOSP. & COMMUNITY PSYCHIATRY 797, 798 (1991); *see* Steven S. Sharfstein, *Prospective Cost Allocations for the Chronic Schizophrenic Patient*, 17 SCHIZOPHRENIA BULL. 395, 397 (proposing medical cost allocation system under which capitation rates would be based on health status or risk). Capitation rates for individuals presenting high-risk (individuals who may require a significant amount of services) must necessarily focus on the patient's past use of services, current health status and disability. *See id.* (noting that high-risk patients require more frequent and more intensive treatment). Such mechanisms often assume the exclusion of high-risk individuals. *See id.* (noting that most health care organizations operating under system of capitation "function by removing as many high-risk patients as possible from the pool of covered lives . . . enrolling as many healthy people as possible . . . to offset the high costs of the high-risk patients"); *see also* Lehman, *supra* note 67, at 32 (noting that persons with chronic illnesses may be excluded from plans funded by capitation system because of resistance by health care providers to utilize expensive health services needed for treatment of chronic illnesses).

69. *See* Andrew Ruskin, *Capitation: The Legal Implications of Using Capitation to Affect Physician Decision Making Processes*, 13 J. CONTEMP. HEALTH L. & POL'Y 391, 392 n.3 (1997) (evaluating liability created by capitation).

approximately fifty-five percent of HMOs using this form of payment.[70] By the year 2005, more than fifty percent of the population will be in capitated health plans.[71]

In capitated managed care physician groups, mandates in their provider contracts control the management of risks and promotion of quality assurance.[72] Quality assurance activities to date have focused on overuse of medical care; this focus reflects managed care's obsession with cost containment and preventive services.[73] Little attention has been paid to quality issues in chronic disease care and to negative effects of underuse of care.[74] The latter issues are the subject of much criticism of HMOs at present and are the focus of much private accreditation activity by NCQA.

The IPA model is now the most common HMO model.[75] Physicians in IPA group together to contract with managed care plans.[76] The plans then make capitated payments to the IPA as a group for all physician and related professional services for enrolled patients, in advance of the provision of services. The IPA then pays the individual physician members, assuming responsibility for managing costs and quality of care provided by participating physicians. The payments may not be set at a level to compensate for the care actually provided during the capitation period, and therein lies the financial risk. Around sixty percent of the 550 HMOs now in operation use this model.[77]

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70. *See id.*

71. *See* Julie Johnson & Mike Mitka, *Managed Care Maelstrom*, 37 AM. MED. NEWS 1, 1-2 (1994) (following trends in health care organizations).

72. *See* Eve A. Kerr et al., *Quality Assurance in Capitated Physician Groups: Where Is the Emphasis?*, 276 JAMA 1236, 1236 (1996) (noting that groups under capitation, as part of constraints, assume fiscal responsibility as well as responsibility for quality assurance).

73. *See id.* at 1238 (noting that most capitated physician groups focus quality assurance programs on overuse rather than underuse). The concentration of quality assurance assets on overuse of services may reflect an effort to ensure the economic viability of the particular physician group. Alternatively, the concentration of assets may reflect the realities of monitoring services. It may simply be more efficient to monitor services that have been provided rather than to monitor services that should have been provided.

74. *See id.* (noting that lack of monitoring for quality assurance in treatment of chronic disease may be reflection of sufficient data systems and monitoring tools).

75. *See* Bodenheimer & Grumbach, *supra* note 66, at 1026 (noting that IPA model of HMO is most common capitation arrangement in United States representing 59% of HMO models by mid-1994).

76. *See id.* (noting that in IPA model, independent physicians from different office practices join together in affiliation for purposes of contracting with managed care plans); Joseph P. Newhouse, *Patients At Risk: Health Reform and Risk Adjustment*, 13 HEALTH AFF. 132, 132, 134-35, 139-40, 142 (1994) (discussing results of study showing that HMOs were able to enroll healthier members while avoiding high costs associated with last few months of life, suggesting that health plans can effectively estimate risk which should facilitate capitation rates that are adjustable based on enrollee's expected cost).

77. *See* Bodenheimer & Grumbach, *supra* note 66, at 1026.

The primary risk in a pure capitation model is that physicians may have to spend time with their patients for no additional compensation, depending upon the frequency of patient visits and the size of the capitation payments. A capitation-plus-bonus model, prevalent in HMOs, adds a level of risk by setting aside some percentage of a physician's income in risk pools. Such risk pools or "withhelds" cover specialist referrals and ancillary services such as radiology and laboratory services. If year-end costs in these pools are less than the amount set aside, then the physicians get bonus payments.[78]

IPAs may track each physician's referral and testing costs, or may pay each member of the group the same bonus based on the group's performance. The group approach weakens direct pressure for an individual physician to cut corners on referrals, but peer pressure is stronger toward a more conservative style of practice. Other IPAs blend the two into a complex formula. Some IPAs add a bonus based on quality of care, based on chart review and patient satisfaction surveys.[79] Risk-adjusted capitation is also developing to properly distribute risks among physicians with different mixes of patients. Rates can be set differently based on age and health status. Capitation has become a "high-risk, high-stakes proposition in the context of a fearsomely competitive, market-oriented health care system."[80]

Capitation might affect the quality of care in two basic ways: by influencing individual decisions, especially on the part of physicians, and by encouraging systemic integration and innovation in the design and delivery of services. Both advocates and opponents of capitation reserve most of their energy for the first of these themes: the effect of capitation on the choices made by individual physicians. Decades of health services research have established that doctors vary widely in their use of diagnostic tests, drugs, therapeutic procedures, hospital admissions and surgery. Though scores for the appropriateness of care do not always correlate well with rates of procedures, many observers believe that the excessive use of unhelpful treatments is more common than the withholding of effective

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78. *See id.* at 1027. Bodenheimer and Grumbach have noted that

> [u]nder some managed care arrangements, the base capitation payments may be sufficient only to cover a physician's office overhead; the physician's take-home income may completely depend on the bonus payments he or she receives. In the current marketplace, payers and HMOS are driving down capitation payments, thereby increasing the importance of bonus payments. The greater the degree to which earnings are determined by these risk-sharing arrangements, the more intense the pressure to restrict patient access to expensive specialty and diagnostic services.

Id.

79. *See id.* For high cost patients, stop-loss insurance coverage is available from commercial carriers, or through self-insurance in large physician groups. *See id.* at 1028.

80. *Id.* at 1030.

ones.[81] Capitation at this level functions as a source of pressure for a reflexive second look by a physician. It creates pressure on physicians to think twice before ordering a test or treatment because they bear some financial risk for the costs of their own choices.[82]

Capitation best alters individual decisions through the intermediate filters of group process, consensus among peers and clinical-policy formulation. In this sense, capitation should be used not as a pure alternative to rules, but rather as a way to cause "soft rules" to take shape at the practice level. The aim would be not to cause an individual doctor to consider the interactions between decision and profit in the case of a particular decision for a particular patient, but rather to induce physicians in group practices to consider the costs and benefits of clinical-management patterns for patients of a general type in the long run.

Although the influence of capitation on doctors' decisions has attracted most of the controversy, a second view of capitation—that it can favorably influence the design of the health care delivery system—may be more important for improving the quality of care. Fragmentation of health care delivery is a major problem in our system because health care developed through professional and organizational categories that emphasized functional specialization. Capitation may create positive pressures toward integration.

B. *Reduction in Physician Income and Autonomy*

The current struggle of physicians and groups to adapt to capitation has created stresses on physician incomes. Practitioners may experience severe financial difficulties because of miscalculations in negotiating a capitated contract. Every issue of *Medical Economics* discusses strategies for negotiating contracts to help physicians avoid pitfalls.[83] These contracts have also become a legal specialty, as lawyers representing physician clients struggle to master the intricacies of actuarial data as part of negotiating capitation agreements.[84] Physicians in some specialties have seen

81. *See, e.g., id.* at 1025 (noting that purpose of capitation is to slow rising costs of health care by reducing excessive amounts of unnecessary medical service).

82. If these incentives are coupled with MCO feedback to physicians about current health services research, practice patterns may shift to a more appropriate level of practice. If a physician or physician group, however, develops a reputation for providing high quality care for the sickest patients, this reputation "will attract new higher-cost enrollees that bring with them only average (flat) premium payments, which is a recipe for bankruptcy or at least a financially weakened organization." Miller & Luft, *supra* note 15, at 7, 20.

83. *See, e.g.*, Woodrow H. McDonald, *The Big Gamble Capitation Forces On You: Managed Care Plans and Family Physicians*, MED. ECON., June 27, 1994, at 47, 48 (noting that before agreeing to capitation rates, health care providers should inquire as to how plan will be marketed and to whom it will be marketed and recommend higher capitation rates based on serving higher-risk populations).

84. *See generally* Judy Capko, *Get Ready for the Changes That Capitation Will Bring; Capitation Payments by Managed Care Health Services Providers*, 38 AM. MED. NEWS 22 (1995); Alex Gramling, *Managed Care Needn't Come Between You and Your Patients*,

their incomes drop, although others have gained.[85] Most physicians, however, feel unhappy with the changes in their work environment, sense that others are managing them and feel that their clinical autonomy is slipping away.[86] As the managed care market matures and MCOs devise newer and less intrusive ways of achieving a cost-effective practice environment, these pressures are likely to abate. A new generation of physicians, accustomed to a salaried or capitated managed care environment, will also find the advantages of the managed care environment more to their liking.

C. *Inconclusive Evidence as to Benefits and Risks*

The central issue for policymakers is whether managed care can lower total resource consumption (not just hospital consumption) while improving quality.[87] The studies to date have found similar or better outcomes in some populations for some procedures, while others concluded that some ill elderly HMO enrollees had worse quality-of-care outcomes than their FFS counterparts.[88]

Critics fear that MCOs, which increasingly operate within a capitated reimbursement system, create incentives to underutilize services because the cost of providing such services is absorbed within a fixed budget.[89] Some studies have found that MCOs have succeeded in maintaining qual-

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MED. ECON., Feb. 1995, at 62, 63-65 (discussing various techniques used by some health care providers to retain control over health services delivery in facilities operated by HMO); Deborah S. Kolb & Judith L. Horowitz, *Managing Transition to Capitation*, HEALTHCARE FIN. MGMT., Feb. 1995, at 64, 64 (advising health care providers to begin implementing programs to ease eventual shift from FFS to a capitation payment system); Jim Montague, *Old Traditions, New Realities; Dealing with New Health Care Delivery Systems*, 68 HOSP. & HEALTH NETWORKS 22, 22 (1994) (noting that complete transformation in delivery of health care had led to "declining incomes and mounting regulations").

85. ZELMAN, *supra* note 60, at 225 ("As for . . . financial incentives—withholds, bonuses, and so on—research by the Mathematica Group found these to be modest, with physicians facing maximum income fluctuation . . . of 'generally 20 percent or less.'").

86. *See* Peter B. Jurgeleit, *Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L.J. 255, 255 (1997) (noting that physician's discretion over medical decisions and professional autonomy generally has been supplanted by institutional pressures from HMOs).

87. Miller & Luft, *supra* note 15, at 18 (discussing results of survey on resource use in managed care).

88. For a further discussion of studies addressing resource consumption by MCOs, see Furrow, *supra* note 6, at 465-69.

89. *See* Andreas Schneider & JoAnne Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U. L. REV. 90, 98-99 (1975) (noting that capitation creates economic incentives to exclude individuals who are likely to utilize services at high rate); Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1676 (1994) ("Despite the political and economic momentum toward managed care as a means to prevent overtreatment and conserve costs, little empirical evidence exists to show how well this system protects patients against undertreatment.").

ity while reducing cost.[90] Managed care consumes fewer resources, such as use of specialists or intensive care units in hospitals, without evidence of increases in patient morbidity or mortality.[91] Some of these differences may be caused by patient factors, such as the relative youth of managed care subscribers.[92] Another explanation might be the practice style of physicians in managed care, who have learned a more conservative style of treatment.[93] As managed care plans, particularly Medicare HMOs, cover more and more older and potentially sicker populations, costs may in-

90. *See* GENERAL ACCOUNTING OFFICE, GAO/HEHS-96-2, ARIZONA MEDICAID: COMPETITION AMONG MANAGED CARE PLANS LOWERS PROGRAM COSTS, REPORT TO THE CHAIRMAN, COMMITTEE ON COMMERCE, HOUSE OF REPRESENTATIVES 2 (1995) (reviewing Arizona's successful state-wide Medicaid program and discussing Arizona's high level of beneficiary access to appropriate care and its techniques for controlling cost and reducing capitation rates). Arizona's state-wide Medicaid program has been successful in containing costs, saving the federal government $37 million and the state $15 million in acute care costs during 1991. *See id.* Additionally, Arizona was able to reduce capitation reimbursement rates by 11% in 1994. *See id.* "Arizona's program succeeded in containing costs by developing a competitive Medicaid health care market. Health plans that submit capitation rates higher than their competitors' bids risk not winning Medicaid contracts." *Id.* Moreover, the emphasis on cost control has not come at the expense of member access because Arizona's Medicaid program specifies standards that must be met by health care providers and gives more weight to factors such as access and quality than are given to capitation reimbursement rates. *See id.*; Nicole Lurie et al., *Does Capitation Affect the Health of the Chronically Mentally Ill?*, 267 JAMA 3300, 3304 (1992) (evaluating Medicaid managed care plan enrolling people with serious mental illness and concluding that "this first randomized trial of prepaid care for [chronic mentally ill] Medicaid beneficiaries did not find consistent evidence of short-term adverse health effects in prepaid plan enrollees"); Bentson H. McFarland, *Health Maintenance Organizations and Persons with Severe Mental Illness*, 30 COMMUNITY MENTAL HEALTH J. 221, 236 (1994) (reviewing research literature on treatment by HMO of people with severe mental illness and concluding that setting realistic reimbursement rates was critical factor in determining whether patients received adequate treatment from health care providers utilizing capitated payment system).

91. *See* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980*, 271 JAMA 1512, 1518 (1994) (reviewing studies conducted since 1980 comparing managed care with indemnity plans and concluding that "HMO plans exhibit significantly lower utilization of hospital services"). A review of studies conducted since 1980 comparing managed care with indemnity plans found that, in 18 of 20 comparisons from nine different studies, HMO plans used 22% fewer procedures, tests or treatments that were considered expensive or had cheaper alternatives. *See id.* at 1515.

92. *See* Derek C. Angus et al., *The Effect of Managed Care on ICU Length of Stay: Implications for Medicare*, 276 JAMA 1075, 1081 (1996) (concluding that, although managed care plans overall appear to offer lower cost health care than traditional FFS medicine, no cost savings were apparent in intensive care management of older and sicker patients). Angus noted that "[o]ne must wonder whether managed care organizations will be able to continue offering health care coverage at lower cost than traditional insurance programs and managed care case mix changes to include sicker and older patients." *Id.*

93. *See* Philip F. Cooper et al., *Patient Choice of Physician: Do Health Insurance and Physician Characteristics Matter?*, 33 INQUIRY 237, 244 (1996) ("[M]embers of health maintenance organizations used specialists significantly less than those with other types of insurance.").

crease for HMOs and HMOs may be tempted to cut back too far on referrals.[94] The evidence, however, does not yet support this concern.

Well-managed MCOs provide substantial benefits to subscribers. HMOS are more effective at providing preventive care and health-promotion services than traditional indemnity plans.[95] HMO patients are more likely to have screening for breast cancer, high blood pressure, cervical cancer and colon cancer than FFS patients.[96] Treatment provided during these services was also found to be as good as or better than that offered by FFS physicians.[97] Female HMO enrollees receive more mammographies, clinical breast exams and pap tests than those with FFS coverage.[98] Additionally, for certain treatments, studies have shown no significant difference in patient outcomes whether the patient is treated in a prepaid group practice or by a traditional FFS medicine.[99]

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94. *See* Angus et al., *supra* note 92, at 1081 (noting that as mix of cases shift to include sicker and older patients, MCOs will not be able to continue offering lower cost health coverage).

95. *See* Miller & Luft, *supra* note 91, at 1516 (analyzing managed care performance since 1980 and noting that HMO plan enrollees receive more preventive tests, procedures, examinations and health-promotion services than indemnity plan enrollees).

96. *See* I. Steven Udvarhelyi et al., *Comparison of the Quality of Ambulatory Care for Fee-for-Service and Prepaid Patients*, 115 ANNALS INTERNAL MED. 394, 398 (1991) (noting that results of study found that for treatment of uncomplicated hypertension and provision of preventative services to middle-aged women without chronic diseases, HMO enrollees received equal or better quality care than FFS patients).

97. *See id.* (noting that HMO patients receiving common ambulatory care received same or better service than FFS patients).

98. *See* DIANE M. MAKUC ET AL., HEALTH INSURANCE AND CANCER SCREENING AMONG WOMEN, (Advance Data from Vital and Health Statistics of the Ctrs. for Disease Control and Prevention, Nat. Ctr. for Health Stat. No. 254, 1994) (reviewing "national data on the relationship between type of health insurance coverage and recent use of mammography, clinical breast examinations . . . and Pap tests by women 40 years of age and over"). The commentators found that among women aged 50 to 64 with 12 years of education or less, 63% of female HMO enrollees had received a mammogram within the year preceding this study, compared with only 48.1% of women with FFS coverage. *See id.* at 4. Almost 71% of the total HMO enrollees had recently received a clinical breast examination and nearly 65% had received a Pap test within the past year. *See id.* By contrast, less than 64% of women with FFS coverage had received a clinical breast exam in the past year, and only 56% had received a Pap test in the past year. *See id.* For women 65 and older, use of mammography and Pap testing was approximately 13% higher for HMO enrollees than for women with FFS coverage. *See id.* at 5.

99. Sheldon Greenfield et al., *Outcomes of Patients with Hypertension and Non-Insulin-Dependent Diabetes Mellitus Treated by Different Systems and Specialties: Results from the Medical Outcomes Study*, 274 JAMA 1436, 1436 (1995) (finding no meaningful difference in health outcomes for patients with hypertension or non-insulin-dependant diabetes mellitus whether treated by prepaid group practices or traditional FFS medicine); Sheldon M. Retchin et al., *Outcomes of Stroke Patients in Medicare Fee for Service and Managed Care*, 278 JAMA 119, 119 (1997) (noting that, although stroke patients in HMOs are more likely to be discharged into nursing homes than stroke patients of traditional FFS medicine who go to rehabilitation facilities, survival patterns for comparable patients in both systems are similar); Edward H. Yelin et al., *Health Care Utilization and Outcomes Among Persons with Rheu-*

Studies of cancer screening have also concluded that providers diagnosed HMO enrollees with melanoma, cervix, colon and female breast cancer at earlier stages in the disease, with melanoma and cervical cancer detected significantly earlier. Even with cancers that lack such routine screening procedures, studies have concluded that the level of diagnosis between HMOs and FFS are the same.

Care of the elderly is often mentioned by critics as being vulnerable to cost-cutting incentives in MCOs.[100] One recent study concluded that elderly patients enrolled in prepaid plans reported better general health and well-being scores than those enrolled in FFS plans.[101] No differences were discovered between the two groups, however, as to number of deaths, the proportion in fair or poor health, physical functioning, activities of daily living, visual acuity, blood pressure or diabetic control.[102] Another study found that elderly patients with hypertension enrolled in HMOs were likely to have their blood pressures checked regularly, to have their histories documented, to be referred to ophthalmologists for examination and to have cardiac examinations.[103] A third study, however, found that eld-

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matoid Arthritis in Fee-for-Service and Prepaid Group Practice Settings, 276 JAMA 1048, 1052 (1996) (finding no major difference between outcomes with FFS or prepaid group practice settings for patients receiving treatment for rheumatoid arthritis). *But see* Andrew M. Kramer et al., *Outcomes and Costs After Hip Fractures and Stroke: A Comparison of Rehabilitation Settings*, 277 JAMA 396, 396 (1997) (finding that stroke patients admitted to rehabilitation facilities had greater functional recovery and were more likely to return to community than comparable stroke patients admitted to nursing homes). Seventy-five percent of stroke patients entering rehabilitation facilities returned to the community within six months after admission. *See id.* at 400 tbl.2. In contrast, only 20% of comparably functioning stroke patients who entered traditional nursing homes returned to the community within six months. *Id.* The commentators note however that results after three months were almost identical to the six-month results. *Id.* Accordingly, the commentators note that "with few exceptions, patients returned home within the first 3 months or not at all." *Id.*

100. *See* Lurie et al., *supra* note 56, at 506 ("Under prepayment, physicians may respond to economic incentives by seeing chronically ill patients less often.").

101. *See id.* at 509 tbl.3 (summarizing and comparing baseline health status measures for HMO and FFS patients). The commentators reported a 0.4 differential in the general health index (range of 4 to 12) in favor of HMO patients. *See id.* Likewise, HMO patients had better well-being scores (range of 3 to 12) by an average of 0.3. *See id.*

102. *See id.* at 508 (summarizing and comparing specific indicators of health and physical dependency for HMO and FFS patients).

103. *See* Jeanette A. Preston & Sheldon M. Retchin, *The Management of Geriatric Hypertension in Health Maintenance Organizations*, 39 J. AM. GERIATRICS SOC'Y 683, 687-89 (1991) (discussing results of study and concluding that elderly hypertensives receive equal or better care from HMOs than from FFS setting); *cf.* Sheldon M. Retchin & Barbara Brown, *Elderly Patients with Congestive Heart Failure Under Prepaid Care*, 90 AM. J. MED. 236, 236 (1991) (concluding that elderly HMO patients with congestive heart failure receive care that is at least equal to quality of care received in FFS settings); Sheldon M. Retchin & Barbara Brown, *Management of Colorectal Cancer in Medicare Health Maintenance Organizations*, 5 J. GEN. INTERNAL MED. 110, 110 (1990) (concluding that elderly HMO patients with colorectal cancer receive care that is equal to quality of care received in FFS settings). *But see*

erly, poor, chronically ill patients experienced worse physical health outcomes in HMOs than in FFS systems while average patients did not.[104] The authors of the study suggested that, although HMOs seem to do well with younger patients, subgroups such as Medicare beneficiaries and the poor were more than twice as likely to decline in health in an HMO compared to a FFS plan.[105]

Children are also vulnerable to deficiencies in health care. Early comparative studies of HMOs and FFS concluded that children receive equal or better care in HMO settings.[106] More recent studies, however, have expressed a fear that, even under risk-adjusted capitation systems, children with chronic health problems such as asthma and diabetes may remain at risk for discrimination in a competitive health care market.[107] As the number of patients within a capitated group becomes smaller, the risk of selection bias increases because plans will try to avoid high cost patients.[108] Without some way to adjust payments to physicians for such risks, MCOs will be tempted to either dump patients or select healthier

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H.S. Luft, *HMOs and the Quality of Care*, 25 INQUIRY 147, 147 (1988) (finding that low income patients in Medicare HMOs receive deficient care for certain chronic medical conditions, including hypertension); Thomas A. Heller et al., *Quality of Ambulatory Care of the Elderly: An Analysis of Five Conditions*, 32 J. AM. GERIATRICS SOC'Y 782, 782 (1984) (same).

104. *See* John E. Ware, Jr. et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study*, 276 JAMA 1039, 1039 (1996) (summarizing results of study). The commentators concluded that

> [e]lderly patients sampled from an HMO were more likely (than those sampled from an FFS plan) to have a poor physical health outcome in all 3 sites studied. Second, patients in the poverty group and particularly those most physically limited appear to be at a greater risk of decline in health in an HMO than similar patients in an FFS plan.

Id. at 1045.

105. *See id.* at 1046 (cautioning policy makers against generalizing overall performance of HMOs to specific subgroups such as Medicare patients or poor patients because younger and healthy patients inflate overall statistics).

106. *See* R. Burciaga Valdez et al., *Prepaid Group Practice Effects on the Utilization of Medical Services and Health Outcomes for Children: Results from a Controlled Trial*, 83 PEDIATRICS 168, 179 (1989) ("Our results support the hypothesis that no serious negative health effects exist for children receiving care in the staff model prepaid group practice compared to those receiving fee-for-service care."). A sample of 693 children ranging in age from newborn to 13 were randomly assigned to either a staff model HMO or to one of several FFS plans. *See id.* at 169. There were virtually no differences between the groups in total health expenditures or in individual health outcomes. *See id.* at 174-76. Children assigned to an HMO had a 40% greater number of routine preventive examinations and had a 50% greater number of office visits than children assigned to a FFS plan. *See id.* at 175.

107. *See* Elizabeth J. Fowler & Gerard F. Anderson, *Capitation Adjustment for Pediatric Populations*, 98 PEDIATRICS 10, 16 (1996) (finding that current risk adjustment models are unable to effectively predict cost of providing medical care to children with special needs and concluding that chronically ill children are at risk in competitive health care market).

108. *See* Joseph P. Newhouse et al., *Risk Adjustment for a Children's Capitation Rate*, 15 HEALTH CARE FIN. REV. 39, 40 (1993) (noting that without risk adjustment,

ones.[109] Risk adjustment measures are available to minimize such selection bias and are likely to provide a standard of care by which to measure the performance of MCOs.[110]

Acute care situations pose another troublesome area for comparison. Yet the studies have found that HMOs provide better care in such situations than FFS plans. A 1994 study concluded that patients with acute appendicitis with only FFS coverage were more likely to suffer a ruptured appendix, which is associated with elevated mortality, than those patients enrolled in HMO plans.[111] Another recent study found no difference between managed care plans and FFS or Medicare plans as to length of stay ("LOS") in a hospital for elderly patients, after adjusting for severity of illness.[112]

One study discovered that HMO patients are more likely to be admitted to a hospital in some acute situations, such as acute chest pain, regardless of their risk level for acute myocardial infarction.[113] A study of

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HMOs would experience "windfall profits and losses" and that such windfalls have greater impact on smaller HMOs because of "law of large numbers").

"Selection bias" refers to the financial incentive for managed care plans to avoid enrolling patients with more serious illnesses. *See* Fowler & Anderson, *supra* note 107, at 10 (discussing situations in which HMOs attempt to avoid enrolling high-risk patients); Newhouse et al., *supra*, at 40 (discussing incentive for HMOs to avoid costly, chronically ill patients in absence of effective method to adjust capitation payments based on risk).

109. *See* Newhouse, *supra* note 76, at 132, 133 (illustrating incentive for HMOs to only enroll healthy patients if risk adjustment methods are not employed).

110. *See* Jinnet B. Fowles et al., *Taking Health Status into Account When Setting Capitation Rates: A Comparison of Risk-Adjustment Methods*, 276 JAMA 1316, 1319-20 (1996) (comparing performance of three risk adjustment strategies). These commentators evaluated the strengths and weaknesses of three risk measures: self-reported functional health status, self-reported chronic diseases and diagnosis assigned by clinicians. *See id.* at 1317. Based on the results of the study, these commentators recommended using a risk adjustment method based on diagnostic information when selection bias is suspected and such information is available. *See id.* at 1316. If diagnostic data is not available, the authors recommended a system based on either of the self-reported measures. *See id. But cf.* Fowler & Anderson, *supra* note 107, at 10 (finding that significant underpayment for high-risk children persists using current risk adjustment methods).

111. *See* Paula Braveman et al., *Insurance-Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444, 446 (1994) (reporting that ruptured appendix occured in 29.3% of patients with acute appendicitis enrolled in FFS plans compared to 25.8% for HMO patients with acute appendicitis). These commentators acknowledged that a possible explanation for the increased risk of appendicidal rupture among FFS patients is that deductibles and higher copayments may contribute to patient delay in seeking care. *See id.* at 448.

112. *See* Angus et al., *supra* note 92, at 1081 (commenting on results of study). These commentators concluded that "[although] managed care plans appear to be providing health care at lower cost in many arenas, cost savings in the ICU management of older and sicker patients are not apparent at present." *Id.* at 1081.

113. *See* Steven D. Pearson et al., *The Impact of Membership in a Health Maintenance Organization on Hospital Admission Rates for Acute Chest Pain*, 29 HEALTH SERVS. RES. 59, 59 (1994) (reporting findings of study aimed at evaluating impact of staff model HMO membership on hospital admission rates for patients entering emer-

clogged artery treatments done in 1988, however, found that HMO patients were 1.5 times more likely to undergo coronary bypass surgery or angioplasty than Medicaid patients, although FFS patients were 2.3 times more likely than HMO patients to have these procedures.[114] Yet, mortality rates for HMO patients were slightly lower than those of FFS patients, suggesting that a significant amount of coronary bypass surgery on FFS patients was unnecessary and led to increased patient mortality and that HMOs used such procedures more appropriately.[115]

Another study compared the treatment and mortality risk of prostate cancer patients covered by FFS plans to such patients enrolled in HMOs.[116] The authors concluded that HMO patients were less likely to receive surgery, but more likely to receive radiation therapy than patients in FFS settings.[117] Mortality risk was also lower for HMO patients than for FFS patients, especially low-income patients.[118] The authors concluded that HMOs favored outpatient care, but did not undertreat their patients.[119]

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gency department with acute chest pain). According to the authors, "[t]hese findings suggest that organizational factors beyond financial incentives may exercise an important influence on hospitalization rates for HMO patients." *Id.*

114. Kenneth M. Langa & Elliot J. Sussman, *The Effect of Cost-Containment Policies on Rates of Coronary Revascularization in California*, 329 NEW ENG. J. MED. 1784, 1787 tbl.2 (1993) (reporting odds of coronary revascularization for private FFS and HMO patients as compared with Medicare patients). The study showed comparatively similar odds for coronary revascularization for FFS and HMO patients in both 1983 and 1985. *See id.*

115. *See id.* at 1788 tbl.3 (reporting odds of inpatient mortality for private FFS and HMO patients as compared with Medicare patients). The results for 1983 and 1985, however, showed a slightly greater risk of death caused by coronary revascularization for HMO patients than for FFS patients. *See id.*

116. *See* Howard P. Greenwald & Curtis J. Henke, *HMO Membership, Treatment, and Mortality Risk Among Prostatic Cancer Patients*, 82 AM. J. PUB. HEALTH 1099, 1100 (1992) (summarizing objectives, methods, results and conclusions of study). The study examined the treatment and survival rates of prostatic cancer patients in a large, well-established HMO and in several FFS plans in the San Francisco-Sacramento region. *See id.* The authors compared areas that directly pertain to the quality of care: (1) stage of cancer at detection; (2) primary cancer treatment during the six months following initial diagnosis; and (3) mortality risks. *See id.*

117. *See id.* at 1102 (discussing results of study). HMO patients also appeared less likely to receive hormone therapy. *Id.*

118. *See id.* (discussing results of study). Acknowledging the possibility that the subjects selected for the study may have differed in health status, health risks and behavioral predispositions, the investigators included other key patient characteristics in their analysis such as age and stage of cancer. *See id.* The relationship between HMO membership and a lower risk of mortality remained statistically significant even after those characteristics were held constant. *See id.* at 1102-03.

119. *See id.* at 1103 (asserting that finding HMO patients with prostatic cancer less likely to receive surgery than FFS patients but more likely to receive radiation therapy is "consistent with reports that HMOs favor outpatient care" and "[contradictory to] the belief that HMOs undertreat their patients"). According to Greenwald and Henke, the finding should encourage people to consider the HMO as a desirable alternative to FFS plans, especially for low-income people. *See id.*

Survival and mortality rates, the ultimate outcome measures for comparing delivery models of health care, appear to be the same or slightly better in HMO patients when compared with FFS patients. HMO preferences for early detection and emphasis on prevention services has a strong positive effect on the stage at which cancer can be detected, improved survival and mortality rates.[120] A study looking at health status outcomes for elderly Medicaid recipients in FFS and in prepaid plans found favorable survival rates for the managed care population, with no difference between prepaid and FFS groups in the number of deaths.[121]

The evidence, therefore, supports claims that managed care has substantial advantages over FFS plans not only in controlling costs, but also in maintaining or even improving the quality of care for subscribers. Managed care also confronts potential weaknesses, including care for the chronically ill, for children and for the elderly. Managed care systems vary substantially in size, quality and organizational design. Some systems will be poorly run, will use abusive marketing practices and will produce poorer outcomes. Others will provide excellent care.

According to some commentators, the mixed results on managed care quality suggest that "managed care and HMO capitation create incentives to reengineer clinical processes, including integrating patient care across services, locations, and time."[122] Favorable HMO quality-of-care results on "state of cancer" detection show that capitation-driven preventive care can create an ideal situation in which earlier detection produces both better consumer outcomes and lower treatment costs for HMOs.[123] These same commentators, however, are not optimistic that change will come rapidly. In their view, such change requires a critical combination of "physician leadership, physician organization, management expertise, and (to some extent) capital that is beyond the present capability of many (although not all) health plans and provider organizations. As a result, quality of care is likely to continue to change slowly."[124] They lament the primitive quality-reporting systems of most HMOs, as well as their crude payment systems and fragmented clinical processes. They fail to acknowledge, however, the possibility of an accelerating rate of change, driven in part by the pressure of MCOs to get and retain their accreditation under

120. *See* Gerald F. Riley et al., *Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees*, 84 AM. J. PUB. HEALTH 1598, 1600 (1994) (finding that HMO enrollees were diagnosed at earlier stages than Medicare and FFS patients for female breast cancer, colon cancer, cervix cancer and melanomas and suggesting that preventative screening services performed by HMOs contributed to earlier detection).

121. *See* Lurie et al., *supra* note 56, at 506 (noting results of study conducted to determine effect of health and functional status outcomes of medicaid recipients in prepaid compared with fee-for-service plans).

122. Miller & Luft, *supra* note 15, at 21.

123. *See id.* (discussing potential of HMOs to provide higher quality care at lower cost because of ability to detect cancer at early stages).

124. *See id.*

pressure from corporate purchasers. The NCQA and JCAHO will measure more and more variables and publish and compare findings across plans. The competition over quality rankings will intensify as the accreditation process emphasizes such findings.

D. *Managerial Power*

Doctors and hospitals are increasingly combining into integrated delivery systems (IDSs).[125] Such systems are complex entities that include group practices, MCOs and hospitals.[126] Health care is now both delivered and managed through protocols of treatment, measurement of past performance, incentive systems and new organizational structures. Health care providers manage diseases through integrated approaches to drug delivery and patient care.[127] MCOs now market quality care as just another mode of competition. This marketing effort requires superior knowledge regarding the level of care received by other subscribers. Further, such organizations now routinely utilize physicians as employees rather than as independent contractors, thus abandoning the traditional hospital-physician employment model of independent contract.[128] More than half of the nation's 640,000 doctors maintain some affiliation with

125. *See* BARRY R. FURROW ET AL., HEALTH LAW 226 (1995) (noting "explosive growth" of integrated delivery systems); John K. Iglehard, *Health Policy Report: Physicians and the Growth of Managed Care*, 331 NEW ENG. J. MED 1167, 1167 (1994) (discussing growth in managed care systems).

126. *See* FURROW ET AL., *supra* note 125, at 225-26 (discussing players involved in various integration arrangements).

127. *See generally* Kevin Lumsdon, *Disease Management: The Heat and Headaches over Retooling Patient Care Create Hard Labor*, HOSP. HEALTH NETWORKS, Apr. 5, 1995, at 34 (discussing emergence of "disease management" strategies that integrate physician care, drug delivery and patient monitoring through development of clinical guidelines and advanced information systems).

128. *See* BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS 235-36 (1991). The fundamental principle of agency law is vicarious liability—the master (employer) is responsible for the torts of his servant (employee), committed while acting in the scope of employment, even though the master was not negligent. *See* RESTATEMENT (SECOND) OF AGENCY § 219 (1957) (stating rule regarding liability of master for torts of servant); W. EDWARD SELL, SELL ON AGENCY 84 (discussing doctrine of vicarious liability). In the medical setting, physicians are usually treated as independent contractors rather than employees; the hospital is thus relieved of any agency-based liability for their negligent acts. *See* FURROW ET AL., *supra* note 125, at 292-93 (discussing vicarious liability as applied to physician-hospital relationship as "independent contractor theory"). As the courts have considered the range of situations in which physicians provide care in the hospital setting, they have extended agency principles to limit the independent contractor defense. *See id.* In the last four decades, the courts have grappled with the independent doctor's connection to health care institutions, using a number of doctrines to circumvent vicarious liability limitations. *See generally* ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION (2d ed. 1988) (discussing various doctrines used by courts to avoid limitations on vicarious liability in context of physician-hospital relationship).

MCOs, and the rate of affiliation is increasing geometrically as managed care competition increases.[129]

Management principles now pervade health care. Critics attack managed care micromanagement of physicians as misguided, arguing with justification that physicians need substantial elbow room in their decision making.[130] MCOs contend that they can provide less expensive care, while maintaining the overall quality of care.[131] Some groups fear this evolution within the health care system. They worry that MCOs will limit physician options.[132] They worry that MCOs will harm patients through systematic cost-cutting.[133] They foresee "cookbook medicine" through im-

129. *See* Edward Felsenthal, *Medical Plans Are Shouldering More Liability for Doctors' Errors*, WALL ST. J., Oct. 18, 1993, at B8 (noting transformation in health care system as to responsibility for delivery of care).

130. *See* David Frankford, *Managing Medical Clinician's Work Through the Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71, 84 (1994) (criticizing management of physicians using incentive-based plans). Frankford argued that "[health care] plans resting upon financial incentives to manage professional work conflict with the values professionals espouse." *Id.*

131. *See* James P. Murray et al., *Ambulatory Testing for Capitation and Fee-for-Service Patients in the Same Practice Setting: Relationship to Outcomes*, 30 MED. CARE 252, 252 (1992) (finding that "[hypertensive] patients with capitation health insurance had fewer laboratory tests and lower overall charges than the fee-for-service patients, with no clinical or statistically significant differences in 1-year health outcomes"); Barbara Starfield et al., *Costs vs. Quality in Different Types of Primary Care Settings*, 272 JAMA 1903, 1903 (1994) (studying relationship between efficiency in use of resources and quality of care provided by physicians in state Medicaid program). These commentators found a general lack of relationship between quality and costs. *See, e.g., id.* at 1907 ("Facilities that provide services at lower costs can achieve adequate quality as often as higher-cost facilities.").

132. *See* Henry Scovern, *Hired Help: A Physician's Experiences in a For-Profit Staff-Model HMO*, 319 NEW ENG. J. MED. 787, 790 (1988) ("[T]he physician in a staff-model HMO is located at the hinge of a V in which patients' needs are funneled down one arm and administrative duties and constraints down the other.").

133. *See* Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330, 331 (1995) (expressing concerns that managed care financial incentives make physicians more cost conscious and may compromise patient care.) According to the Council on Ethical and Judicial Affairs of the American Medical Association ("Council"), there are two ways that financial incentives compromise the physician's duty of loyalty to the patient:

> First, physicians have an incentive to cut corners in their patient care, by temporizing too long, eschewing extra diagnostic tests, or refraining from an expensive referral. . . . Second, even in the absence of actual patient harm, the incentives may erode patient trust as patients wonder whether they are receiving all necessary care or are being denied care because of the physicians' pecuniary concerns.
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> . . . [F]inancial incentives to limit care exploit the financial motive of physicians [and are] less likely . . . to coincide with patients' interests, because patients generally prefer the risk of too much care to the risk of too little care.

Id. at 333. The Council further noted that patients are less likely to notice the effects of incentives, such as the withholding of a treatment option. *See id. But cf.* Pearson, *supra* note 113, at 72 (stating that "the assumption that HMOs achieve cost savings through a broad decrease in hospitalization rates must be closely ex-

posed practice guidelines,[134] bureaucratic controls through utilization review[135] and dissipation of physician-patient trust as a result.[136] They fear that profound inequality within our health care system will result from any rush towards efficiency-based medicine.[137] Primarily, however, they fear a corporatization of health care.[138] They fear that under such corporatization, doctors will come to resemble little more than production workers in a medical version of the assembly line, with corporate management tools and statistical process analysis micromanaging physician work.

An effective managed care system rests on three principles. First, physicians have primary responsibility for both cost control and quality improvement. Physicians act as a spigot in the health care system, controlling enormous dollar expenditures. This flow of dollars into

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amined" after study found higher admission rates for patients with chest pain who were in HMOs than for those enrolled in other types of plans).

134. *See* Emily Friedman, *Changing the System: Implications for Physicians*, 269 JAMA 2437, 2442 (1993) (noting threats to physicians' clinical autonomy resulting from managed care).

135. *See* Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J.L. MED. & ETHICS 223, 225 (1995) (discussing possible negative effects of utilization review in MCOs when not managed and implemented by physicians). "Utilization review" refers to case-by-case evaluation of the necessity, appropriateness and quality of medical care from the payer's perspective. *See* FURROW ET AL., *supra* note 125, at 321-22. It is a cost-containment strategy designed to work by limiting the demand for health services. *See id.* at 322. One commentator states that practice autonomy is usually lowest in staff model HMOs, in which utilization review and other administrative responsibilities are normally controlled by health plan administrators. *See* Christensen, *supra*, at 225. According to Christensen, utilization review, when controlled by nonphysician administrators, can serve as a barrier to patient care, contribute to increased job stress for physicians as they try to get over administrative hurdles on their patients' behalf and cause a direct conflict of interest between physicians' duty to provide quality care and their own financial concerns. *See id.*

136. *See* Ezekiel Emanuel, *Managed Competition and the Patient-Physician Relationship*, 329 NEW ENG. J. MED. 879, 880-81 (1993) (discussing possible adverse effects of managed care on patient-physician relationship).

137. *See* BETTY LEYERLE, THE PRIVATE REGULATION OF AMERICAN HEALTH CARE 169 (1994) (criticizing America's "mechanistic approach" to health care for being "not democratic at all"). According to Leyerle, the United States' "mechanistic" health care system weighs most heavily on the people who are most ill—"the poor, the very old, and the very young." *Id.* Leyerle asserts that a more sensible system would be based on flexible, substantive, "cause-and-effect reasoning" in which treatment decisions are made in response to the seriousness of a patient's condition and the likelihood of successful treatment. *See id.*

138. *See id.* at 7-8. (arguing that managed competition, as instituted by American corporate leaders, has already added to health care costs, deprived millions of health care coverage, denied care to many of America's most ill citizens and created a bureaucratic system of private regulation). Leyerle views managed care as an industry-spawned development that increases "surveillance and control over many parts of the health care delivery system." *Id.* at 9. In Leyerle's view, these developments in health care are one example of the "encroachment of bureaucratic organization into almost every area of our lives. Bureaucracy, today, is the mechanism through which an increasingly total kind of social control can be exercised." *Id.*

health care often diverts resources unproductively away from other social needs. Any delivery system must provide methods for physicians to learn about costs, effective treatments and limitations on available treatments.

Second, health care institutions, more than individual physicians, have a responsibility to reduce the risks of accidents by aiming for a zero-defect health care setting. Institutional care is often toxic to patients. Failures of institutions cause harm to patients; all too often patients are overdosed, infected in the hospital, suffer surgical accidents and even die from medical accidents.[139] Physicians are one source of errors within a complex technological enterprise, but overall systems design is very often the real culprit.[140]

Third, bureaucratic structures are essential in managed health care to control costs and manage risks. Bureaucracy can effectively address problems of variation, medical errors and expensive medical practices. Bureaucratic innovations should strive to control costs of medical treatment, improve the quality of care delivered, protect the health status of those receiving such care and improve social equity.[141] Bureaucracy's hierarchical style, which imposes vertical controls, differs from medicine's more informal collegial organization; yet both coexist successfully within the hospital environment.[142] Medical professionals maintain high educational standards and continually acquire knowledge and experience sufficient to act independently.[143] A bureaucracy, by contrast, functions

139. *See* Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1855 (1994) [hereinafter Leape, *Error in Medicine*] (discussing sources and types of medical errors and error prevention methods); *see also* Lucian Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377, 377 (1991) (reporting study of patients hospitalized in New York in 1984 that found that four percent of patients suffered injury that prolonged their hospital stay and caused measurable disability); E.M. Schimmel, *The Hazards of Hospitalization*, 60 ANNALS INTERNAL MED. 100, 101. (1964) (reporting that 20% of patients admitted to one university hospital suffered injury resulting from medical care received and that 20% of those injuries were serious or fatal); K. Steel et al., *Iatrogenic Illness on a General Medical Service at a University Hospital*, 304 NEW ENG. J. MED. 638, 638 (1981) (reporting that 36% of patients admitted to medical service of university teaching hospital suffered injury resulting from medical care and that more than half of injuries were related to use of medication); D. Gopher et al., Presentation at the 33rd Annual Meeting of the Human Factors Society (October 18, 1989) (reporting that one study of errors in medical intensive care unit revealed average of 1.7 errors per day per patient).

140. *Cf.* Leape, *Error in Medicine*, *supra* note 139, at 1856 (recommending various changes to health care delivery systems as primary means to discover and prevent health care errors).

141. *See generally* Elizabeth A. McGlynn, *Six Challenges in Measuring the Quality of Health Care*, 16 HEALTH AFF. 7, 7-21 (1997) (discussing how quality assessment in medical field can impact managed care and patient care overall).

142. *See* ODIN W. ANDERSON, HEALTH SERVICES AS A GROWTH ENTERPRISE IN THE UNITED STATES SINCE 1875, at 309 (1990) (describing hospitals as one of most complex organizations possible, integrating hierarchical bureaucracy and informal professional decision making under one roof).

143. *See* WILLIAM F. MAY, THE PHYSICIAN'S COVENANT: IMAGES OF THE HEALER IN MEDICAL ETHICS 176 (1975) ("They have a direct grasp of first principles. This

primarily through commands and sanctions, using financial incentives, performance guidelines and other devices to channel employee behavior.

An MCO can coordinate and integrate its individual providers, using its bureaucratic advantages to collect data, monitor its professionals and alter behavior.

E. *Poor Integration of Services*

IDSs offer a range of benefits to enrolled populations by coordinating hospital, physician and insurer activities; they accept the risk of providing a range of benefits to the subscriber population for a fixed fee. By accepting such risk, these systems must demonstrate the quality and effectiveness of the treatment they provide. As a result, hospitals seeking to form IDSs have forged closer relationships with primary care physicians, the gatekeepers in the new IDS.[144] Hospitals have also created management relationships or even more integrated employment relationships with these physicians.[145] Moreover, hospitals have sought to create effective specialist networks in an effort to seize control over ambulatory care—a new line of business for hospitals—and to create partnerships with managed care plans that would complete a truly integrated strategy.[146]

The physician's role within these health care delivery systems is redefined. Physicians, accustomed to small group practices or solo practice, will lack sufficient access to patients unless they belong to an integrated system. This will result simply because the integrated systems, not the physicians, will ultimately control the delivery of care to plan patients.

Hospitals, MCOs and IDSs offer a starting point for reforms that link cost and outcomes. These institutions can best promote good health care outcomes within a system designed to direct physician service payments towards them.[147] Thus, organizations within which physicians practice must recognize their central role in both cost controls and quality improvement. Consequently, MCOs and IDSs are thinking more frequently about effective ways to link provider performance and institutional incen-

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bestows upon them the mark of independence. The principle of collegiality expresses this independence within a community of professionals; colleagues ideally act in concert with one another chiefly by persuasion rather than command.").

144. *See* Barry R. Furrow, *Enterprise Liability and Healthcare Reform: Managing Care and Mangaging Risk*, 39 ST. LOUIS U. L.J. 77, 130 (1994) (discussing new integrated relationships between hospitals and physicians); Stephen M. Shortell et al., *Reinventing the American Hospital*, 73 MILBANK Q. 131, 144-46 (1995) (same).

145. *See* Shortell et al., *supra* note 144, at 145 (noting existence of several structured hospital-physician collaborative approaches, including physician hospital organizations, management service organizations and foundation, staff and equity models).

146. *See id.* (discussing hospitals' efforts to integrate services as part of systems-based approach to health care provision).

147. *See* STEPHEN M. SHORTELL, STRATEGIC CHOICES FOR AMERICA'S HOSPITALS: MANAGING CHANGE IN TURBULENT TIMES 260-62 (1990) (advocating vertical organization in health care delivery, so hospitals are central focus of integrated continuum of care).

tives.[148] With competition among IDSs, quality care marketing might become as important as low-cost care marketing.

IV. STRATEGIES FOR QUALITY REGULATION IN MANAGED CARE: CARP

Consumer Shopping
Adversarial Approaches
Regulation in the States
Private Accreditation

A. *Consumer Shopping*

Consumers and purchasers (including employers and government) lack information on health plans or on providers' access to care and quality of care performance.[149] Little information is available that is truly comparable across organizations. One commentator noted that "[a]s a result, consumers and purchasers cannot 'vote with their feet' and stimulate competition among plans and providers on the basis of quality-of-care performance, rather than simply on the basis of price."[150] Such comparative information is developing, however, as the accreditation process, state and federal government, and the media all seek the ability to compare providers. Web sites are developing to allow consumers to access physician information, comparisons of MCOs and hospitals, and practice guidelines and treatment regulations.[151]

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148. *See* Mark C. Hornbrook & Sylvester E. Berki, *Practice Mode and Payment Method: Effects on Use, Cost, Quality, and Access*, 23 MED. CARE 484, 485-90 (1985) (discussing and advocating use of "structure-conduct-performance paradigm"). The structure-conduct-performance paradigm is a model based on economic theory and organizational behavior that sets out the crucial dimensions of these three factors and describes their causal interrelationships and feedback effects. *See id.* at 485. The model can be used to hypothesize the structure of the health care market and an MCO's objectives to influence the MCO's behaviors with regard to products, promotions and strategy. *See id.* These behaviors are then hypothesized to influence physicians' performance, including profitability, efficiency and effectiveness. *See id.*

149. *See* John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 707 (1997) ("[Consumers] are and will remain technically unable to assess, unguided, the relative quality [and availability of medical care].").

150. *See id.* at 766 ("To be fully effective, a market-driven system of quality assurance must permit a consumer to act on the information they receive."). Jacobi points out that "[t]he structure of the insurance system should be adjusted to permit consumers to 'vote with their feet' by directly selecting their insurance plans." *See id.*

151. *See, e.g.*, *HPO's and Physician Skills for MCO's*, (visited Apr. 12, 1998) <http//www2.umdnj.edu/gpph/ira4.html>; *Physician and Service Guide of the Medical College Hospitals* (visited Apr. 12, 1998) <http://www.mco.edu/hosp/apmco/>.

B. *Adversarial Approaches*

Critics of the tort system observe that too few malpractice suits are brought, for reasons that include the costs of bringing lower dollar amount claims, the lack of return for the plaintiff lawyer on small cases and a lack of awareness of many injured patients that they had a potential claim for malpractice.[152] Patients with small claims rarely sue, so that a substantial number of potential claims are never brought into the civil justice system.[153] The current system thus compensates far fewer patients than actually suffer injury, at least in the hospital setting. The Harvard Medical Practice Study

> estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.[154]

Another study, based on a match between hospital files and litigated actions, concluded that this estimate was too high.[155] Because many claims filed reflect cases in which researchers found no negligent adverse event, fewer than two percent of negligent adverse events, or less than one in fifty, resulted in claims.[156]

The flaws of the tort system have been well-described elsewhere.[157] The limits on individual malpractice suits against physicians are matched by the limitations on suing health care institutions such as MCOs. Because it preempts state law causes of action in many circumstances, the primary

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152. *See generally* Sheila M. Johnson, *A Medical Malpractice Litigator Proposes Mediation*, 52 DISP. RESOL. 42, 43-44 (1997) (discussing reasons for failure of tort system).

153. *See* Furrow, *supra* note 144, at 77, 130 (stating there is underfiling of valid injury claims).

154. REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK (1990), *in* PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 6 (1993).

155. *See* Troyen A. Brennan, *An Empirical Analysis of Accidents and Accident Law: The Case of Medical Malpractice Law*, 36 ST. LOUIS U. L.J. 823, 847 (1992) ("[T]he true odds of a claim following an actual negligent adverse event is much closer to one in fifty than one in eight.").

156. *See id.* at 847 ("The result is that large numbers of claims followed hospitalizations in which our review process uncovered no injury and/or no negligence.").

157. *See, e.g.*, Jacobi, *supra* note 149, at 746-47 ("The medical malpractice system, therefore, addresses very few alleged cases of medical injury compared to the negligent injuries experienced, and, even for that small number, it does so poorly.").

barrier to such suits is the Employment Retirement Income Security Act of 1974 (ERISA).[158]

ERISA established uniform national standards for employee benefit plans and broadly preempted state regulation of these plans.[159] Section 1144(a) states that ERISA supersedes state laws to the extent that they "relate to any employee benefit plan" covered by ERISA.[160] Congress passed ERISA to provide for national uniform administration of employee pension and health plans, to promote the growth of private plans by freeing them from a patchwork of state laws that complicated benefits administration.[161]

ERISA has been wildly successful. ERISA plans are the leading source of payment for health services nationwide.[162] If ERISA preempts a state law claim, then the plaintiff is relegated to section 502(a)(1)(B) of ERISA.[163]

In *Massachusetts Mutual Life Insurance Co. v. Russell*,[164] the United States Supreme Court held that an employee covered under his or her employer's welfare benefit plan could not recover compensatory and punitive damages for financial losses that were allegedly caused by "improper

158. 29 U.S.C. §§ 1001-1461 (1994).

159. *See* Robert L. Roth, *Recent Developments Concerning the Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, and Utilization Review Agents*, HEALTH LAW., Early Spring 1996, at 3 (noting that ERISA provided national uniform administration of employee pension plans by freeing private plans from "scramble of state laws that unnecessarily complicated employee benefit administration"); *see also* New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 650-51 (1995) ("ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide 'medical, surgical or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.'" (quoting 29 U.S.C. § 1002)).

160. 29 U.S.C. § 1144(a); *see* Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 375-80 (1994) (discussing effect of ERISA preemption clause). One commentator noted that

> [t]he Supreme Court has held that a state law will be considered to 'relate to' an employee benefit plan, and therefore be preempted, if it has a 'connection with or reference to such a plan' unless the law has an impact on ERISA plans that is 'tenuous, remote, or peripheral.'

Roth, *supra* note 159, at 3.

161. *See* Pittman, *supra* note 160, at 357-59 (noting that primary purpose of ERISA is to "provide protection to employees and not employers"); Roth, *supra* note 159, at 3 (discussing background and purpose of ERISA).

162. Jack K. Kilcullen, *Groping for the Reins: ERISA HMO Malpractice & Enterprise Liability*, 22 AM. J.L. & MED. 7, 9 (1996) ("ERISA-governed plans now cover more that one-half of all American workers.").

163. *See* 29 U.S.C. § 1132(a)(1)(B) (stating that civil action may be brought "by a participant or beneficiary to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . ."); *see also* Pittman, *supra* note 160, at 430-31 & n.487 (discussing employee and beneficiary recovery under ERISA).

164. 473 U.S. 134 (1985).

or untimely" processing of the employee's claim for disability benefits.[165] Section 409(a)'s statement that the fiduciary "shall be subject to such other equitable or remedial relief as the court may deem appropriate" precludes compensatory and punitive damages to compensate beneficiaries for personal injuries.[166] Although a beneficiary can sue a benefit plan or benefit plan manager or other fiduciary, a beneficiary cannot collect any personal compensatory or punitive damages under section 409(a).[167] ERISA therefore substantially restricts the amount of recovery possible in what would otherwise be an ordinary malpractice case.[168] ERISA allows a defendant to remove an ordinary malpractice case to federal court and invoke ERISA preemption to end the traditional lawsuit and require its reframing as a breach of ERISA.[169] The plaintiff's potential damage award is severely curtailed as a result.

ERISA was interpreted by the federal courts in the first wave of litigation as totally preempting common law tort claims.[170] Apparently, any managed care plan that was ERISA-qualified would receive virtually complete tort immunity.[171] The federal courts began to split, however, as to the limits of such preemption, and more recently, several decisions have limited the preemption clause of ERISA, holding that many tort theories

165. *Id.* at 148. Respondent, a beneficiary under an ERISA plan, became disabled and received benefits for several months. *See id.* at 136. Her benefits were then discontinued only to be reinstated on review several months later. *See id.* at 136-37. Respondent sued for improper refusal to pay benefits for that period of time. *See id.* The Court held that section 409(a) of ERISA does not provide a cause of action for extracontractual damages for untimely processing of benefits. *See id.* at 148.

166. 29 U.S.C. § 1109(a); *see Russell,* 473 U.S. at 144 (stating that "Congress did not intend that section to authorize any relief except for the plan itself").

167. *See Russell,* 473 U.S. at 144 (finding no express authority for awarding extracontractual damages to beneficiary).

168. *See id.* at 146-47 (stating that Court is "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA"). The result is that a plaintiff is limited to the remedies that ERISA expressly provides. *See id.* at 147 (noting Court's further reluctance to read other remedies into statute).

169. *See* Butler v. Wu, 853 F. Supp. 125, 129 (D.N.J. 1994) (agreeing with district court's decision to grant motion to remove medical malpractice claim to federal court because "plaintiff's claims 'related to' an employee benefit plan as that term is defined by ERISA").

170. *See, e.g., id.* at 129-30 (concurring with reasoning adopted by other courts that ERISA preempts state law tort claims); Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966, 973 (S.D.N.Y. 1994) (holding that plaintiff's claims that HMO was liable under several common law theories were preempted); Ricci v. Gooberman, 840 F. Supp. 316, 318 (D.N.J. 1993) (holding that state tort claims were preempted by ERISA and leaving it up to Congress to clarify scope of ERISA); Altieri v. CIGNA Dental Health, Inc., 753 F. Supp. 61, 64 (D. Conn. 1990) (finding that ERISA preempts plaintiff's negligent supervision claim against HMO).

171. *See, e.g.,* Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 146 (2d Cir. 1989) (listing three laws that are generally preempted: (1) those that "provide an alternative cause of action to employees to collect benefits protected by ERISA;" (2) those that refer specifically to ERISA plans and apply solely to them; and (3) those that "interfere with the calculation of benefits owed to an employee.").

have little or nothing to do with the administration of pension plans or other benefits.[172] Although the circuit courts and the Supreme Court may continue to carve out exceptions to the general preemption of ERISA, it is unlikely that Congress will act to eliminate it. Thus, one must assume that MCOs will be largely protected against the most powerful tort theories: corporate negligence and direct negligence for defective plan design.

C. *Regulation in the States*

Over the past three years, states have begun to micromanage HMOs by adopting a variety of laws that provide direct access to specialists, prohibit gag clauses and grant physicians the right to health plan information about their practice patterns.[173] These laws fall into four general regulatory categories: (1) protection of patient information, (2) limits on plan control of physicians, (3) improvements in access to treatment, and (4) improved physician rights vis-a-vis plans in such areas as appeal rights, contracting and no-gag clauses.[174] Four states have restricted financial incentives that HMOs can impose on physicians to deny medically necessary care.[175] Some states have required that HMOs disclose financial incentives to patients.[176] The legislation is often in response to a highly visible politically charged set of anecdotes, such as the "drive-by" delivery, when women are discharged from the hospital only twenty-four hours after giving birth.[177] Other restrictions are physician-protective in response to the

172. *See* Prihoda v. Shpritz, 914 F. Supp. 113, 118 (D. Md. 1996) (holding that ERISA does not preempt action against physicians and HMO for physicians' failure to diagnose cancerous tumor and allowing vicarious liability action to proceed); *see also* Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 188 (E.D. Pa. 1994) (concluding that ERISA preempts plaintiff's direct negligence claim but not vicarious liability claim); Elsesser v. Hospital of the Phila. College of Osteopathic Med., 802 F. Supp. 1286, 1291 (E.D. Pa. 1992) (determining that negligence claim against HMO for selecting, retaining and evaluating plaintiff's primary-care physician was not preempted by ERISA); Independence HMO, Inc. v. Smith, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (finding that ERISA does not preempt state medical malpractice-type claims brought against HMOs under vicarious liability theory).

173. *See* Tracy E. Miller, *Managed Care Regulation: In the Laboratory of the States*, 278 JAMA 1102, 1103 (1997) (discussing most significant state regulatory activity in past years).

174. *See id.* at 1103-07 (explaining four general regulatory techniques employed by states recently).

175. *See id.* at 1104 (discussing restrictions in Georgia, Maryland, Texas and Rhode Island).

176. *See id.* (adding that American Medical Association called for disclosure of financial incentives to patients in 1990).

177. *See generally id.* at 1104 (noting that "[s]ome commentators have suggested that incentives will decrease patients' access to needed treatment"). Maryland, for example, has a statute empowering physicians to order up to a two-day hospital stay following a vaginal delivery, and a four-day stay for Cesarean sections. *See* MD. CODE ANN., HEALTH-GEN. I § 19-1305.4(c) (1996 & Supp. 1997) (stating that shorter stays may be permissible provided that review agent complies with additional requirements such as home visits). New Jersey's statute has the same

anger of providers who lose patients because MCOs do not contract with them.[178] These "any willing provider" laws aim to preempt the power of HMOs to create restricted lists of participating providers.[179]

State insurance regulation suffers from three major flaws. First, many of the reforms aim at the cost-cutting strategies of MCOs without regard to the cost efficiencies that underlie many of these strategies. The easy political gain from some of the patient-protective provisions, such as extensions of maternity stays in the hospital, make tempting targets for legislators. The problem with these reforms is that they rush to reform a market that is just developing. Second, the focus on physician incentives and loss of autonomy in the clinical setting 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. Constraining experimentation as to physician incentives and workplace changes risks slowing the reforms that are rapidly improving much of medical practice. Third, state regulation has the classic problem of all localized regulation: it is piecemeal and variable from state to state, requiring nationwide plans to custom tailor their plans in each state. If reform is desirable, it is better undertaken at the national level. The states as laboratories of experimentation is a noble idea, but states are also subject to interest group lobbying to a more powerful extent than is Congress.

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minimum stays, but allows the mother as well as the treating physician, to insist on the full two or four days. *See* N.J. STAT. ANN. § 17B:27A-7.1 (West 1996) (dealing with health insurance benefits following childbirth).

At the federal level, Senators Bradley and Kassebaum have introduced a bill creating The Newborns' and Mothers' Health Protection Act of 1996, also overturning MCOs' ability to set hospital stay limits. Pub. L. No. 104-204, 110 Stat. 2935; *see* 141 CONG. REC. S9175 (daily ed. June 27, 1995) (statement of Sen. Bradley) (introducing bill to require minimum hospital stay for mother and child after childbirth); *see also* Art Caplan, *Halting the 'OB Express' Is Tempting, But Tricky: It's Misguided to Pass Laws Protecting Single Class of Patient*, PHILA. INQUIRER, July 3, 1995, at A9 (discussing Bradley-Kassebaum bill).

178. *See* Miller, *supra* note 173, at 1106 (noting that first generation of physician protective laws took form of any willing provider laws).

179. *See id.* at 1106 (finding that any willing provider laws permit physician participation in health care plans if they meet stated criteria); *see also, e.g.*, IND. CODE § 27-8-11-3 (1995 & Supp. 1997) (providing that before entering agreement insurer shall establish conditions that must be met by providers); UTAH CODE ANN. § 31A-22-617 (1997) (outlining preferred provider contract provisions). Any willing provider laws impose a governmental limit on an MCO's ability to restrict subscribers' health care provider choice. *See* Gary Francesconi, Note, *ERISA Preemption of "Any Willing Provider" Laws—An Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227, 229-31 (1995) (noting that any willing provider laws are example of current regulation that "thwarts the growth of managed care alternatives"). Francesconi noted that "[y]et, the freedom to select only a *limited number* of providers is essential to the success of preferred provider organizations." *Id.* at 232 (emphasis added) (concluding that determination of whether ERISA preempts any willing provider laws is critical) .

D. *Private Accreditation*

The process of accrediting health care institutions has been around since the creation of the JCAHO.[180] One commentator proposed a definition of accreditation:

> Accreditation can be defined as the formal expression by a private body of an authoritative opinion concerning the acceptability, under objective quality standards fairly applied, of the services rendered by a particular institutional provider.[181]

Accreditation typically articulates standards for establishing and then measuring quality.[182] It then evaluates organizations to determine if they have met these standards.[183] In health care, as in education and other social activities, private accrediting bodies replace or supplant government regulation of the activity.[184] Their approval allows providers to receive government money, to continue to train professionals and so on.[185] The Administrative Conference of the United States calls this process "audited self-regulation."

1. *Benefits of Private Accreditation*

The first reason for delegating to private organizations what appears to be an appropriate public function is that it reduces the public payroll by moving enforcement costs off-budget, and shifts the financing of regula-

180. *See generally* Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 882 (1983) [hereinafter Jost, *JCAHO Private Regulation*] (noting that "JCAH accreditation also limits health care delivery to institutional settings by excluding competing non-institutional alternatives"); Timothy Stoltzfus Jost, *Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?*, 57 LAW & CONTEMP. PROBS. 15, 15 (1994) [hereinafter Jost, *Medicare and JCAHO*] (noting that Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation program is "oldest and most substantial regulatory use of health care accreditation in the United States"); Eleanor D. Kinney, *Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When Is It Appropriate?*, 57 LAW & CONTEMP. PROBS. 47, 52-55, (1994) (finding that JCAH, now JCAHO, has been "predominant private accrediting body"); Douglas C. Michael, *Federal Agency Use of Audited Self-Regulation as a Regulatory Technique*, 47 ADMIN. L. REV. 171, 218-22 (1995) (noting that JCAHO was "founded long before the Medicare and Medicaid programs").

181. Clark C. Havighurst, *Foreword: The Place of Private Accrediting Among the Instruments of Government*, 57 LAW & CONTEMP. PROBS. 1, 2 (1994).

182. *See* Jost, *Medicare and JCAHO*, *supra* note 180, at 17 (describing JCAHO revision of accreditation manuals to focus on streamlining its standards).

183. *See* Havighurst, *supra* note 181, at 2 ("The central purpose [of accreditation] is usually to reassure consumers and other users concerning the quality of the industry's products or services.").

184. *See id.* at 3 (noting that when government has regulatory presence, private groups hope it will "respect their standards and seals of approval").

185. *See generally* Michael, *supra* note 180, at 219 (discussing private accrediting bodies).

tion to fees paid by firms seeking accreditation.[186] Second, the standards issued by the accrediting body can be more effective because the organization can develop superior knowledge of the subject when compared with the government agency, and self-regulation allows for more diversity in methods of compliance with legal rules than a government agency can provide.[187] This government reliance on private accreditation arguably helps to "foster pluralism in the regulatory state."[188] Third, self-regulation may result in better compliance with rules, no matter who promulgates them or how they are designed, because self-enforcement is more effective and more easily accepted by the regulated entities.[189] Finally, self-regulation achieves compliance through more flexible methods than bureaucratic "command and control" methods.[190] This approach to regulation is "consistent with modern regulatory reform."[191]

2. *Limits of Private Accreditation*

Critics of the private accreditation process respond to the above discussion with several critical observations of the process.[192] First, they note the lack of independence of private accrediting organizations.[193] These organizations charge fees and consult with the organizations that they charge.[194] Second, the survey process is predictable. On-site inspections

186. *See* Havighurst, *supra* note 181, at 7 (commenting that one explanation for government reliance on private accrediting is reduced public payroll); *see also* Michael, *supra* note 180, at 184 (discussing cost savings to federal government as result of self-regulation).

187. *See* Michael, *supra* note 180, at 181-82 (explaining that accrediting body has more technical expertise than government). JCAHO, for example, can confer "deemed status" on hospitals. *See* Havighurst, *supra* note 181, at 8-9 (discussing constitutionality of conferring "deemed status" on hospitals). This does not raise a constitutional issue because the Health Care Financing Administration ("HCFA") retains the authority to revoke a hospital's status if it finds that the JCAHO has failed to provide adequate evidence of compliance with federal standards. *See id.* at 8 (explaining constitutionality of process). Havighurst noted that "[c]omparable 'look-behind' authority is generally provided whenever private accreditors are recognized by government." *Id.* at 9.

188. Havighurst, *supra* note 181, at 10.

189. *See* Michael, *supra* note 180, at 181 (noting that another advantage of self-regulation is increased compliance with rules that are "tailored to the conditions of the particular industry or workplace").

190. *Id.* at 181.

191. *Id.* "Self-regulation is widely regarded by researchers as having great potential to produce effective results from the sweeping mandates of modern legislation." *Id.* at 185.

192. *See* Havighurst, *supra* note 181, at 9-14 (highlighting possible objections to self-regulation); Michael, *supra* note 180, at 189 (discussing three disadvantages of audited self-regulation).

193. *See* Havighurst, *supra* note 181, at 9 (noting that "statutory definition of independence permits governance by a self-perpetuating board of professional society insiders, with only a small minority of board-selected 'public members'").

194. *See id.* (questioning whether government should ever entrust groups with interest conflicts).

of hospital and nursing homes are announced well in advance and provide opportunities for administrators to fix problems.[195] Third, accrediting bodies such as JCAHO have a limited ability to investigate complaints.[196] Interested third parties typically cannot speak confidentially with a survey team.[197] JCAHO policy requires disclosure to the health facility of the identity of the person seeking a public information interview with a surveyor, making it unlikely that staff, patients or interested members of the public will volunteer complaints or information about actual health plan policies and practices.[198] Fourth, the private accreditation process generally lacks public accountability and access by the public to the standard development process.[199] When HCFA or a licensing authority develops new standards, they notify the public and provide opportunity for public comment. Written comments are filed and available for public inspection, and the authorities explain why comments were accepted or rejected. The standards and survey guidelines are then made available on the Internet, in libraries and through government publications. NCQA, JCAHO and other private accrediting bodies have no obligation to publish proposed accreditation standards, but are able to copyright and sell these standards at high prices. Survey reports are surrounded by secrecy, with only summaries released. Even when public authorities rely on private accreditation to deem facilities in compliance with federal and state standards, public access to meaningful information about those facilities is virtually nonexistent.[200] Fifth, the standards often give too much discretion to the organizations inspected with regard to compliance.[201] Private accrediting organizations do not evaluate how consumers move through and between systems of care.[202] Many standards provide only a minimum

195. *See* Havighurst, *supra* note 181, at 12-13 (discussing the possibility that competition among accreditors would "encourage laxity in standards and oversight").

196. *See* Jost, *JCAHO Private Regulation*, *supra* note 180, at 876-77 (noting limitations on who may speak with survey team).

197. *See id.* at 879 n.352 (outlining public information interview procedure).

198. *See* Claudia Scholsberg, National Health Law Program, *Quality Oversight and Improvement: Different Levels of Accountability, Testimony Before the Advisory Commission on Consumer Protection and Quality in the Health Care Industry* (Sept. 10, 1997), *in* 189 HEALTH ADVOC. 5 (1997).

199. *See* Kinney, *supra* note 180, at 67, 78 (noting that private accreditation lacks accountability and that "[p]rivate accreditors do not have . . . formal processes [like the notice and comment procedures under Administrative Procedure Act] by which to contact consumers in a systematic fashion and to assure that all consumers have an opportunity to influence the content of the standards").

200. *See* Jost, *JCAHO Private Regulation*, *supra* note 180, at 882 (acknowledging that JCAHO provides little useful information to public about accredited institutions).

201. *See id.* at 877 ("JCAH does not require facilities to meet all or indeed any of its requirements or standards but only to 'substantially comply' with the standards as a whole.").

202. *See, e.g., id.* at 877 n.334 (noting that JCAHO handles many complaints by asking facility to evaluate itself).

framework and give plans enormous discretion to define the standards and the level of compliance.[203] NCQA Managed Behavioral Health Care Standards for Accreditation require plans to make timely utilization management decisions, but the health plan, and not NCQA, has discretion to define its own timeliness standard. The most relevant indicators of good outcomes, such as deaths or adverse drug reactions, are often not measured. Sixth, survey results sometimes fail to translate into meaningful accreditation decisions. Although JCAHO, for example, does identify problems, these problems may not translate into low scores or poor-performance reports, because of the flexibility and variability in the scoring process. Seventh, enforcement has been weak.[204] Accreditation status may be full, with recommendations, one year, denial or deferral. There are no intermediate sanctions, and patterns of repeat violations rarely affect accreditation status. On-site follow-ups are not required to lift deficiencies in hospitals.

The actual operation of private accreditation, however, is more responsive and more complex than simple government regulation would be.[205] NCQA and JCAHO are both increasingly responding to both consumer criticism and employer alliances. This purchaser orientation is in contrast to the older view of accreditation as essentially self-regulation—a way of avoiding real government regulation while not achieving much. A closer look at NCQA, for example, reveals that the merits of private accreditation may be substantial.

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203. *See id.* at 878-79 ("Research has found low correlations between JCAHO accreditation and other measures of hospital quality and wide variation in quality between JCAHO accredited hospitals.").

204. *See* Jost, *JCAHO Private Regulation*, *supra* note 180, at 881 ("JCAHO is a consultant and not an enforcer.").

205. *See* Jost, *Medicare and JCAHO*, *supra* note 180, at 45 (reviewing private accreditation process). Jost has noted that

> [a]ccreditation has traditionally been identified with industry self-regulation. The federal government's reliance on private accreditation for guaranteeing the quality of Medicare participating providers has thus been seen as suspect by those who fear that self-regulation is a poor vehicle for protecting consumers. The self-regulation model is too simplistic to explain the Joint Commission, however. The Joint Commission is responsive not only to the hospitals it accredits, but also to the physicians who created it and still play a major role in its governance, and to the federal and state governments whose recognition effectively gives the Joint Commission monopoly power in the hospital accreditation business. In the future, the Commission may also become responsive to the consumer or employer alliances that will direct the purchase of health care. Because it must respond to these various interests, the Joint Commission is arguably better able to assure the quality of health care than would be any simple self-regulatory body.

Id.

V. THE MERITS OF NCQA PRIVATE ACCREDITATION: FORCE

Forcing Data Generation
Originating Quality Factors
Ranking HMOs
Creating Competitive Pressures in the Marketplace
Energizing Consumers

The NCQA is an independent, nonprofit standard-setting organization that surveys and accredits MCOs and develops performance standards for health plan report cards.[206] Accreditation is an indication that an MCO is committed to principles of quality and is continuously improving the clinical care and services provided.[207] NCQA reviews how a plan manages its delivery system of physicians, hospitals and other providers. Its performance measures look at specific indicators of quality and it has become the leading source of quality information on MCOs.[208] The survey process can lead to a denial of accreditation for an MCO, giving NCQA and JCAHO substantial and increasing power to influence managed care development.[209]

A. *Forcing Data Generation*

NCQA history goes back to the Health Maintenance Organization Act of 1973.[210] It was established by HMO trade groups to forestall federal oversight, and for years, it did very little, with no full-time staff, and no standards against which to measure HMO performance. HMOs had little

206. *See NCQA Government Page* (visited Mar. 12, 1998) <http://www.ncqa.org/government/welcome.htm> (stating that, although NCQA is not government entity, independent, non-profit agency does interact with federal and state governments).

207. *See generally What Is MCO Accreditation?* (visited Mar. 12, 1998) <http://www.ncqa.org/accred.html> (explaining what NCQA evaluates when accrediting MCOs).

208. NCQA has reviewed 333 of the nation's HMOs. *See NCQA Consumer Brochure: Choosing Quality: Finding the Health Plan That's Right for You* (visited Mar. 11, 1998) <http://www.ncqa.org/consumer.htm> [hereinafter *NCQA Consumer Brochure*] (offering guide of nation's HMOs for consumers). Several states, including Connecticut, Florida, Kansas, New Jersey, Oklahoma, Pennsylvania and Rhode Island, South Carolina, Vermont and West Virginia, allow MCOs to use NCQA accreditation to satisfy an external quality review requirement. Alabama, Iowa, New York, Ohio and Tennessee require MCOs to obtain NCQA accreditation. *See NCQA Government Page, supra* note 206 (listing states); *see also, e.g.*, FLA. STAT. ch. 641.512 (1997) (allowing accreditation by accreditation organization approved by state department); KAN. STAT. ANN. § 65-429 (1996) (same); NEV. REV. STAT. § 449.476 (1997) (same); R.I. GEN. LAWS § 40-8-23 (1996) (discussing accreditation standards); S.C. CODE ANN. § 44-7-3110 (Law. Co-op. 1997) (same); VT. STAT. ANN. tit. 18, § 9414 (1997) (same).

209. *See* MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 341 (1997) (quoting unnamed HMO medical director as saying, "You flunk an NCQA exam, you get a new medical director and a new CEO").

210. 42 U.S.C. §§ 300e to 300e-14a (1994).

incentive to seek accreditation, absent threats such as withholding Medicare reimbursement or employer threats to switch out of unaccredited plans. This situation changed with the growing demands by corporate employers for accountability.[211] Xerox was first; in 1990, Xerox demanded that the MCOs which served its employees nationwide get NCQA accreditation within five years or be ejected from the Xerox network. This employer purchasing process was accelerated further by collaboration between Xerox and several other large employers to measure and compare HMOs on quality indicators. This collaboration gave rise to the Health Plan-Employer Data and Information Set (HEDIS). HEDIS 1.0 appeared in 1991, and in 1992, its development was turned over to NCQA. By 1993, plans covering more than fifty-five million HMO members had embraced HEDIS 2.0 and its more than sixty separate performance measures.[212] Accreditation then became more difficult and expensive to procure. HEDIS emphasized population-based quality improvement projects like pap smear screening or asthma outreach.

NCQA has become a tough inspector. Only forty percent of plans get the full three-year accreditation; thirty-five percent get a one-year approval; eight percent are accredited provisionally; and eleven percent are denied accreditation.[213] By 1997, fifty percent of licensed HMOs were reviewed by NCQA and twenty-five percent were scheduled.[214] Nearly ninety HMOs publicly reported the seventeen HEDIS measures of performance, ranging from average maternity stay to member access to services.[215] NCQA has now begun to release comparative information on the quality of care provided by the majority of capitated systems in the United States, covering more than thirty-seven million Americans.[216]

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211. *See* Peter V. Lee, *The Promise & Perils of Managed Health Care, Consumers Search for a Level Playing Field*, 18 WHITTIER L. REV. 3, 9 (noting that some larger employers provide incentives to employees to choose NCQA accredited HMOs); Gordon Simonds, *Quality of Care Issues*, at 303, 325 (P.L.I. Corp. L. & Practice Course Handbook Series No. B4-7190, 1997) (noting growing list of employers who require or request NCQA accreditation of plans). Some of the companies that require or request NCQA accreditation surveys include Allied Signal, Ameritech, Bristol Myers-Squibb, Chrysler, Digital Equipment, Ford, GE, GTE, IBM, Marriott, Mobil, NationsBank, PepsiCo, Procter & Gamble, UPS, USAir and Xerox. *See National Committee For Quality Assurance: An Overview*, (visited Mar. 11, 1998) <http://www.ncqa.org/overview3.htm> (listing companies).

212. *See* Simonds, *supra* note 211, at 309 (discussing NCQA's integration with Health Plan Employer Data and Information Set (HEDIS) program).

213. *See id.* at 326 (displaying table of NCQA accreditation status statistics).

214. *See National Committee for Quality Assurance: An Overview*, *supra* note 211 (noting that half of HMOs in nation are currently involved in NCQA accreditation process and "[m]ore than 75% of all Americans have been reviewed by NCQA").

215. *See The State of Managed Care Quality* (visited Apr. 1, 1998) <http://www/ncqa.org/news/report.htm> (displaying HEDIS data).

216. *See id.* (recognizing "unprecedented opportunity to examine and compile performance across the managed care industry").

B. *Originating Quality Factors*

The rising criticism of managed care, state legislative backlash and media attention has strengthened NCQA review. HEDIS 3.0, now in effect, has seventy-one indicators in eight areas: effectiveness of care, accessibility and availability of care, satisfaction with experience of care, cost of care, stability of the health plan, informed health care choices for patients, use of services and plan descriptive information.[217] Another thirty testing indicators are also being issued.

NCQA standards include written policies and procedures in the credentialing process; credentialing, recredentialing, recertification and reappointment of physicians and other licensed practitioners; visitation and review of the offices of primary care practitioners, obstetricians, gynecologists and other high-volume specialty physicians as to medical record keeping; and review of data during the recredentialing or recertification process involving member complaints, utilization management, quality review and member satisfaction surveys.[218] NCQA standards define quality improvement (QI) structures and demand that accredited HMOs have QI programs and require health management systems to improve the health status of members with chronic conditions.[219] The 1997 standards require each MCO to adopt and disseminate practice guidelines for the provision of acute and chronic care services, and annually measure its performance against at least two guidelines. Standard QI9 addresses clinical QI activities, monitors utilization and continuity and coordination of care that members receive. Standard QI10 requires clinical measurement activities, using data collection, measurement and analysis to track the clinical QI issues. Standard CR9 addresses recredentialing and requires an MCO to incorporate the following data in its decision making: member complaints, information from QI activities, utilization management, member satisfaction, medical record interviews and site visits.

The NCQA 1997 accreditation standards include five standards on the establishment and monitoring of clinical practice guidelines for acute and chronic conditions. As part of this review, the MCO must demonstrate that it has adopted clinical practice guidelines, that the guidelines are based on reasonable medical evidence, that MCO practitioners had substantial input into the development of the guidelines, that the MCO reviews and updates them and that the MCO measures performance against them.[220]

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217. *See HEDIS 3.0 Executive Summary: What Kind of Measures Are in HEDIS 3.0?* (visited Apr. 1, 1998) <http://www.ncqa.org/hedis/30exsum.htm#whatmeasures> (noting eight performance domains for which measures were sought).

218. *See generally* STANDARDS FOR ACCREDITATION OF MANAGED CARE ORGANIZATIONS (Nat'l Comm. for Quality Assurance 1997).

219. *Id.* Standard QI7.

220. *See generally* STANDARDS FOR ACCREDITATION OF MANAGED CARE ORGANIZATIONS (Nat'l Comm. for Quality Assurance 1997). JCAHO has also developed managed care standards, reflecting performance expectations in areas such as

Pressure to measure quality has built up because of the perception that the prices in many markets have been driven to such a low point that quality might be affected. This disclosure-based regulation has three goals: (1) accuracy enhancement, by helping consumers know enough to select among and bargain with providers; (2) agency cost reduction, counterbalancing provider and fiscal intermediary incentives to conceal conflicts of interest; and (3) performance improvement.[221]

Such external measures of quality provide a useful benchmark, helping organizations to resist cost-cutting pressures that might show a measurable reduction in subscriber quality of care.[222] The NCQA's HEDIS program now incorporates Medicaid and Medicare performance measures, focusing on outcomes.[223] Under HEDIS data measures, MCOs are tested on their effectiveness in caring for patients, accessibility and availability of care, enrollee satisfaction with care, costs of care, financial and provider stability, availability of information on treatment options and choices, use of services and descriptions of provider, clinical, utilization and risk management activities.[224] The quality indicators in HEDIS measure selected areas to assess overall quality, such as mammography screening, cervical cancer screening, first trimester pregnancy care, prevention of low birth weight, pediatric immunizations, cholesterol screening rates, in-patient admission rates for asthma patients, a diabetic retinal exam and ambulatory follow-up after hospitalization for major affective disorders.[225]

Defining and measuring quality from the consumer's perspective can be difficult.[226] And the limited value of plan-wide data to the consumer is an additional problem. Consumers are often limited in their choice of plan and are "more interested in information about specific physicians, groups of physicians, or specific hospitals than health plans."[227] Nonetheless, invidious comparisons by employers searching for the best plans for

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preventive care, continuation of care, management of doctors, nurses and staff; patient rights; and procedures for measuring and improving the quality of patient care. *See* JCAHO, *Joint Commission Standards* (visited Apr. 1, 1998) <http://www.jcaho.org/prefmeas/stds.htm> (discussing JCAHO's "broad spectrum" of standards).

221. *See* William M. Sage & Dave Anderson, *Health Care Disclosure Requirements, in* HEALTH LAW HANDBOOK 185, 186 (Alice G. Gosfield ed., 1995) ("Mandating that a managed care organization measure and report a process or outcome is a clear signal to devote attention to the activity being tested.").

222. *See generally HEDIS 3.0 Executive Summary* (visited Mar. 12, 1998) <http//www.ncqa.org/hedis/30exsum.htm#whatis> (explaining that HEDIS will allow decisions to be made based on overall value and not only cost).

223. *See id.* (stating private and public section measurement efforts are brought together).

224. *See HEDIS 3.0 Reporting and Testing Set Measures* (visited Mar. 12, 1998) <http://www.ncqa.org/news/hedismeas.htm> (listing quality indicators).

225. *See NCQA Consumer Brochure, supra* note 208 (offering guide of nation's HMOs for consumers).

226. *See* Paul D. Cleary & Susan Edgman Levitan, *Health Care Qualtiy: Incorporating Consumer Perspectives*, 278 JAMA 1608, 1608-09 (1997).

227. *Id.* at 1609.

their employees will still create pressure on MCOs to meet the level of performance of the better plans.

C. *Ranking HMOs*

A 1997 report by NCQA, based on 333 HMOs, covering forty-five million Americans representing seventy-five percent of HMO enrollees, found substantial variation among HMOs on several indicators.[228] The study looked at HEDIS data, including measures such as advising smokers to quit, beta blocker treatment, breast cancer screening, cervical cancer screening, cesarean section rates, childhood immunizations, diabetic eye exams and prenatal care in the first trimester. The study found, for example, that heart attack patients in one region were treated with beta blockers less than twenty percent of the time in some health plans, but more than ninety percent of patients receive beta blocker treatment in the best performing plans.[229] Similar variations were found for the other indicators.

These comparisons of individual HMOs are now available by telephone and on the Internet for consumers to examine, as are news magazine rankings. No organization wants to be on the bottom, or below average, in any comparison.

D. *Creating Competitive Pressures in the Marketplace*

Comparative data as to outcomes and success rates in hospitals and particular medical specialties is proliferating. Information gathering by health care institutions is beginning to produce disclosure of comparative success rates and outcome data when available, particularly under pressure from corporate purchasers of health care who want good results for their employees. And it is about time. As long ago as 1913, Ernest Amory Codman, the medical pioneer of outcome studies, argued that institutions and surgeons should disclose their successes and failures so that the public could choose the best provider.[230] Progress has been slow in the face of medical resistance.

The production of such plan-specific comparative data allows purchasers of health care, both private and public, to shop for performance as well as the lowest price. HEDIS data is also increasingly used by news media, such as *U.S. News and World Report*, and by corporate groups and states

228. *See NCQA Consumer Brochure, supra* note 208 (offering guide of nation's HMOs for consumers).

229. *See id.* (stating that NCQA report focuses on eight HEDIS measures, although data for more than 50 HEDIS measures is available).

230. *See* Gary S. Belkin, *The Technocratic Wish: Making Sense and Finding Power in the "Managed Medical Marketplace"*, 22 J. HEALTH POL. POL'Y & L. 509, 523-24 (1997) (discussing Codman's ideology).

producing report cards.[231] One commentator noted that "[t]he challenge is to take the information and use it to reward plans that demonstrate high quality and improvement over time. Through these efforts consumers and purchasers will receive greater value for their health care dollar."[232] Public release of consumer reports will not only help consumers, but will also create incentives for providers to respond to bad grades.

E. *Energizing Consumers*

In a market economy, information is king. Even though the health care economy does not approximate a free market, readily accessible information on quality of care helps corporate purchasers and individual subscribers to choose appropriately. If consumers have information about comparative outcomes of care, they may be able to evaluate the quality of that care. Comparative information about patient satisfaction with health care institutions allows them to choose without having to explore the underlying process of health care. Some form of report card will produce quality through shifts in consumer demand induced by the data.

One commentator has delineated the limitations of a report card.[233] First, such cards are hard to implement, in light of data collection and aggregation.[234] The size of the plan is a major determinant of the significance of the data. Second, the collection of meaningful outcome data is difficult, because the quality of life and other indicators, short of mortality, are hard to measure and define. Third, the quality of the data at present is "often incomplete, misleading, or inaccurate."[235] Fourth, it is difficult to adjust for parent characteristics and other variables. Risk data can be manipulated by providers to inflate their performance. Even with perfect data, random variation will present some providers as below average. Fifth, uniformity of reporting systems is difficult to achieve at present, means of auditing the performance data to deter its manipulation by providers is needed and data may not be timely, but rather based on the activities of providers who have left a system. Sixth, consumers may face information overload if too many quality measures are presented, although consumer theorists argue that consumers typically employ a sim-

231. *See* Joseph W. Thompson et al., *The NCQA's Quality Compass: Evaluating Managed Care in the United States*, 17 HEALTH AFF. 152, 157 (1998) (stating that popular magazines and newspapers use HEDIS data to inform readers).

232. *Id.* at 157-58.

233. *See* Jason Ross Penzer, *Grading the Report Card: Lessons from Cognitive Psychology Marketing and the Law of Information Disclosure for Quality Assessment in Health Care Reform*, 12 YALE J. ON REG. 207, 221-23 (1995) (noting several limitations of performance report cards).

234. *See id.* at 222 (noting cost prohibition and lack of technology deter report card implementation).

235. *See id.*

ple strategy that focuses on one or two attributes of choice to eliminate most plans.[236]

The advantages of such information are twofold: corporate purchasers of care demand more and more of this information as part of their choice of the best plans for their employees and individuals can at least look at some factors that may be relevant to their decision making. More important is the relentless pressure created by these two classes of consumers on MCOs. As NCQA continues to develop and expand the classes of information in HEDIS so that more and more clinical performance indicators are listed, MCOs are forced to hire epidemiologists, statisticians and others to gather data and interpret it for their physicians in an unrelenting process of continuous QI. Even if the data is flawed and the comparisons lack complete relevance, the technologies of data collection and performance measurement will evolve more rapidly under pressure.

VI. CONCLUSION

Managed care bureaucracies necessarily emphasize technical performance. When a bureaucracy "presses for excellence, it tends to opt for its most technical and measurable forms."[237] This applies not only to the evolution of MCOs, but also to the private accreditation process in NCQA and the development of HEDIS 3.0. Managed care standards are moving toward high performance combined with affordable outcomes.[238] A system ethos, increasingly driven by the demands of private accreditation, may well be reoriented away from an obsession only with cost savings and toward quality in managed care performance.

A primary focus on health care quality and outcomes ensures that a health care system will produce the best results that the system's level of resources allows. A new model of provider ethics, based on good outcomes and high quality, therefore can create the impetus for an improved health care system. Perhaps Evans is wrong; perhaps the pressure of pri-

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236. *See id.* at 223 ("More information in the form of raw data, statistics, and rates may not lead to quality-based decision-making on the part of consumers.").

237. Thompson et al., *supra* note 231, at 181.

238. *See generally* Lester Carl Thurow, *Sounding Board: Learning to Say "No"*, 311 NEW ENG. J. MED. 1569, 1571 (1984). Lester Thurow stated that

> [i]t will be far better if American doctors begin to build up a social ethic and behavioral practices that help them decide when medicine is bad medicine—not simply because it has absolutely no payoff or because it hurts the patient—but also because the costs are not justified by the marginal benefits. To do this we are going to have to develop and disseminate better information on the cost effectiveness of alternative medical techniques for treating different ailments . . . .
>
> The medical professional now has professional norms concerning what constitutes bad medical practice. These norms have to be expanded to include cases in which high costs are not justified by minor expected benefits.

Id.

vate accreditation can help achieve public objectives of high quality yet cost-effective health care.[239]

239. For a discussion of Evans' viewpoint, see *supra* note 1 and accompanying text.