ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8072

9325 HOUSE LABOR & COMMERCE

TITLE 3. COMMERCE AND ECONOMIC DEVELOPMENT.

PART 2. DIVISION OF INSURANCE.

CHAPTER 29. PROPERTY, CASUALTY, AND RELATED INSURANCE.

3 AAC 29 is amended by adding new sections to read:

ARTICLE 5. SCHEDULE AND INDIVIDUAL RISK RATING PLANS.

Section

3 AAC 29.400. PURPOSE. The purpose of 3 AAC 29.400 - 3 AAC 29.469 is to establish minimum standards for schedule rating to ensure that

(1) a credit or debit under a schedule rating plan modifies premiums based only on risk characteristics that can be reasonably expected to have an effect upon losses or loss adjustment expenses;

(2) the application of a credit or debit under a schedule rating plan results in a rate that is not excessive, inadequate, or unfairly discriminatory; and

(3) documentation in an insurer's underwriting file provides sufficient detail to establish that the application of a credit or debit under a schedule rating plan complies with 3 AAC 29.400 - 3 AAC 29.469. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040

3 AAC 29.405. APPLICABILITY. 3 AAC 29.400 - 3 AAC 29.469 apply to all insurers and rating organizations subject to the requirements of AS 21.39. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040

3 AAC 29.410. APPLICATION OF SCHEDULE RATING PLAN. An insurer may only apply a schedule rating plan under 3 AAC 29.400 - 3 AAC 29.469 to business or commercial insurance as defined in AS 21.36.310. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040
AS 21.36.310

3 AAC 29.415. FILING REQUIREMENTS. (a) When filing a schedule rating plan, an insurer or rating organization must include in the filing

(1) the criteria that an applicant or insured is required to meet to be eligible for the plan;

(2) a description of each risk characteristic for which a debit or credit will apply; and

(3) the range of permissible credits or debits for each risk characteristic, including the total maximum permissible debit or credit that may be applied to the policy.

(b) A schedule rating plan filing must conform to the requirements of 3 AAC 31.200 - 3 AAC 31.240 and must demonstrate compliance with the standards under 3 AAC 29.420 and 3 AAC 29.430. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040

3 AAC 29.420. PLAN REQUIREMENTS. If an insurer uses a schedule rating plan, the plan

(1) must be uniformly applied to all eligible insureds or applicants;

(2) must be applied at each policy renewal;

(3) must assign credits or debits only for risk characteristics or that have measurable variations in anticipated losses or loss adjustment expenses; however, an insurer may apply underwriting judgement to determine the appropriate amount of credit or debit to be applied to the insured from within the filed range; and

(4) may not be applied in such a way as to duplicate other rating or rate development factors, including those in

(A) a manual rate;

(B) the assignment of insureds to classifications within a rating system; and

(C) an experience rating plan. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040

3 AAC 29.425. UNFAIR DISCRIMINATION. The application of a schedule rating plan is unfairly discriminatory and a violation of AS 21.36 if it fails to meet the requirements of 3 AAC 29.420. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.36.150 AS 21.39.030

AS 21.36.120

3 AAC 29.430. REQUIRED DOCUMENTATION. (a) An insurer shall maintain in its underwriting file documentation of the application of the appropriate schedule rating plan for each eligible insured.

(b) The documentation required in (a) of this section must include a worksheet that is prepared annually for each policy and that

(1) describes each risk characteristic and the range of permissible credits or debits for each characteristic of the plan for which the insured is eligible; and

(2) shows

(A) the underwriting determination of a credit, debit, or zero change for each risk characteristic;

(B) the date the determination was made;

(C) the identity of the person making the determination; and

(D) the basis for the determination.

(c) The file documentation required in (a) of this section must provide support for each underwriting determination and may include inspection reports, photographs, licensee observations and analysis, premises evaluations, formal safety plans of the insured, and narrative reports covering other aspects of the insured's hazards. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030

3 AAC 29.435. REQUIRED FILING OF SCHEDULE RATING PLANS. (a) An insurer wishing to use schedule rating to modify the premium for an insurance policy issued or renewed in Alaska after November 1, 1998 shall

(1) withdraw any schedule rating plan filing approved before the effective date of these regulations; and

(2) either

(A) file a schedule rating plan in compliance with 3 AAC 29.400 - 3 AAC 29.469; or

(B) reference a complying schedule rating plan filed by a rating organization of which the insurer is a member or subscriber.

(b) A rating organization may file a schedule rating plan on behalf of its member and subscriber insurers. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040

3 AAC 29.469. DEFINITIONS. In 3 AAC 29.400 - 3 AAC 29.469,

(1) "experience rating plan" means a procedure that is used to modify a manual rate based on the past loss experience of an individual insured;

(2) "manual rate" means the rate developed for an insured prior to the application of an experience rating plan or any subjective discount, credit, or surcharge;

(3) "risk characteristic" means an attribute that contributes to the variation in hazard among insureds;

(4) "schedule rating" means the recognition, through the application of judgmental credits and debits to a manual rate, of characteristics that are expected to affect a person's loss or loss adjustment expense experience, but that are not reflected in the class rates or the experience rating plan; schedule rating is the same as individual risk rating; and

(5) "schedule rating plan" means a description of the rules and eligibility criteria for schedule rating. (Eff. / / , Register)

Authority: AS 21.06.090 AS 21.39.030 AS 21.39.040

FORM FOR ADDITIONAL REGULATIONS
NOTICE INFORMATION
(AS 44.62.190(d))

1. **Adopting agency:** Department of Commerce and Economic Development, Division of Insurance

2. **General subject of regulation:** Schedule and individual risk rating plans

3. **Citation of regulation (may be grouped):** 3 AAC 29.400 - 3 AAC 29.469

4. **Reason for the proposed action:**
   - ___ compliance with federal law
   - ___ compliance with new, or changed, state statute
   - ___ compliance with court order
   - _X_ development of program standards
   - ___ other: (please list)

5. **Program category and BRU affected:** Public Protection/Insurance

6. **Cost of implementation to the Division of Insurance and available funding (in thousands of dollars):**

	Initial Year FY 98	Subsequent Years
Cost	$ -0-	$ -0-
General Funds	$ -0-	$ -0-
Federal Funds	$ -0-	$ -0-
Other Funds(specify)	$ -0-	$ -0-

7. **Contact person for the regulations:**

Barbara Thurston
Actuary
Division of Insurance
P.O. Box 110805
Juneau, AK 99811-0805

Telephone: 907/465-2515
Fax: 907/465-3422

8. **The origin of the proposed action:**
   - _X_ staff of the state agency
   - ___ federal government
   - ___ general public
   - ___ petition for regulation change
   - ___ other (please list)

9. **Prepared by:** _____
(Signature)

Name (typed): Joe Ver
Title (typed): Administrative Manager
Telephone: 907/465-2515
Date: March 10, 1998

JV/pb2616d.doc

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE DIVISION OF INSURANCE

Notice is given that the Division of Insurance, under authority vested by AS 21.06.090 and AS 21.39.040 proposes to adopt regulations in Title 3 of the Alaska Administrative Code, dealing with schedule and individual risk rating plans, to implement, interpret, and make specific AS 21.36.120, 21.36.150, 21.36.310, AS 21.39.030, and 21.39.040 as follows:

3 AAC 29.400 - 3 AAC 29.469 are proposed to be adopted to state the requirements that must be met by insurers and rating organizations who file schedule rating plans and insurers who use schedule rating plans to establish rates, specifically:

1. Sections 400 and 405 state the purpose of the regulations and to whom they apply.

2. Section 410 limits the application of a schedule rating plan to business and commercial insurance.

3. Section 415 states the requirements for filing a schedule rating plan.

4. Section 420 lists the requirements for using a schedule rating plan.

5. Section 425 indicates what constitutes unfair discrimination in the application of a schedule rating plan.

6. Section 430 tells what documentation an insurer is required to maintain.

7. Section 435 establishes a requirement for filing complying schedule rating plans.

8. Section 469 provides definitions of terms used in the other sections.

Notice is also given that any interested person may present oral or written comments relevant to the proposed action, including the potential costs to private persons of complying with the proposed action, at a hearing to be held in the conference room of the Division of Insurance, 3601 C Street, Suite 1324, Anchorage, Alaska, at **10:30 a.m., on Friday, April 3, 1998**. The hearing will be held from 10:30 a.m. to 12:00 noon and might be extended to accommodate those present before 12:00 noon who do not have an opportunity to testify. If you wish to attend the hearing via teleconference from another location, please contact Barbara Karl at (907) 269-7900, or TDD (907) 465-5437 no later than March 26, 1998 so that necessary arrangements may be made. If you wish to teleconference from a site outside of Alaska, you must pay the long distance charges. Additionally, any interested person may present written comments relevant to the proposed action, including the potential costs to private persons of complying with the proposed action, by writing to the Division of Insurance, Attention: Barbara Thurston; P.O. Box 110805; Juneau, AK 99811-0805, so that they are received no later than 5:00 p.m., (Alaska Daylight Time) April 10, 1998.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

FORM FOR ADDITIONAL REGULATIONS
NOTICE INFORMATION
(AS 44.62.190(d))

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   - _x_ development of program standards
   - ___ other: (please list)

5. **Program category and BRU affected:** Public Protection/Insurance

6. **Cost of implementation to the Division of Insurance and available funding (in thousands of dollars):**

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Federal Funds	$ -0-	$ -0-
Other Funds(specify)	$ -0-	$ -0-

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Telephone: 907/465-2515
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8. **The origin of the proposed action:**
   - _x_ staff of the state agency
   - ___ federal government
   - ___ general public
   - ___ petition for regulation change
   - ___ other (please list)

9. **Prepared by:** _____
(Signature)

Name (typed): Joe Ver
Title (typed): Administrative Manager
Telephone: 907/465-2515
Date: March 10, 1998

JV/pb2616d doc

If you are a person with a disability who may need a special accommodation in order to participate in the process on the proposed regulations, please contact Barbara Karl at (907) 269-7900, or TDD (907) 465-5437 no later than March 26, 1998 to ensure that any necessary accommodations can be provided.

This action is not expected to require an increased appropriation.

Copies of the proposed regulations may be obtained by writing to the Division of Insurance at the above address or by telephoning (907) 269-7900 in Anchorage or (907) 465-2515 in Juneau.

After the close of the public comment period, the Division of Insurance will either adopt these or other proposals dealing with the same subject, without further notice, or decide to take no action on them. The language of the final regulations may vary from that of the proposed regulations. You should comment during the time allowed if your interests could be affected.

DATE: March 10, 1998.

Marianne K.. Burke
Director of Insurance

MKB/BK/pb2616.doc

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State of Alaska
Department of Commerce
& Economic Development
Division of Insurance
P.O. Box 110805
Juneau, Alaska 99811-0805

IMPORTANT INSURANCE INFORMATION

California and the West

CONTRACEPTIVE MANDATE FOR INSURERS VETOED

Capitol: Wilson rejects bill requiring policies to cover birth control prescriptions, because it did not properly exempt employers who object on moral grounds. Legislator says he tried to meet governor's concerns.

by Max Vanzi, Times Staff Writer
Los Angeles Times, Thursday, February 12, 1998
Home Edition, Page: 3 Pt. A
Word Count: 690

SACRAMENTO - Despite intense daylong negotiations between a Los Angeles lawmaker and administration officials, Gov. Pete Wilson on Wednesday vetoed a bill that would have required health insurers to offer prescription contraceptives as a paid benefit in workplace health plans.

As he had declared earlier, Wilson said he would sign the bill by Assemblyman Bob Hertzberg (D-Sherman Oaks) only if it included a "conscience clause" allowing employers to opt out of such coverage on moral or religious grounds.

Hertzberg said that he went as far as he could toward meeting the governor's demands but that "it just wasn't good enough."

Wilson said he vetoed the measure because Hertzberg offered amendments that were "deemed unconstitutional by legal counsel."

The governor called on the Legislature to send him a similar bill that meets legal requirements. The Hertzberg measure failed to do that, he said, because it was so narrowly drawn that many religious organizations would not have qualified for the exemptions that Hertzberg offered.

The effect, he said, would have been to deny needed health coverage to women who work for such organizations that could not, in good conscience, have agreed to offer contraceptive coverage.

About 97% of HMO health plans in California already cover contraceptives, including prescription birth-control pills. But other types of insurance plans, including physician groups and fee-for-service arrangements, offer paid contraceptives to only about one-third of their 7 million California enrollees, according to consumer groups.

Hertzberg and administration officials in the Capitol, who were in touch with Wilson by telephone while the governor was in Los Angeles, held discussions throughout the day, the assemblyman said. Hertzberg "gave them huge exemptions in terms of the conscience clause," he said.

But he said he refused to go beyond his final offer to win the governor's signature: agreeing to exemptions only for employees of church organizations and church-affiliated hospitals.

"I was willing to allow an employer an exemption if there is the connection between someone's employment and their faith," Hertzberg said. 'But if someone worked for a (university) or a hotel chain that's owned by a religious organization, then they wouldn't have been exempt."

Wilson had been threatening a veto ever since the Assembly gave final legislative passage to the measure (AB 160) Jan. 28. Hertzberg at that point had refused to amend the bill along lines that Wilson wanted.

Any such legislation, Wilson's office said, should allow businesses an exemption on conscientious or religious grounds. The issue remained up in the air until the veto was announced in late afternoon.

"We are very disappointed . . . and surprised by the governor's action because of his long-standing support for access to family planning," said Nancy Sasaki, president of Planned Parenthood Los Angeles.

Wilson has consistently favored a woman's right to choose whether to have a child.

Ned Dolejsi, executive director of the California Catholic Conference, however, said Wilson's veto of the bill was "consistent with the governor's belief in expanding contraceptive services . . . but in a way that is respectful of the religious freedom of people who do not hare that view."

Enactment of the bill, he said, would have made it difficult for Catholic organizations to purchase health insurance consistent with church beliefs.

(BEGIN TEXT OF INFOBOX / INFOGRAPHIC)

Births and Contraception

Gov. Pete Wilson on Wednesday vetoed a bill to require health insurance companies to cover prescription contraceptives. Here are some related statistics:

* 97% of HMOs in California cover costs of contraceptive medication and devices. About 14 million Californians are enrolled in HMOs.

* 33% of non-HMO insurance plans cover contraceptives; 86% cover sterilization; 66% cover abortions. About 7 million Californians are enrolled in such plans.

* Adoption of the measure would have cost affected businesses about $16 per employee per year.

* The abortion rate in California is 42 per 1,000 women ages 15 to 44; the rate nationally is 26 per 1,000.

* California's family planning clinics served 804,000 women in 1994, and in clinics nationally, 6.5 million.

* Publicly funded clinics avert 187,000 pregnancies per year in California; nationally, 1.5 million.

Sources: Health Insurance Assn. of America; Alan Guttmacher Institute; Women's Research and Education Institute

MAR-23-98 MON 03:51 PM ANC LEGIS INFO OFC FAX NO. 907 258 1261 P. 01

TELECOPY COVER

Anchorage Legislative Information Office

Office - (907) 561-7007 Fax - (907) 562-4376

TO: Rep Rokeberg - Chair - (H) L+C Comte

ATTN: _____ FAX: 465-2040 PHONE: _____

FROM: _____ PHONE: _____

INSTRUCTIONS: Written (T) from yesterday 3/23 tele conference

SENT: Date 3/23 Time _____

DISPOSAL OF ORIGINAL: Discard _____ Hold for Pickup _____

NUMBER OF PAGES: 5 (counting cover sheet)

TRANSMITTED BY: JLD

March 20, 1998

Re: IIB 300. An Act Relating to Patients Rights, et al

Testimony of Rosemarie Kalamarides, Administrator of the Alaska Teamster-Employer Welfare Trust. Testifying against the proposed legislation.

I've worked with the Teamster Trust funds for 18 years and I understand that the issues facing this body are complex. I also know that many competing interests will provide compelling testimony making your job even more difficult.

The sponsors of this bill are attempting to legislate patient choice. This is a noble goal. Unfortunately, this bill is misguided and while it may initially give the patients more choice, ultimately, it will increase the patient's health care costs.

Make no mistake; this legislation will force medical costs up. And who will pay the additional costs? Not the employers who are struggling to compete in a tight marketplace. They will shift the added costs to the employees, your constituents, many of whom are already struggling to make ends meet.

Here is how the industry works. Employers pool their health care dollars and either purchase health insurance or *self-fund* the benefits for all their employees. Smaller employers tend to purchase insurance contracts while larger employers, with the economics to do so, self-fund their benefits

Our Trust funds the health care benefits of approximately 8,000 covered lives, most of them in Alaska. Under our health care plan, over 100 employers have pooled their health care dollars and assigned the task, of providing meaningful benefits with the dollars available, to me as the Administrator. Health care plans are *pay-as-you-go*--the contributions received are used to pay the medical bills received.
It is then my job to spend the limited dollars as effectively as possible. One way is to enter the marketplace and negotiate reduced medical costs with providers, provider groups or hospitals. The way these preferred arrangements are negotiated is very simple--for ***volume referrals***, providers and hospitals agree to ***discounted rates***. They will only negotiate reduced rates with some assurance that they will receive volume referrals in exchange for their discounts.

This legislation may sound good on the surface--typically called *Any Willing Provider Legislation*, it says that we must pay any willing provider the amount that we would pay the preferred provider. The irony is that plans will not be able to negotiate preferred arrangements if this legislation is passed. Why would a provider agree to discounted rates or fees for services if the volume is not sufficient to cover the deep discounts? They won't! There is no way to assure volume if this legislation is passed.

This legislation also proposes additional oversight by requiring that plans have a physician

approve any action that may be deemed a reduction in benefits. Plans are already paying for this type of oversight and now you would legislate increased administrative costs. More money would be spent on administration, not medical costs, which is where these dollars belong.

The demand for health care will not change, but if this legislation passes, the cost of the services will continue to increase with no ability of the consumer to control the cost. With this legislation, you take the control from the consumer.

As an Administrator, I would prefer not to steer our members to certain hospitals or certain doctors. But, without these arrangements in place, I would be telling them that their coverage is no longer 90% (for preferred providers) or even 80% (for non-preferred providers), but 50%, because misguided politicians passed ill thought-out legislation which undermined the ability to negotiate reduced medical rates.

This legislation makes no sense in Alaska. Alaska Providers and consumers have agreed that there is a reasonable balance between ***quality care*** and ***affordable care***--that ***patient centered care*** is everyone's goal. Patient centered care can only be attained through the teamwork of the **doctor**, the **patient** and the **health care payer**.

This balance of patient centered care is reached through careful negotiations between providers and consumers. These negotiations will not continue if this legislation is passed.

This legislation attempts to solve very complex problems with simplistic, uninformed solutions. This legislation is a step backward. It is a hostile and divisive law, which will do more harm than good.

Several years ago, when I testified against similar legislation, I quoted Henry Aaron of the Brookings Institute who put it best when he said *Any Willing Provider Legislation "...is meant to prevent the impairment of doctors' incomes."* That is what this legislation is about, not consumer choice.

You've heard from several doctors and their employees who support this legislation under the banner of *consumer choice.* But they are not the consumers.

You did hear from a consumer. On Friday, you heard from Debbie Dumman. Ms. Dumman sits on the Task Force, consisting of the rank & file Teamster members. They recognize that this legislation would shift health care dollars from their pockets into the pockets of doctors and hospitals. It will not improve their health care! It may give them more choice, but at too high a price.

You heard from folks who fund health care. Employer, Walter Hickel, Jr., put it very well when he said " ... *there are not many options for Alaska Businesses to adequately manage the cost of health insurance benefits for their employees.*"
The employers who fund health care will tell you that they cannot remain competitive and pay

more for medical costs. This means that their employees, your constituents, our members, will have to pay the additional costs.

The message this legislation sends to Alaskans is simple, ***doctors and hospitals do not have to negotiate with anyone. They can set the price and Alaskans must pay. Competition be damned.*** This legislation is a thinly veiled protectionist law, which benefits a few wealthy individuals and a huge, very profitable, national, hospital chain.

This legislation is anti-competition. It is all about regulating the free marketplace. Proponents will tell you this legislation gives choice to consumers. That is baloney. If you pass this legislation you will accomplish only one thing--you will drive health care costs up, and in doing so you will shift dollars from the pockets of hard-working Alaskans, and increase the incomes of a few doctors and hospitals. Period.

Thank you again for this opportunity.

465-2040

HB300

FACTS

* HB300 would stifle or eliminate the use of HMO's or PPO's in Alaska by insured Clients
* Costs of health care in Alaska are among the highest in the nation
* Insurance companies do not mandate this type of coverage; they offer policies to employers. Employers accept policies, some with/some without Preferred Provider agreements.
* The majority of benefit plan sponsors have some form of contractual agreement with hospitals/physicians/dentists using the clout of joint purchasing on behalf of employee to maintain or increase benefits
* Generally benefits are increased not decreased when a PPO is adopted
* Employees are advised in advance of implementing a PPO agreement not "when they come to use the plan"as stated in the Sponsor Statement

THE GUARANTEED RESULTS OF THE LEGISLATION WILL BE TO:

- Substantially increase costs to Alaska employers or reduce benefits to Alakan employees currently needing to insure their benefits and are now using same form of PPO
- Financially damage small/medium size employers most
- Not have any material impact on larger self insured plans

- Benefit provider community - hospitals/physicians/dentists
- Eliminate incentives to providers to be competetive with other (Alaska and Lower 48) providers on both costs and quality of service if patient does not have incentive to buy through a PPO network.
- Will force employers to move toward self-funded plans governed by ERISA and Federal Statutes thereby avoiding State of Alaska mandated benefits and legislation of this nature.

At the very least, ask experts to determine the adverse cost impact to benefit plan sponsors if this legislation is passed

SAVING THEIR ASSETS
How to Stop Plunder at Blue Cross and Other Nonprofits

Judith E. Bell

First it was hospitals and nursing homes, ambulatory care centers and health maintenance organizations (HMOs). Now it is Blue Cross plans and major teaching institutions. In an accelerating rush to the marketplace, many of America's largest health care nonprofits are being converted into profit-making organizations. As this wave continues—and nothing, currently, seems likely to stop it—billions of dollars in charitable assets are at risk. If we follow one course, state regulators and an aroused public can at least force converting nonprofits to transfer the value of their assets to new charitable foundations. But if regulators fail to act, the charitable legacy will be lost and more executives of nonprofits will become overnight millionaires by capturing the assets for themselves and their investors.

Recent experiences in California and Georgia illustrate the contrasting possibilities. California now has two new grant-making foundations with a total endowment of $3.3 billion, transferred from the nonprofit Blue Cross of California when it converted into a for-profit company. The foundations, which resulted from years of advocacy by consumer groups, regulators, and a few outspoken legislators, will be devoted to improving health care and public health. Georgia, on the other hand, enacted legislation in 1995 that made it much easier for the state's Blue Cross and Blue Shield plan to go for-profit and to argue successfully that it had no obligation to use its assets for any public benefit. Instead of establishing a foundation, Georgia Blue Cross is likely to provide its executives and investors with a windfall amounting to hundreds of millions of dollars.

Blue Cross and Blue Shield plans in at least 17 other states are either contemplating converting to for-profit operation or are already in the process, and more will undoubtedly follow. Conversions of other health care nonprofits are continuing at breathtaking levels. Nationally, the number of nonprofit hospitals merging with or being acquired by for-profit businesses climbed from 18 in 1993 to 176 in 1994. A November 1995 review by the *Chronicle of Philanthropy* found at least 65 conversions of nonprofit health care institutions pending around the country. Columbia-HCA Healthcare, the nation's largest for-profit hospital chain, said in 1994 that it planned to acquire as many as 500 more hospitals in the next few years, and in 1995 it purchased or began joint ventures with 41 nonprofit hospitals; on March 29, 1996, Columbia announced it would start a joint venture with Blue Cross and Blue Shield of Ohio, pending approval by state regulators.

The Blue Cross plans alone represent an enormous treasure. As of the end of 1991, according to a U.S. Senate committee report, Blue Cross and Blue Shield plans had assets of $30.1 billion and reserves of $9.8 billion. A national spokesperson for the Blues recently claimed that the plans' asset value is now double, about $60 billion. The value of a nonprofit hospital can easily exceed $100 million.

The commercialization of health care raises many troubling questions. The culture of health care used to

value the care of the vulnerable; now it is increasingly devoted to the care of the shareholders. One issue in this turn toward the market is simply what happens to all the public resources that have gone into building America's health charities: Will the executives and investors simply be allowed to walk off with billions of dollars? Or will the public at least reclaim the value of the assets? At the west coast regional office of Consumers Union, which I codirect, we have sought for more than 12 years to preserve the charitable assets of converting nonprofit health care companies. Our project, originally focused in California, is now a joint effort with Families USA (Boston) in 50 states and involves hundreds of people across the country. As more health care nonprofits seek legal approval to go for-profit, what we have learned is of growing importance.

THEY CAN'T TAKE IT WITH THEM

The directors and executives of nonprofit institutions are not legally entitled to any of the organization's assets. Under virtually all state laws, the assets of nonprofit organizations must be permanently dedicated to charitable purposes. Nonprofit health care organizations were established and grew, in large part, through relinquished taxes and access to public start-up and investment funds, including tax-free bonds. Charitable contributions as well as volunteer time and effort have also been invested in nonprofit hospitals. In effect, the public is the "shareholder" of every nonprofit. Nonprofits receive their special legal status, including their tax exemption, not for any executive's private benefit, but to serve broad public and charitable missions, which the executives are supposed to put ahead of any financial return. The Blue Cross plans and hospitals now seeking to convert to for-profit status want to free themselves of their original public mission so they can raise capital, grow larger, and make the financial return to investors their governing interest. It is this change that requires them to give up the assets they have received for charitable purposes.

The effects of commercializing America's health care system are unclear. Studies comparing nonprofit and for-profit health care companies—many of them funded by the industry itself—have been inconclusive. Some research suggests for-profits behave no differently from nonprofits or are more efficient. Curiously, this information often comes from conservative economists or business school professors. Other studies suggest that nonprofits provide higher-quality care and devote more of their resources to health care (relative to administrative costs and income) than do for-profit companies.

As health care charities convert to for-profit businesses, the Republican Congress has not raised any questions about the conversions; instead it has turned a critical eye on the remaining nonprofits. Congressional hearings have questioned whether nonprofits deserve tax-exempt status and have singled out the high salaries and generous benefit packages of some nonprofit executives. A report by the investigating agency of Congress, the General Accounting Office, estimates that in three states about 57 percent of the nonprofit hospitals spent less on indigent care than they would have paid in taxes if they were taxable.

On the other hand, studies by the California Medical Association suggest that nonprofit operation of HMOs makes a positive difference. In 1995 the state's largest nonprofit, the Kaiser Foundation Health Plan, devoted 96.8 percent of its revenue to health care and retained only 3.2 percent for administration and income. In the same year, the newly converted for-profit California Blue Cross plan spent only 73.03 percent on health care while devoting 26.97 percent to administration and profit. Of the ten HMOs that in 1994 spent the highest proportion of revenue on medical care, seven were nonprofit; in 1995, nine out of ten were nonprofit.

Nonprofit organizations seeking to convert typically argue that they need investment capital to expand and that nonprofit status is a barrier. Historically, private donations, government grants, and tax exemptions were important sources of capital; in recent decades, nonprofits have obtained capital primarily from retained earnings and debt. Supposedly, the cutthroat competitive market now requires access to equity investment for survival. Yet the recent history of America's nonprofit hospitals and health insurers does not suggest they have suffered from any capital shortage; in fact, most analysts agree that the hospitals overexpanded. What is certain, however, is that turning nonprofits into profit-making businesses has generated enormous gains to the people involved in the transactions.

When a nonprofit decides to convert to for-profit, merge, or be acquired by a for-profit company, state laws typically require that the value of the nonprofit's assets be transferred to another nonprofit pursuing similar charitable goals. The responsibility for overseeing and approving these transactions usually lies with the commissioner of insurance and the attorney general. In most states, the insurance commissioner is responsible for nonprofit HMO and insurance company conversions, while the attorney general oversees hospital and nursing home transactions. In California, the corporations commissioner regulates HMOs.

Unfortunately, the regulatory agencies typically lack the experience and staff to oversee these complex transactions. In some cases, regulators do not recognize the distinctive public-benefit responsibilities of nonprofits and fail to enforce the laws governing the use of a nonprofit's assets upon conversion. For instance, until the *Baltimore Sun* highlighted the proposed conversion of Maryland Blue Cross, the state insurance commissioner was not even planning to hold public hearings on the transaction. New York's insurance commissioner refused to release any records about Empire Blue Cross's creation of two for-profit subsidiaries until the transaction was approved.

In general, a conversion should result in the transfer of the full value of the nonprofit's assets to a charitable foundation or nonprofit organization with similar goals to those of the dissolving nonprofit. These transactions, however, are not straightforward. Past conversions, mergers, dissolutions, and joint ventures have been riddled with problems. Even when regulators have insisted on a transfer of assets to a new foundation, they have often undervalued the assets and allowed millions of dollars to be squandered on huge windfalls in executive stock options.

THE GREAT HMO TURNOVER

The HMO industry graphically illustrates the trend toward for-profit control and the problems raised by the conversion of nonprofits. Most HMOs began as nonprofits; many were formed to take advantage of government subsidies that were reserved for nonprofits. The federal HMO Act of 1973, for example, provided grants only to nonprofit HMOs. Many HMOs also sought nonprofit status to enjoy the benefits of tax exemption and to receive tax-deductible donations. Government invested public resources to help achieve a public good: lower cost and increased access to health care.

Initially, state statutes prohibited HMOs from being profit-making businesses. By the mid-1980s, however, HMOs had convinced every state legislature, except in Minnesota, to allow HMOs to be for-profit companies and in some cases to allow nonprofits to convert to for-profit businesses. The stage was set for an explosion of conversions. In California, for-profits went from 16 percent to 65 percent of the HMO market between 1980 and 1994; now all but two of the state's largest HMOs are for-profit. In

June 1994, in a dramatic shift, the national Blue Cross and Blue Shield Association voted to allow members to become for-profit companies.

While they have publicly claimed that for-profit status was necessary for expansion, insider executives have made millions of dollars converting nonprofits. The conversion of HealthNet, now called Health Systems International (HSI), shows one reason why top executives find the case for conversion so persuasive. When HealthNet converted in 1992, 33 executives purchased 20 percent of the company for just $1.5 million; as of April 1996, those shares were worth approximately $315 million. Roger Greaves, formerly co-CEO and cochairman, paid only $300,000 for shares that are now worth $31 million, a 10,000 percent gain.

By moving their organization into the for-profit sector, the executives also typically get paid a lot more. In 1994 HSI paid its current CEO, Malik Hasan, $8.8 million; Foundation Health's chief executive received $13.7 million. In contrast, David Lawrence, the chairman of Kaiser Permanente, has a salary of $803,000 even though Kaiser, which remains nonprofit, is the nation's largest staff-model HMO (that is, with group medical practices staffed by its own doctors).

The path to riches is now familiar. In the typical scenario, both the converting nonprofit and the regulators severely undervalue the organization, the executives buy shares of the new company at low prices, and the transaction gets approved by regulators. Executives then become millionaires when the company goes public and its stock climbs to its actual market value. Recent HMO conversions offer many examples of this pattern. Two years after the California Department of Corporations approved a $38 million price tag for Family Health Plan (FHP), the market value of the for-profit was $135 million. When PacifiCare converted in 1984, it was valued at $360,000; less than one year later, the market value of the for-profit was $45 million. Greater Delaware Valley Health Care was valued at $100,000 in 1984, yet the new for-profit was worth $20 million in 1986. Group Health Plan of Greater St. Louis was valued at $4 million in 1985, but the for-profit was worth $40 million in 1986. In each case, the public lost millions of dollars in charitable assets because state regulators failed to ascertain the nonprofit's fair market value.

And no wonder: The methods used by regulators were virtually guaranteed to generate windfall profits to the executives. In some cases, the regulators have valued only tangible property even though an HMO's most valuable assets may be its name recognition, provider contracts, and subscriber lists. Some valuations have failed to include the trademark, effectively making it a gift to the new for-profit business. This is no small matter, particularly for Blue Cross plans. According to trademark experts, Blue Cross may be the most recognized trademark in the United States after Coca-Cola. And, finally, most valuations have not used competitive bidding or stock market value to determine the fair market value of the company. An accurate valuation should focus on the value of the organization as a business, not its prior value as a charity, because it is the organization's profit-generating potential that is at issue.

CALIFORNIA'S NEW PRECEDENTS

The two most recent large California transactions—the conversions of HealthNet and Blue Cross—should set important national precedents for properly valuing nonprofit assets. When HealthNet announced it wanted to go for-profit in 1991, it had nearly 900,000 members, yet the company said it was worth just $104 million. This paltry estimate ignited demands by Consumers Union for greater public scrutiny. Sure enough, after the California Department of Corporations rejected the valuation, a bidding war broke out among Health Net's competitors, including Blue Cross of California, Humana, Qual-Med,

and Foundation Health. Even though HealthNet rejected all outside bids, it was forced to raise its valuation of itself to $300 million in cash plus an 80 percent equity interest in the new for-profit. These assets went to a new foundation, the Wellness Foundation, and are now worth between $800 million and $900 million. In other words, the people of California got eight to nine times more than HealthNet's original offer because regulators finally acted to defend the public's assets, and the addition of an equity share captured the true value of the nonprofit far more accurately than did the methods used in previous conversions.

The original proposal for Blue Cross of California's conversion reflected just how successful the HealthNet transaction had been in capturing the nonprofit's assets. Blue Cross came up with a novel legal theory to avoid endowing a new charitable foun dation. It called its plan a "restructuring" and proposed to create a new publicly traded for-profit with 90 percent of the nonprofit's assets. Since the nonprofit would continue to exist and hold the majority of stock in the new for-profit, Blue Cross claimed it was not converting to for-profit. Sup posedly, California law applied only when an entire nonprofit corporation became a for-profit business.

Under the proposal, which contained a generous stock option plan for top executives, the management of Blue Cross would have been able to reap huge financial rewards and use the remaining nonprofit charitable assets to finance their for-profit ventures. Although Consumers Union and others fought the proposal, the Department of Corporations approved it in December 1992. The new for-profit, Wellpoint Health Networks, took over the vast majority of Blue Cross assets, while the continuing nonprofit, Blue Cross, held 80 percent of the stock in Wellpoint.

The chairman of the State Assembly's Judiciary Committee, Democrat Phil Isenberg, was later able to negotiate a commitment from Blue Cross to make a minimum of $5 million per year in charitable donations for the next 20 years. Then a new corporations commissioner, Gary Mendoza, reignited the debate and dramatically changed the results. In August 1993 Mendoza asked Blue Cross to provide him with a plan for meeting its charitable responsibilities under the law. By May 1994 he made clear that he regarded the answers from Blue Cross as inadequate from the standpoint of Blue Cross's shareholders—the people of California.

Commissioner Mendoza's ac.ions provided public interest groups with the opportunity to marshal support for protecting the public's charitable assets. A campaign started that included letters of protest, administrative petitions, and an onslaught of legal and policy analyses. Somewhat later, the California Medical Association, unions (particularly the Service Employees International Union), and the California Nurses Association also became involved. In September 1994 Blue Cross submitted a "public benefit plan" that included a commitment to use all of the nonprofit's assets to create a new foundation. A careful review revealed, however, that the proposal was self-serving and could turn into a dangerous precedent. The new foundation was to be established under a section of the Internal Revenue Code typically reserved for political organizations, such as the National Rifle Association and Common Cause. The old Blue Cross board of directors would become the board of directors of the new foundation, which would have been able to contribute to election campaigns and sponsor ballot initiatives. Far weaker conflict-of-interest rules would have applied to the new foundation than if it were established as a genuine philanthropy under stricter IRS rules; in fact, funds not used for po'itical purposes could have supported Blue Cross's for-profit business in other ways, such as conducting its research.

Naturally, public interest groups did not accept this sham and questioned the legal status of the new foundation, the lack of a new independent board, and the absence of strict conflict-of-interest rules. In the midst of this contentious debate, the national Blue Cross and Blue Shield Association announced new rules for member organizations that strengthened the hand of California Blue Cross. The new rules

protected the management of any Blue Cross plan from being replaced and attempted to maintain the Blue Cross board of directors as a supermajority of the new foundation board and to keep them in control of the sale of any stock. The association's source of power is its ability to deny the license to use the Blue Cross name to any organization that fails to follow its rules. Since the license was a key element of the conversion and the proposed merger, the association could not be ignored.

The corporations commissioner criticized the national Blue Cross and Blue Shield Association but did not succeed in having the rules significantly changed. Nonetheless, the final transaction succeeded in preserving the majority of the company's assets for charitable uses. Under the approved plan, Blue Cross of California will create two new foundations. The first, the Western Foundation for Health Improvement, established under the more restrictive section 501 (c) (3) of the Internal Revenue Code, will ultimately have an endowment of more than $2 billion and be controlled by a board with a majority of new and independent members. The second foundation, Western Health Partnerships, established under the looser section 501 (c) (4), will have a board with a majority of old Blue Cross directors, but it will be prohibited from participating in any political or lobbying activities. It will also be required to follow the strict conflict-of-interest rules that apply to 501 (c) (3) foundations. These protections are included in the foundation's charter documents and may not be changed without the approval of California's attorney general.

The combined assets of the two new foundations represent the tenth largest philanthropic endowment in the United States. In 1996, they will make at least $150 million in grants; thereafter, grants will be at least 5 percent of the consolidated assets of the two foundations—the required minimum for philanthropies. The "independent" board members were chosen under a complex scheme, managed by three search firms and overseen by the corporations commissioner. The attorney general will monitor the new foundations, as he currently monitors other philanthropies. Legislation enacted in 1995 in California, modeled on the final Blue Cross transaction, provides a statutory framework for regulatory review of conversions to ensure that nonprofit HMO assets are preserved for charitable purposes. The approved conversion is not perfect, but it is no small victory for the people of California—and a useful paradigm for other states to build upon as they face proposed nonprofit conversions.

THE ROAD FROM CALIFORNIA

The pace of nonprofit HMO and insurance company conversions has dramatically accelerated since the conversion of Blue Cross of California, which was the first state Blue Cross plan to convert after the national association changed its rules to allow for-profit members. Proposed conversions of Blue Cross plans or other large nonprofit HMOs or insurers are now completed, pending, or about to be announced in such states as Colorado, Maine, New York, Missouri, Maryland, Georgia, Virginia, and Oregon. Blue Cross of California has signaled its intention to acquire plans in other states, and the joint venture between Blue Cross and Blue Shield of Ohio with Columbia-HCA, if it occurs, will open an era of mergers and acquisitions that promises to make some executives, financial advisers, and investors very rich.

Public interest groups and regulators around the country should benefit from California's experience. The proposed Missouri conversion, for example, resembles the original gambit of Blue Cross of California. Blue Cross and Blue Shield of Missouri has similarly tried to avoid endowing a new foundation by creating a for-profit subsidiary with about 75 percent of the organization's assets. The Missouri debate has sparked strong language from the state's insurance commissioner and the formation of a new

consumer coalition spearheaded by the Missouri Association for Social Welfare.

In other states, such as Colorado, Maine, and New Jersey, Blue Cross plans intending to convert have first attempted to change state laws to make it easier and cheaper. The proposed laws typically eliminate or severely restrict the nonprofit's responsibility to transfer any assets to a foundation upon conversion. In Colorado and Maine, consumer groups were alerted in time to push for important amendments. Trigon, Virginia's Blue Cross plan, succeeded in pushing legislation that allowed it to convert by giving the state $175 million, to be used to fund a shortfall in the state's education budget. The price tag did not reflect any independent assessment of the company and appeared to be a severe undervaluation of the company's fair market value.

Given current trends and the incentives facing top decisionmakers, the future of nonprofits in health care looks bleak. Americans should be asking the basic question of whether it makes sense to turn our health care institutions into for-profit businesses whose fundamental obligation, as a matter of law, is to serve the stockholders. Traditionally we have considered health care to be different from an ordinary business. Patients are vulnerable; they do not have the same ability of most buyers to defend their interests. Stockholder demands for high returns may result in reductions in the quality of care that patients cannot easily detect or anticipate. The drive toward the marketplace also makes it difficult for the remaining nonprofits to continue to serve the charitable mission of delivering care to patients who cannot pay.

Instead of caving in to pressure from Blue Cross plans, state legislators should enact protections for their states' valuable nonprofit resources. Legislation should provide for public notice and hearings and require transfer of 100 percent of the nonprofit's assets based on a fair market valuation. Companies seeking to convert should be required to pay fees so that regulators can seek independent expert advice needed to dissect and digest proposed transactions. To protect the successor foundations from conflicts of interest and to assure that they act as responsible philanthropies, the new foundations should be established under Internal Revenue Code section 501 (c) (3) and governed by a board with all new independent members. Moreover, state statutes should build in mechanisms that ensure that proposed conversions take place in the full light of public scrutiny. Regulators should take a particularly broad view of hospital conversions because of the risk to indigent care and other public services. Congress can eliminate the ability of individuals involved in nonprofit tax-exempt institutions from receiving windfalls from transactions. Today, only some transactions are covered and carefully reviewed by the Internal Revenue Service.

While we may be unable to stop every proposal by a nonprofit institution seeking to go for-profit, regulators and the public can at least protect nonprofit assets for charitable purposes, rather than watching idly as they are lost forever. Public attention and participation can make the difference in whether conversions result in any public benefit. The Blue Cross plans, HMOs, and hospitals seeking to convert typically have highly paid, well-connected lobbyists and executives. To succeed, consumer groups, investigative reporters, and the public at large must raise their voices early and loudly. The lesson from California—in health care as in other things—is that even if flood, fire, and earthquake cannot be prevented, we can still rescue something of value.

Patty

Information you requested

Dr. Robinson - Here's what I found out. 3-17-98

Question: Will insurance companies leave the state if a bill provision is enacted which allows insureds to sue an insurance company / HMO should those entities treat them unfairly?

There are two states who currently have patient liability provisions - Missouri, signed in August, 1997 and Texas - signed in September, 1997.

In Missouri, I spoke with acting executive director, Dr. Jake Lippert. He tells me that when the law was signed it then went to the Division of Insurance to develop rules and regulations to govern the new law. These are still being drafted and probably won't be ready until July, 1998. The provision enacted kicks in only when insurance policies now in force renew. This means that there will be a wide variance of times before there will be any demonstration of "harm" to the insurance companies. So far, there has been no exit from the state of insurance companies, and because the rules aren't finished, no lawsuits against insurance companies.

In Texas, I spoke with Lobbyist Sally Hanners. Aetna has now filed suit against the state of Texas to overturn this law. The way any litigation works is that the litigant makes known the desire to sue. If the matter is contested, the situation goes before an "IRO" (Independent Review Organization). The IRO is a contracted entity with the State Board of Insurance. Currently the IRO in Texas is the Texas Medical Foundation. To date, Sally knows of no insurance companies / HMO's who have pulled out of the state. The Aetna challenge is in the courts, but not on a fast track, and there have been no major lawsuits against an insurer or HMO.

Dr Bob Robinson 373 0747

Problem No. 1: Rising Health Care Costs

Joseph Califano, former Secretary of Health, Education and Welfare (now the Department of Health and Human Services), has estimated that one out of every four dollars spent in our health care system is wasted. Robert Brook of the Rand Corporation maintains that "perhaps one-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without." But like waste in government, waste in health care is not tagged for easy identification. What is wasteful to one person is not necessarily wasteful to another. And waste has its own constituency.

Good Idea: Use Markets. Virtually the entire world has come to realize that markets are powerful tools for encouraging efficiency. With competitive markets, 250 million Americans would have a self-interest in eliminating waste. Buyers would patronize low-cost providers. Providers would search for low-cost methods of delivering services. As noted above, creating Medical Savings Accounts that empower patients is probably the single best step towards market-based solutions. [See sidebar on making markets work.]

"Seven states have exempted Medical Savings Accounts from state taxes."

Good Idea: Medical Savings Accounts at the State Level. Several states have taken steps to enact or endorse some version of Medical Savings Accounts (MSAs) — also called Medical IRAs and Medisave Accounts. These tax-free, interest-bearing personal accounts permit people to set money aside for small health care expenditures while purchasing catastrophic health insurance for major medical expenses. For example, Colorado, Arizona, Idaho, Illinois, Michigan, Mississippi and Missouri have passed bills exempting MSAs from state taxes.

Texas, Montana and Utah have passed resolutions calling on the federal government to adopt Medical Savings Accounts. MSA legislation is also being considered in other states. An unsuccessful bill in Montana would have combined MSAs with workers' compensation insurance so that employers could put money in the employee's account and then provide each employee with a high-deductible workers' compensation policy.

Making Markets Work in Health Care

The medical marketplace - particularly the hospital marketplace - has none of the normal features of a competitive market. In most places, patients cannot find out the cost of even routine procedures before entering a hospital. At the time of discharge, they are presented with lengthy, line-item bills that are virtually impossible to read or understand. Small wonder that there is so much waste in our health care system! The people who make the purchasing decisions cannot discover the price before they buy and cannot understand what they were charged afterward.

Hospital Prices. Patients who try to find out about hospital prices before they are admitted face a depressing surprise. A hospital can have as many as 12,000 different line-item prices. For patients doing comparison shopping among the 50 hospitals in the Chicago area, for

example, there are as many as 600,000 prices to compare. To make matters worse, different hospitals use different accounting systems. Definitions of a service as well as prices may differ from hospital to hospital.

Bureaucracies. The major reason why the market is not competitive is that it is dominated by large, bureaucratic institutions. Because 95 percent of hospital revenues come from third-party payers, prices charged to patients are not market-driven. Instead, they are artificial prices designed to maximize revenue against third-party reimbursement formulas. The federal government has encouraged an institutionalized, bureaucratized market by subsidizing third-party payment. Yet the evidence suggests that the market would be radically different if patients were spending their own funds.

Why Empowering Patients Makes a Difference. In a few areas of the medical marketplace, most of the above generalizations are no longer true. For example, cosmetic surgery is not covered by private or public health insurance. Yet in every major city, it is a thriving industry. Patients pay with their own money, and they are almost always given a fixed price in advance - covering all medical services and all hospital charges. Patients also have choices about quality (e.g., surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Overall, patients probably have more information about the price and quality of cosmetic surgery than about any other type of surgery.

Other Examples. Cosmetic surgery is not an isolated case. Because of the trend toward higher deductibles, parents today can expect to pay a large portion of the bill for well-baby delivery. In response, Humana and other hospital chains are beginning to advertise package prices in competitive cities. Uninsured patients who pay in advance also sometimes get package prices - especially for day surgery. And in England, private hospitals frequently offer package prices for routine surgery to patients who pay with their own funds.

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992; and John C. Goodman and Gerald L. Musgrave, Patient Power: Solving America's Health Care Crisis (Washington, DC: Cato Institute, 1992).

Good Idea: Deregulate. Standing in the way of the use of markets are numerous legal barriers to competition. Take certificate-of-need (CON) laws, for example. Encouraged by the federal government in the 1970s, these laws require permission from government before a new hospital may be opened or an expensive piece of medical equipment purchased. They tend to protect existing suppliers against potential competitors by raising barriers to market entry. Although many states have eliminated these regulations, they remain an anticompetitive force elsewhere.

"There is not much evidence that managed care saves money, except on the most expensive procedures."

Another anticompetitive force is legislation that limits the ability of third-party payers to engage in managed care. There is not much evidence that managed care saves money, except on the most expensive procedures. But whether managed care works or not should be determined by the market, not by politicians. Unfortunately, too many special interests in the health care industry are unwilling to allow the market to work. In 1991, for example, 195 pieces of state legislation were introduced to stop, or cripple, managed care and other cost-control techniques.

Among laws currently on the books, one in Indiana requires that Preferred Provider Organizations (PPOs) accept any physician willing to join. Thus Indiana Bell's PPO includes every physician in the state. Montana and Oklahoma have adopted similar measures. In some states, hospitals and physicians' groups are supporting legislation that would (1) require all utilization review to be done by local providers, (2) mandate that utilization review firms remain open 24 hours a day and (3) require state-specific statistical reporting. Such legislation would raise the cost of utilization review and inhibit its aggressive application. In addition, some states restrict the discount that insurers can give to patients who choose PPO doctors.

Mediocre Idea: Managed Competition. Claiming to avoid the polar extremes of socialized medicine and free markets, the advocates of managed competition say they have found a workable middle ground — capturing the benefits of competition and solving social problems at the same time. Managed competition has been championed by the Clinton administration and is the key element in the health care reforms recently passed in Washington and Florida.

Under this approach, employees choose from an array of health insurance plans. The employer contributes fixed sum of money, and the employee pays the balance of the premium. So if an employee chooses a more expensive plan, the extra cost comes out of that employee's pocket. The intent is to make employees price-conscious and encourage health insurers to be more competitive by holding down the costs of their plans.

"The problem with managed competition is that there is too much management and too little competition."

However, the prices employees face would be artificial, because insurers would be forced to charge the same premium to everyone (community rating) or to everyone of the same age (modified community rating) and to accept all applicants (guaranteed issue). The theory is that insurers should compete and try to keep their premiums low by becoming more skillful at managing care rather than at pricing and managing risk. To the degree that there is a trade-off between cost and quality, insurers would compete based on their ability to manage that trade-off in ways pleasing to potential customers.

To see one problem with managed competition, imagine two competing HMOs. In the first, enrollees can see a primary care physician at the drop of a hat, but there are screening procedures and sometimes lengthy waiting periods for kidney dialysis, heart surgery and other expensive procedures. In the second, dialysis and heart surgery are available when needed, but there are few primary care physicians. Given a choice, most of us would enroll in the first HMO until we really got sick, then switch to the second. But if everyone did that, the second HMO would not survive financially. As in the case of national health insurance, absent a market for real insurance the tendency would be to gravitate away from expensive, lifesaving medical technology.

To see another problem, imagine several HMOs offering identical services. Because they must take all applicants at the same premium, each has an incentive to attract healthy people and avoid those likely to generate high health care costs. In the attempt to avoid sick people - a game, like musical chairs - some will be more successful than others. The less successful will have higher costs, which will require higher premiums, which will result in fewer customers, etc.

For these reasons, managed competition - and, indeed, any plan that combines community rating with competition - is inherently unstable. In order to keep the market from disintegrating, proponents invariably propose a complex government bureaucracy designed (a) to redistribute funds from profitable to unprofitable insurers or (b) to tightly regulate the content of health insurance policies, preventing insurers from offering higher deductibles on any feature likely to attract healthier subscribers.

"Under managed competition, no plan could afford to have a reputation as being the best for those with expensive-to-treat illnesses."

Even with these restrictions, however, managed competition creates extremely perverse incentives for the managers of the health plans. For example, no plan could afford to have *a reputation as being the best for those with expensive-to-treat illnesses*. Indeed, the plans that attracted a disproportionate number of sick people would eventually fail and leave the market. Moreover, each health plan would have an incentive to underprovide services to the sickest people and overprovide services to the healthy.

Health policy analysts believe that the patients at greatest risk initially would be those with chronic conditions - those in need of mental health care, custodial care or long-term care. Where physicians have discretion, as in the treatment of leukemia or in efforts to save premature babies, the tendency would be to save money rather than prolong life. Expect a substantial decrease in the number of CAT and MRI scans and other costly tests that detect brain tumors, cancer and other life-threatening conditions. Where possible, expensive surgery (such as bypass operations) would be delayed - if for no other reason than that the patient might switch health plans and have the surgery performed by a competitor.

By pointing out the need for market-based reforms, the advocates of managed competition have performed a valuable service. The problem is that they promise too much management and permit too little competition. What is needed is real competition. We should allow individuals rather than bureaucrats to choose health insurance benefits based on market prices and to make their own decisions about the desirability of managed care. Competitive markets can perform quite well without the heavy hand of government.

Can managed competition slow the rise in health care costs? The existing systems that most closely resemble managed competition provide little cause for optimism, as the following case studies show.

Case Study: The FEHBP. The program most often cited as an example of managed competition at work is the Federal Employees Health Benefits Program (FEHBP). But almost anyone familiar with the FEHBP knows that it desperately needs reform. This is the opinion of the Office of Personnel Management (OPM), which oversees the program, and of other analysts inside and outside of government. For example, a Towers, Perrin, Forster & Crosby study concluded that "fundamental legislative reform is urgently needed."

The program has three main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans, (2) government contributes a fixed amount that can be as much as 75 percent of each employee's premium and (3) the plans are forced to community rate, charging the same premium for every enrollee. Despite the appearance of competition and the large number of HMO enrollees, the program has not succeeded in controlling costs. As Figure V shows:

- During of the 1980s, the federal government's spending on employee health benefits grew at a faster rate than employer-provided health insurance generally (10.15 percent versus 7.9 percent).

- When spending is adjusted for the number of employees, the federal employees plan grew more than 25 percent faster than private sector plans.

"The cost of the federal employees plan has grown 25 percent faster than costs for employer plans generally."

One reason why the FEHBP has not held down costs is that deductibles in the fee-for-service plans are

quite low. While most private employers are increasing their deductibles, Blue Cross's FEHBP "high-option" plan has a deductible of $200 and its "standard-option" plan has a deductible of $250. Why are the deductibles so low? Because OPM won't allow Blue Cross, or any other plan, to raise its deductibles or copayments. Again, why? Because plans with greater patient cost-sharing are cheaper and are likely to attract younger, healthier employees. OPM rigorously reviews every attempt to tailor the plans to the employees' needs to make sure it does not appeal more to good risks than to bad ones. For example, OPM will not allow a plan to include coverage for teeth cleaning but omit coverage for dentures — on the theory that such a change would make the plan more attractive to young people.

Even with this regulatory micromanagement, outside analysts say that whatever competition exists is only for good risks and is not competition in the sense managed competition advocates imagine. And it is because insurers cannot price risk accurately that Aetna, the only systemwide insurer other than Blue Cross, left the FEHBP. Despite glowing descriptions by its defenders, the FEHBP has none of the desirable characteristics of a competitive system.

"Despite the appearance of competition and the large number of HMO enrollees, the federal employees plan is not controlling costs."

Case Study: CalPERS. Another example of managed competition is the California Public Employees' Retirement System (CalPERS). A recent study found that the insurance premiums for CalPERS enrollees increased more rapidly between 1982 and 1992 than the national average — 9.8 percent for CalPERS HMOs and 12.9 percent for its PPOs versus 9.4 percent for all employers nationally. [See Figure VI.] Furthermore, critics contend that CalPERS' ability to hold down premium increases is due primarily to cost shifting to other plans. For example, while Foundation Health Plan, which has about 10 percent of all CalPERS enrollees, did not increase premiums for CalPERS in 1993, it increased premiums for its other customers by 5 to 7 percent.

"Insurance premiums for CalPERS HMOs and PPOs grew faster than the national average for all employers' health plans."

Mediocre Idea: Managed Care. A key component of managed competition is "managed care." Although the term is applied to a wide range of activities designed to make medical care more cost-effective, in almost all of its versions it involves third-party interference with the practice of medicine. Practitioners of managed care argue that they can make the health care system more efficient and more affordable, in part by promoting primary care with an emphasis on wellness and reducing the need for specialized and acute care.

Studies show that, at their outset, managed care programs such as HMOs save money by substituting less expensive for more expensive therapies. For example, physician therapy and drug therapy are both less expensive than hospital therapy. However, William Schwartz (USC) and Daniel Mendelson (Lewin-VHI) argue that managed care has already achieved most of the savings that are achievable by reducing hospitalization. The only way for managed care to control the long-term rise in health care costs, they say, is to deny people access to expensive but useful technology.

"After an initial drop, managed care costs grow at the same rate as costs in the rest of the health care system."

This observation is consistent with the evidence. Studies show that the adoption of managed care techniques should lead to a one-time reduction in costs of about 10 to 15 percent. But after that initial drop, managed care costs grow at the same rate as costs in other types of health care delivery systems — if

not faster. The reason managed care is not able to reduce costs significantly is that it has not come to grips with the primary problem of the health care industry: when consumers enter the medical marketplace, the vast majority are spending someone else's money. Economic studies and common sense confirm that we are less likely to be prudent shoppers if someone else is paying the bill.

Instead of waiting to see if managed care can outcompete the alternatives, some want government to simply declare it the winner. In other areas of economic life, we subject ideas to the market test and allow competition to determine which ones survive. This is a good practice to follow in health care as well.

Mediocre Idea: Outcomes Research and Practice Guidelines. A natural extension of the concept of managed care is the establishment of "practice guidelines", which could be used by public and private sector bureaucracies to dictate the standard-of-care therapy for any given diagnosis. Proponents want medical professionals to conduct "outcomes research" in order to determine the most effective medical treatments. They argue that such practice guidelines will help physicians deliver quality care and prevent them from ordering unnecessary tests or procedures.

Currently, the American Medical Association and the Rand Corporation are working on national practice guidelines, and Congress has mandated that the Department of Health and Human Services do the same. The resultant "computerized protocols" will tell physicians what to do when confronting certain patient symptoms and conditions.

In a competitive marketplace, practice guidelines might prove useful. Clearinghouses for information on prices and quality could be valuable to patients. With greater information at their disposal, patients and physicians could make better decisions. However, if they are imposed by third-party bureaucracies, the same guidelines could discourage new and innovative therapies. They could also inhibit the use of unconventional therapies that sometimes save time, money and lives.

"Price controls tend to become a vehicle for health care rationing."

Worse Idea: Price Controls. The idea that government should fix the price for third-party reimbursement is increasingly popular. For Medicare patients, the federal government already fixes prices for hospital services and is in the process of doing so for physicians' services. Two things can go wrong when government arbitrarily fixes prices. If it sets the price too high, it encourages overprovision. If it sets the price too low, it encourages underprovision. The tendency is to set the price too low, in order to control spending. As a result, price controls tend to become a vehicle for health care rationing. Take Medicare, for example. Intentionally or not, Medicare's payment formulas are affecting patients:

- Although hearing loss is the most prevalent chronic disability among the elderly and affects one-third of all Medicare patients, the program's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.

- When Medicare reduced the reimbursement rate (in real terms) for kidney dialysis in the 1980s, many physicians reduced the treatment time — a practice that reduced patients' chances of survival.

- A survey of 21 medical conditions for which an implanted medical device is indicated found that for 18 of them the government's payment was well below hospital cost, and in more than half of the cases Medicare patients did not receive the device.

Even when Medicare's reimbursement equals the average cost of treatment, price fixing discriminates against above-average-cost patients. These tend to be the sickest patients and more often than not they are

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THE "DE-SKILLING" OF AMERICAN HOSPITALS

By Brooke Davidson

To save money, many health care systems have replaced highly skilled professionals with lesser trained, lower paid workers.

Rapid changes in health care delivery and policy are moving patient safety and quality of care to the forefront of health care discussions. As health care systems place greater emphasis on cutting costs, the replacement of highly skilled professionals with lesser trained, lower paid workers has become pervasive.

Many hospitals react to cost pressures in an increasingly competitive environment by cutting labor costs, in particular shifting duties performed by registered nurses (RNs) to minimally trained, unlicensed assistants. Hospital administrators argue that some tasks, such as drawing blood samples, taking vital signs, bathing and feeding patients, or inserting and removing urinary catheters can be safely handed over to unlicensed people with special training.

Nurses and consumers are worried about the changes and how they affect patient care.

Many patients, consumer advocates and RNs disagree. They say hospitals are transferring more complex procedures requiring a certain level of judgment at a time when patients are sicker, require more difficult care and have shorter hospital stays. Consumers and RNs are worried about the changes and how they affect the safety and quality of patient care.

Key findings of a study conducted by the American Hospital Association found that consumers believe health care quality has declined and will continue to fall. The report raises questions about replacing nursing staff with aides. Some patients in the study were so concerned with the quality of care that they believed they needed a family member or friend to stay with them in the hospital to act as a protector.

Hospitals don't necessarily save costs by replacing RNs. For example, Mercy Medical Center in Baltimore, Md., recently scrapped its nursing assistant and technician positions and boosted its RN staff 40 percent. Administrators expect to improve patient care and save $500,000 a year in labor costs across four medical/surgical units. A 1996 study of data bases in California, Massachusetts and New York showed that when there are more registered nurses, patients have fewer complications, shorter hospital stays and lower mortality rates.

A 1996 Institute of Medicine report ordered by Congress expresses concern about the lack of research and data to demonstrate effectiveness or the effects on patient safety of replacing RNs with lower skilled workers. The report calls for placing a high priority on collecting empirical evidence on the relationship between quality of care and staffing levels.

Amount of On-the-Job Training Provided to New Unlicensed Personnel by Hospitals

Number of Hours	*Percent of Hospitals*
Less than 40	41%
41—120	58%
201—280	1%

Source: Nursing Economics, Vol. 12, no. 2, 1994.

Federal Action

A pending congressional bill, the Patient Safety Act of 1997 (HR 1165) would require Medicare-funded hospitals to make information readily available to the public, including:

- Numbers of RNs, licensed practical nurses and unlicensed personnel providing direct care;

NATIONAL CONFERENCE OF STATE LEGISLATURES

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What could possibly go wrong at your pharmacy? More than you might think. Lately, even some pharmacists wonder if the current revolution behind the counter is a

Prescription for Trouble

by Andrea Rock

PHOTOGRAPH BY JEFF MERMELSTEIN

CORRECTION

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- Patient injury rates;
- Hospital acquired infection rates;
- Patient satisfaction; and
- Incidence of bed sores.

State Action

State legislatures have a long history of regulating different health care professions through licensure and certification. The replacement of RNs with lower skilled workers is an emerging legislative concern.

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The Pennsylvania House appointed a committee to study these changes; their findings, reported in November 1996, generated the following recommendations:

- Require the Health Care Cost Containment Council to collect and disseminate data on the quality of nursing care as well as the number of staff, LPNs and RNs employed by the hospital.
- Require employees working in hospitals to wear name tags that designate their status.
- Create whistle blower protection for hospital staff reporting dangerous or inadequate medical care.
- Ensure that hospitals maintain a safe environment for patients that is not excessive in price.
- Ensure that certain invasive medical procedures be performed only by licensed individuals. Others who are not licensed should be properly trained, and hospitals should be legally responsible for the care given by unlicensed workers.

A 1996 Florida law required a task force to study and report on quality assurance measures and outcomes in hospitals. A report was due December 1997. And a 1997 Rhode Island resolution created a special commission to study the impact of nurse staffing in licensed health care facilities. Their report was due by February 1998. Five states considered bills in 1997 to require hospitals and other facilities to make information on nurse staffing and patient outcomes available to the public. Bills introduced in 1997 in Pennsylvania, New York and Washington were carried over to this year. The California governor's Managed Care Improvement Task Force also recommended making this information available to the public.

Ten states considered bills in 1997 requiring health care providers to wear name badges that include their credentials. Measures passed in Georgia, Illinois, Minnesota, Missouri and New Jersey. Utah implemented the language by administrative rule. Rhode Island adopted a photo ID badge requirement. And Minnesota and New Jersey passed whistle blower legislation last year to protect providers who report unsafe or poor patient conditions in the workplace.

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What could possibly go wrong at your pharmacy? More than you might think. Lately, even some pharmacists wonder if the current revolution behind the counter is a

Prescription for Trouble

by Andrea Rock

PHOTOGRAPH BY JEFF MERMELSTEIN

PRESCRIPTION FOR TROUBLE

GABRIELLE HUNDLEY TOOK THE first of two pills that would change her life at breakfast on Feb. 21, 1995, right before she rushed off to first grade at Trinity Christian School in Rock Hill, S.C. The new prescription that her mother Peggie had gotten filled at the local Rite Aid pharmacy the night before was for Ritalin, a drug commonly used to treat hyperactivity and attention deficit disorder in children.

But later that day, in a nearby emergency room, doctors discovered that what the little girl had taken was not Ritalin at all but rather a high dosage of Glynase, a medication used to lower diabetics' blood sugar, according to the Hundleys' attorney, James C. Anders. In a court case last year, Anders argued that the pills in the bottle contained 16 times the normal starting dose for adult diabetics, causing Gabrielle's blood sugar level to plummet so severely that she suffered permanent brain damage. The jury in that case awarded $16 million to the little girl and her family. (Rite Aid is appealing the verdict and intends to question the extent of Gabrielle's injuries and whether they were caused by the alleged misfill.)

At first blush, it's tempting to minimize the story of Gabrielle Hundley—this incident was just one in a million, right? Pharmacy transactions certainly seem easy: Someone in a white coat counts out the pills your doctor ordered, puts them in a vial with the instructions on the label and hands them over. How often can such a straightforward process go awry?

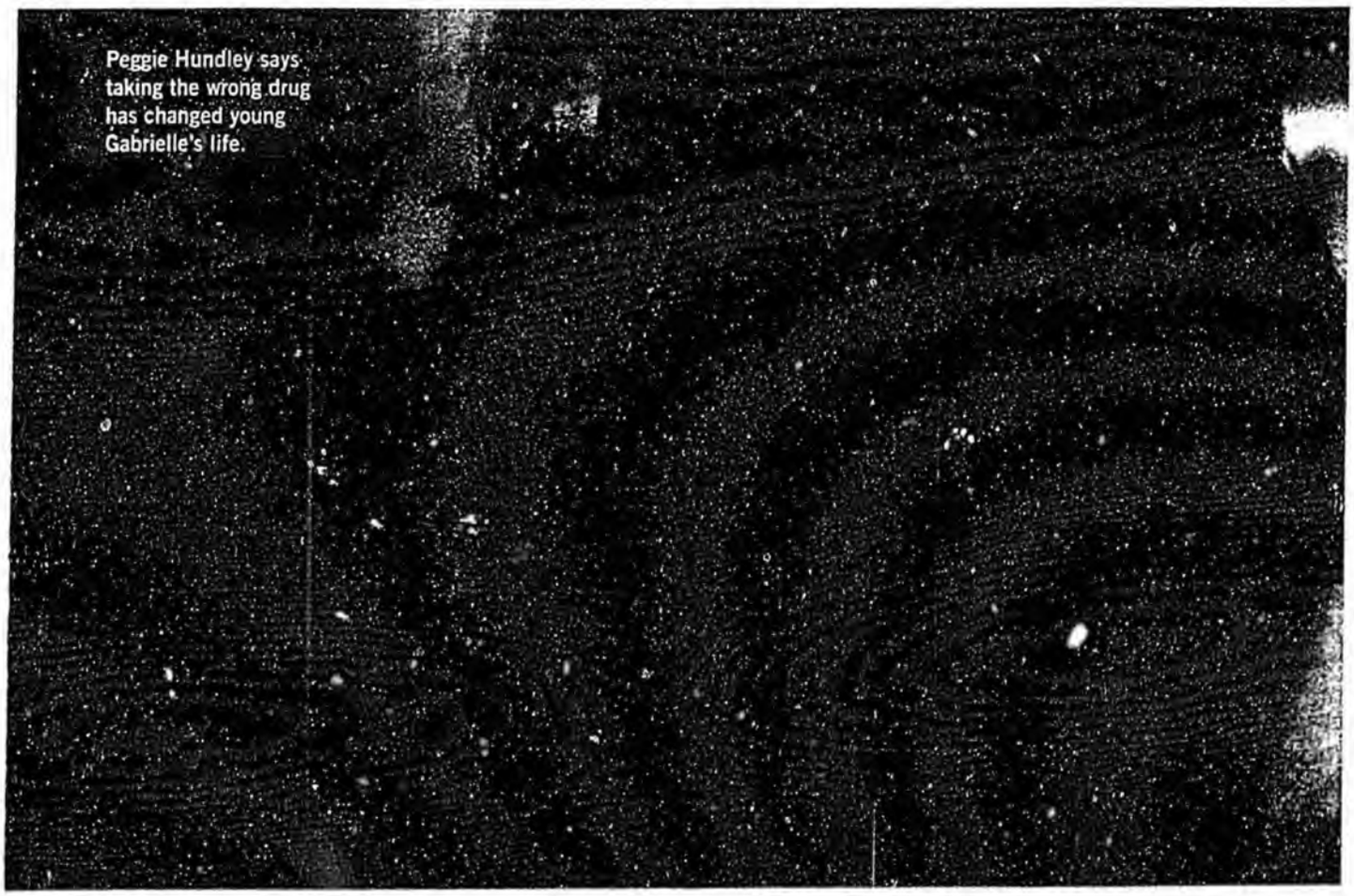
Many state regulators, consumer advocates and even pharmacists contend that an ongoing revolution in the retail drug business—with the number of prescriptions filled swelling even as pharmacy economics tighten—is making dispensing errors a bigger problem than you think. And while there are no definitive national statistics on how many such errors occur each year, there is evidence strongly suggesting that those critics are right.

In a 1997 nationwide survey of pharmacists conducted by *Drug Topics*, a trade publication, 53% admitted having made drug errors in the preceding two months, with the typical respondent making 2.5 errors in that period and one admitting to 15 mistakes. Work overload was the main reason cited by the majority of these respondents. And a June 1996 survey of 3,361 pharmacists in California and Oregon revealed that dispensing errors were occurring at a rate of 324 per pharmacy annually—nearly one per day.

"Ten years ago, an acceptable error rate was considered one per year per pharmacy," asserts Ralph Vogel, president of the Guild for Professional Pharmacists, a union representing 2,000 pharmacists in four states. "What we're seeing today is chaos that comes from understaffing and other new stresses in the pharmacy."

To be sure, many of these errors are not disastrous. And the pharmacy industry insists that worries over error rates are overblown. Phillip Schneider, spokesman for the National Association of Chain Drug Stores, dismisses the contention that understaffing and high prescription volume are leading to more mistakes as "the viewpoint of [pharmacy workers] wanting to unionize."

Nevertheless, that same contention is echoed by some of the state regulators who monitor pharmacies. "Consumer complaints about dispensing errors last year increased nearly 40%," maintains Rick Allen, deputy director of Georgia's Drugs and Narcotics Agency, which conducts regulatory and investigative work for the state's pharmacy licensing board. "We've talked to pharmacists who go home with nightmares, wonder-

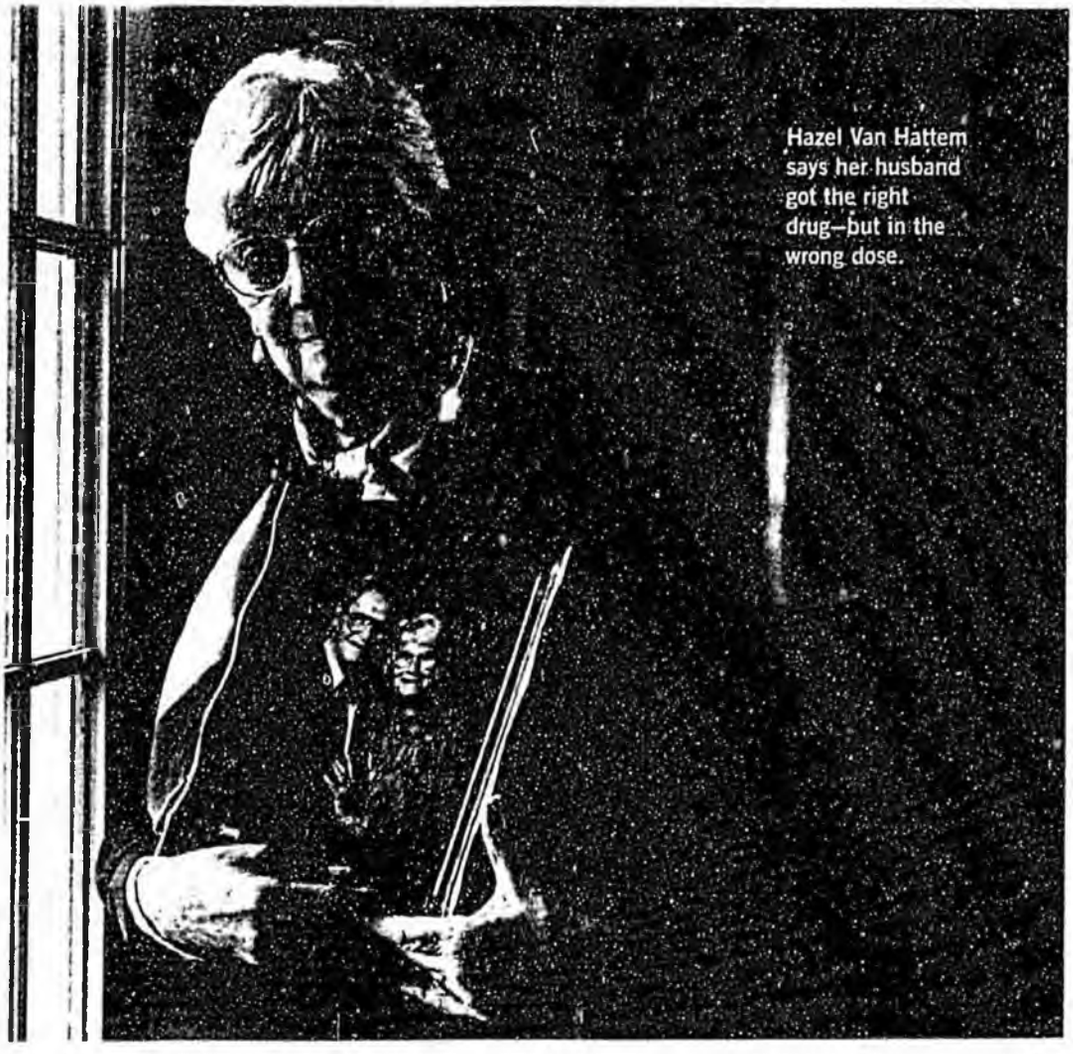


Peggie Hundley says taking the wrong drug has changed young Gabrielle's life.

ing if they misfilled a prescription that day—which is no wonder when they're trying to fill a prescription every one or two minutes."

From your side of the pharmacy counter, such concerns hardly seem warranted. But when MONEY got behind the counter, interviewing dozens of pharmacists, regulators and other experts, we found that there are many points at which the prescription process can go awry. We'll look at each of them, against the backdrop of the current sea change in the prescription business. That includes the role played by the most complacent actor in this story—you, the consumer. (For what you can do to catch a pharmacy error, see the box on page 120.) Too many people take the mechanics of the prescription transaction for granted. In fact, for the past nine years, Americans responding to Gallup polls have ranked pharmacists as the most trustworthy professionals in the country—ahead, even, of clergy members. No wonder so many people—people like Peggie Hundley—simply assume that nothing can go wrong.

"When I got [my daughter's] prescription, I could see that the pharmacist was working by himself, filling prescriptions, answering the phone and running the cash register," Hundley recalls now. "But I had blind faith."



Hazel Van Hattem says her husband got the right drug—but in the wrong dose.

You can't simply rely on your doctor

For many, that blind faith starts outside the pharmacy. You might think your pharmacist is little more than a pill counter who follows orders from your doctor. Truth is, a pharmacist receives more information about prescription drugs than a doctor does. Doctors get one year of formal training on the use of prescription drugs in medical school but generally are not required to obtain continuing education on medications. In contrast, many states require pharmacists to complete an average 15 hours of continuing education each year to keep up with the new drug information.

And there's no dearth of homework: New drugs are pouring into the market, stimulated by a program launched in 1992 under which the FDA shortened its drug-approval times. In the past two years alone, a record-setting 92 new drugs hit the market—compared with 131 new drugs approved for the previous five years.

So don't assume you'd never walk out of your doctor's office with a dangerous prescription. That's what Ruth Paxton, 44, of Carson City, Nev. believed in July 1992, when she sought treatment for a sinus infection. Paxton previously had severe allergic reactions to penicillin and to Keflex, an antibiotic. Her doctor, unaware of the severity of her reactions, prescribed an antibiotic called Ceftin, which can cause potentially life-threatening allergic responses in people with extreme sensitivities to either of the other two drugs.

Within 20 minutes of taking Ceftin, Paxton experienced a frightening allergic reaction; her throat began to swell, making it difficult to breathe or swallow. Swift treatment with Benadryl and a trip to the emergency room solved the problem. Nevada's board of pharmacy reprimanded Paxton's pharmacist, saying he should not have allowed her to leave the pharmacy with a prescription for Ceftin without calling her doctor and warning Paxton of the potential for an allergic reaction.

The incident prompted Paxton to make a career change she'd long been contemplating: She went back to school for her nursing degree, which she now uses to safeguard herself and others. Says Paxton: "You've got to protect yourself now more than ever before."

A white coat does not make a pharmacist

The burden of knowing about potentially dangerous drug reactions is one reason pharmacists must complete five or six years of academic training. Yet increasingly the white-coated person who types your prescription into the computer system, pulls medicine from the shelf and places it in a vial with a

PORTRAITS BY STEVE JONES

label on it is not a pharmacist at all. Instead it's often a pharmacy technician, who may have nothing more than a high school degree and on-the-job training.

There is little question that the use of these techs is growing and that this is happening as pharmacy chains face a major squeeze on profit margins; techs typically earn $5 to $12 an hour—compared with the average of $30 to $39 for pharmacists.

Pharmacists, of course, are supposed to check their technicians' work. And CVS spokesperson Fred McGrail points out that properly trained, well-supervised technicians enhance safety by providing two sets of eyes on every prescription and freeing the pharmacist to focus on counseling customers.

What concerns some regulators and pharmacists is whether the training and supervision are truly adequate. "Last night I filled 200 prescriptions in an eight-hour shift, and I corrected six errors made by techs," says Rose DeLeonardis, who works as a relief pharmacist rotating among several stores in California for a chain (not CVS). She also claims she's worked in pharmacies where the number of techs exceeded the maximum allowed by state law.

Most states impose a 1-to-1 ratio between pharmacists and technicians, but some drugstore chains are pressuring states to change that. Both Florida and Arizona are now considering allowing up to three techs per pharmacist. The rules governing techs' qualifications also vary dramatically. Illinois requires only that techs be at least 16 years old and preparing for their high school equivalency exam; Virginia imposes no minimum requirements at all. Wyoming's standard is about as strict as it gets: Techs must pass a state board exam to become certified after up to two years' training on the job or at a community college.

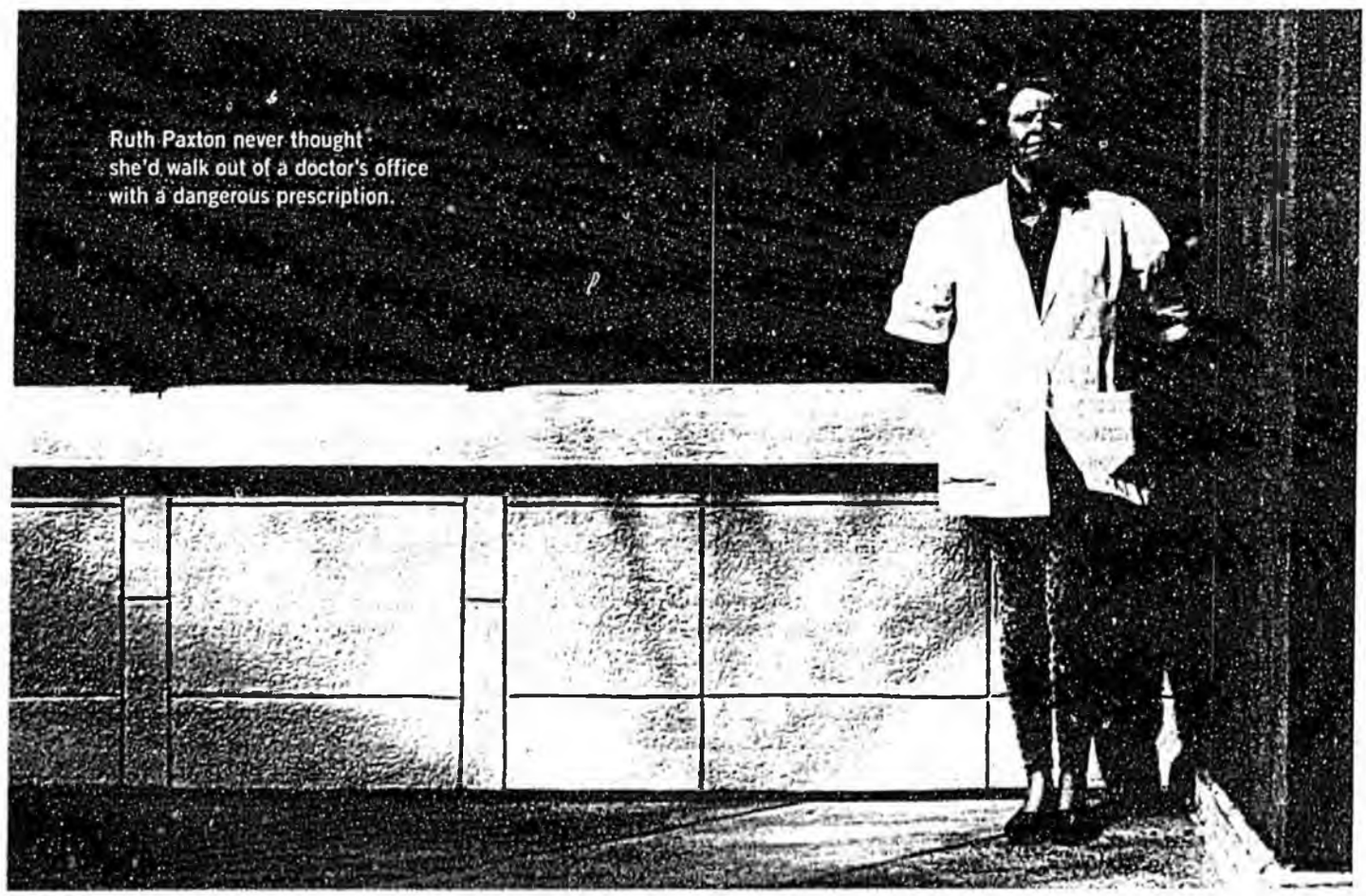
Also, failure to check techs' work was cited as a major cause of dispensing errors by nearly a third of pharmacists in the 1997 *Drug Topics* nationwide survey.

As Carmen Catizone, executive director of the National Association of Boards of Pharmacy, which represents state licensing boards across the U.S, sees it, the bottom line is this: "If the corporation puts in more techs than the pharmacist is comfortable supervising, errors are going to get out."

Right drug, wrong dosage

One of the most common pharmacy dispensing errors is giving out the wrong drug. The other is giving out the wrong dosage of the right drug. That's what Hazel Van Hattem of Crete, Ill. says happened in her family.

The way Van Hattem, now 80, remembers it, there were three technicians and two pharmacists on duty on May 30, 1995, when she picked up a refill of Coumadin, a powerful blood-thinning medication her husband Ernest, then 76, had been taking. "At the trial, they said they couldn't really be sure who filled the prescription," Hazel says, referring to the lawsuit she filed against K Mart. Her attorney argued that whoever filled the vial mistakenly did so with pills that contained 5mg of Coumadin rather than Ernest's usual dose of 2mg—an overdose that the attorney said caused massive bleeding that led to Ernest's death two weeks later. A Chicago jury levied an $810,000 judgment against K Mart in January. (According to court documents, K Mart attorneys questioned whether a misfill actually



Ruth Paxton never thought she'd walk out of a doctor's office with a dangerous prescription.

caused Ernest's death; K Mart spokeswoman Mary Lorencz says the company is considering its legal options.)

Some pharmacists and state regulators contend that dispensing errors made by pharmacists are at least partly attributable to increasing workloads. They point to two factors. First, overall prescription volume keeps rising—up 30% over the past five years, according to IMS America.

The second factor is economics. The percentage of prescriptions paid for by insurance or HMOs has risen from less than 50% to 80%; those third-party payers are imposing ever-lower reimbursement rates on pharmacies, which must churn out a high volume of prescriptions to keep margins up. That reality has helped force mom-and-pop local pharmacies out of business at the rate of three a day in the past five years, according to the National Community Pharmacists Association. Even the Big Four chains—Rite Aid, CVS, Eckerd and Walgreens—must control costs and fill as many prescriptions as possible to stay ahead. For example, two Rite Aid pharmacists interviewed by MONEY say the chain has scheduled single pharmacists to work 12-hour shifts rather than have two pharmacists overlap for part of the day as it had in the past. (Rite Aid spokeswoman Suzanne Mead says pharmacy managers schedule such shifts based on prescription volume, pharmacists' preferences and other variables.)

Three of four medical studies on the subject published between 1983 to 1994 found a correlation between pharmacists' workload and error rates. "There does appear to be a greater risk of errors when a pharmacist is expected to fill more than 24 prescriptions per hour," says Elizabeth Allan Flynn, research associate at Auburn University's School of Pharmacy and author of one of those studies.

Large-chain drugstores counter that this isn't so. "We question the validity of those studies as being too narrow and not looking at the practical variables in the pharmacy workplace," says Rite Aid's Mead. What's more, the chains say their own data on dispensing-error reports—which they decline to share—show no link between pharmacists' workload and error rates. Walgreens spokesman Michael Polzin maintains that the actual percentage of errors per prescription filled at his chain is lower now that it was 10 years ago (though,

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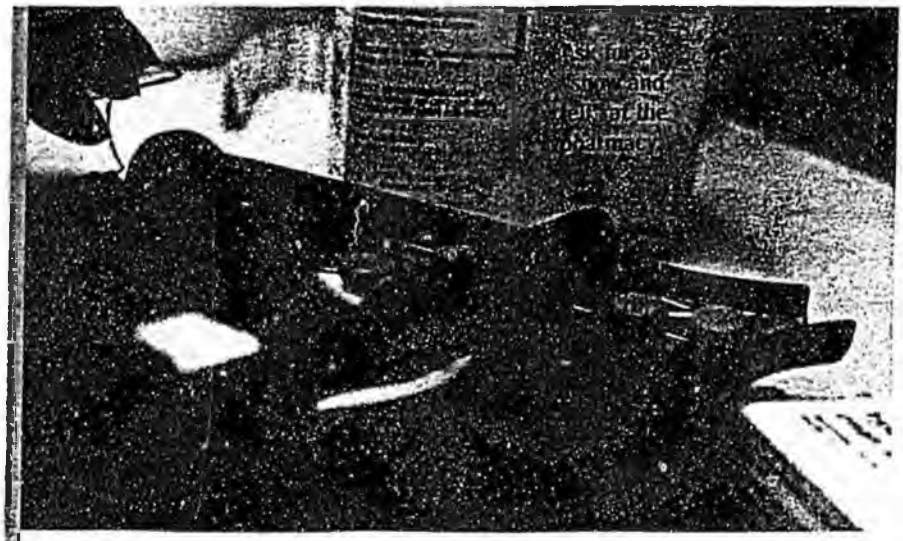

How to avoid prescription errors

Most pharmacy misfills could be detected before the customer leaves the pharmacy if only pharmacists and customers took the time to open the vial and double-check the contents against the original prescription at the time the prescription is being picked up. Pharmacists are required by law in most states to at least offer to counsel their customers about new prescriptions, but as several pharmacists MONEY interviewed pointed out, that's a law that often gets only lip service because of overriding pressure to keep prescriptions moving.

Other pharmacists report that most customers turn down offers for a "show and tell"; and admittedly, many of us have a grab-the-pills-and-go mentality. Fact is, it takes only a few extra minutes with both your doctor and your pharmacist to increase the odds that the medicine you get helps rather than harms you. Says Stephen Giroux, a pharmacist in Middleport, N.Y.: "If people understood the harm that could be done to them by a pharmacy dispensing error, they wouldn't treat going to a pharmacy like going to a fast-food store." Following are a few additional pointers:

- While you're at your doctor's office, write down the generic and brand names of the medicine you're being prescribed, along with the dosage being ordered and the purpose of the medicine. That way you have the correct information in your own writing to double-check against the medication the pharmacist hands you. In a 1997 nationwide survey, pharmacists said that physicians' handwriting was illegible on 16% of prescriptions they filled.
- Protect yourself against possible adverse drug reactions by reminding both your doctor and your pharmacist of any other drug allergies you have, as well as any other medications you are taking; be sure to include over-the-counter pain or cold remedies. It can't hurt to repeat the information each time a prescription is being written and filled.
- Check refills carefully to make sure the pills are the same color and size you usually get. If they are different, assume they are wrong until a pharmacist has physically examined the medicine.
- Avoid getting prescriptions filled on a Monday, traditionally the busiest day at a pharmacy. Also, call in refills a day or two ahead to lessen the chances that your prescription will actually be filled during busy late afternoon and early-evening rush hours.

Text continues from page 120.

again, he will not give precise figures).

Some pharmacists say that pushing beyond that 24-per-hour benchmark is not unusual these days. At a September 1996 hearing on work overload held by the Wyoming Board of Pharmacy, one pharmacist testified: "On a Tuesday after the recent holiday I filled more than one prescription every two minutes for 12 hours straight. And quite honestly, that day I did make a few errors that were caught by the customer or myself. But how many weren't caught?"

The safety net? It has holes

Wrong drugs, wrong dosages, missed drug conflicts—surely you are protected from such understandably human missteps when your pharmacist taps into a computer terminal, or when you pore over the information that comes with your prescription. Not necessarily.

Most pharmacies do rely on computer setups to compensate for any gaps in a pharmacist's knowledge. These run programs marketed by third-party vendors and are supposed to be updated regularly with information about new drugs or new risks for existing drugs. But in practice, these systems don't always provide the protection they should. In a study reported in the *Journal of the American Medical Association* in April 1996, Raymond Woosley, chairman of the department of pharmacology at Georgetown University Medical Center, and his colleagues presented two prescriptions to be filled for the same patient to 50 pharmacists in the Washington, D.C. area. One was for the antihistamine Seldane and one for the antibiotic erythromycin. Although the FDA and manufacturers had issued warnings since 1992 that mixing the two drugs could cause fatal cardiac problems, 32% of the pharmacies filled the prescriptions without comment. Of those, 29% had computer programs that should have warned them not to. In some cases, Woosley says, pharmacists had simply shut down the systems or gotten used to overriding them.

And what about the patient information leaflets stapled to your prescription bag at most pharmacies? These are also designed to give added protection against drug interactions or side effects. They usually aren't prepared by your pharmacist or physician, however, but by one of several commercial vendors. And, as MONEY found when we sent reporters to 15 pharmacies in six cities to check the quality of this material uch of it is out of date or vague.

We asked for patient information about the antihistamine Hismanal, which can cause heart rhythm disturbances, potentially fatal, when combined with erythromycin and several other antibiotics; the FDA first warned of that risk five years ago. Only seven of the pharmacies we visited gave an explicit warning stating that the drug should not be taken with a specfic list of antibiotics. Six others offered only a vague warning: "Inform your doctor if you are taking erythromycin or drugs related to it." And two pharmacies gave us leaflets that included no mention of this potentially fatal risk at all.

One survey of West Coast pharmacists showed dispensing errors at a rate of 324 per pharmacy annually—nearly a mistake a day.

Who's minding the store?

One of the most embarrassing aspects of the drug safety system in this country is that we can't tell you how many people are injured or die each year as a result of the wrong drug being dispensed or prescribed," says Larry Sasich, pharmacist at Public Citizen, a consumer advocacy group in Washington, D.C.

In fact, most state boards do not require pharmacies to report dispensing errors, and national error reporting programs run by the Food and Drug Administration and the U.S. Pharmacopeia, a nonprofit group that sets drug manufacturing quality standards, are both voluntary.

Drug chains usually require pharmacists to submit error reports to management. But even those internal reports do not always prevent future errors. Case in point: Malvina Holloway, 59, of Mobile received a vial filled with Tambocor, a dangerous heart rhythm-altering medication, rather than the Tamoxifen her oncologist had prescribed. When Holloway sued Harco Drug, the regional chain where the mistake was made, her attorney presented 233 incident reports that had been submitted to Harco management, the majority of which involved dispensing errors at stores throughout the chain over the preceding three years. Her attorney, Davis Carr, argued that both the pharmacist and Harco were at fault for the misfill, and won a $255,000 jury award for Holloway. (The verdict was upheld by the Supreme Court of Alabama in 1995.)

Such awards have motivated chains to improve internal procedures on error reports, notes Richard Abood, a professor of pharmacy practice at University of the Pacific in Stockton, Calif. But Catizone of the National Association of Boards of Pharmacy argues for greater oversight. "We are proposing that each individual pharmacy be required to report serious dispensing errors to the state board," he says.

Of course, while reporting problems after the fact would be useful in the long term, it's of little comfort to those who are victims of prescription errors. And in the short term, certainly, the burden will rest on consumers. Says Neil Davis, a former Temple University pharmacy professor: "Unfortunately, this is a problem that will continue until enough people are getting hurt that pharmacy management can no longer afford to ignore it." ⊖

JEFF MERMELSTEIN

And Robert Gellman, a privacy consultant who led Shalala's outside advisers on the recommendations, stressed that the package would be "stronger than any comparable state law." [14] But both men also faulted the law enforcement provisions, among other exceptions. "The administration," Annas concludes, "has a long way to go." ■

BACKGROUND

Health Insurance

Health care became widely available to most Americans, and a financially secure profession for most doctors, only in the recent past. [15] Well into the 20th century, routine health care was a luxury available only to well-to-do Americans. And many doctors had only modest incomes, since they did not see enough patients often enough to have a lucrative practice.

Two 20th-century developments changed the face of health care in the United States: widespread private health insurance and government-funded medical programs. Together, the two developments produced the mythic image that forms the backdrop of today's debate over medical care. In that idealized vision, most Americans enjoyed the services of a family doctor, a Marcus Welby figure who gave skilled and compassionate care from birth to death with little concern about fees. And the government stepped in to provide care for those few who could not afford medical services. But the two developments also contained the germs of the cost problems that beset the health-care system today.

Private insurance entered the health field tentatively, limited at first to covering accidental injury and death. By the late 19th and early 20th centuries, however, many employers were providing limited medical care for their workers — motivated as much to reduce absenteeism caused by illnesses as to promote their employees' welfare.

The labor scarcities of World War II prompted some employers to begin offering health insurance as a benefit for workers. Labor unions, strengthened by New Deal legislation in the 1930s, included demands for health benefits in contract negotiations. And the postwar economic boom allowed major U.S. corporations to grant the demands.

Through the 1950s, more and more big corporations were including health benefits in union contracts; other employers followed suit. By the end of the decade, around two-thirds of the population at least had hospitalization insurance. [16]

The bill for these benefits was largely invisible. The expense was not a big cost item for employers, at least initially. For employees, the benefits were not taxed: In fact, the amounts did not even appear on pay stubs. As a result, many critics and observers contend, no one — neither business, labor, insurers nor health-care providers — had much incentive to watch the bottom line.

A second problem — access to care — was also somewhat obscured. With so many Americans sharing in the widened availability of health care, it was easy to overlook those who were not: the elderly, the poor and the uninsured.

Government's Role

The government's initial moves to help provide health care were also tentative and limited. Some local governments began including medical benefits for the poor in general welfare programs in the early 20th century, and a New Deal program helped bring health care to some rural areas during the Depression. Throughout the century, progressives and labor interests called for compulsory national health insurance, but the efforts were blocked by business interests and, most important, the medical profession.

The two big federal health programs, Medicare and Medicaid, were enacted over the continuing opposition of the medical profession in the brief moment of liberal triumph in the 1960s. Congress had passed a limited bill to provide health insurance for the elderly poor in 1960, but the program proved to be unpopular. President Lyndon B. Johnson put the issue of health care for the elderly at the top of his Great Society agenda and pushed legislation through the overwhelmingly Democratic Congress in 1965.

As enacted, Medicare included the original idea of a contributory insurance program to cover hospitalization for the elderly (Part A) plus a similar plan for doctors' services (Part B). In addition, the law established the framework for Medicaid, the federal-state health-care program for the poor and the disabled.

Some doctors talked of boycotting Medicare, but they quickly realized that the program was — as Starr writes — "a bonanza," guaranteeing payment for medical services that many doctors had previously provided for free or for reduced fees. [17] Medicare and Medicaid closed the biggest gaps in health-care access, but liberals still said health care was too costly and favored broader national health insurance to ensure access for all.

Under President Richard M. Nixon, however, the federal government took a different tack to deal with the intertwined issue of access and costs. It backed a free-

Continued on p. 108

profession opposed the idea, however, and succeeded in getting laws passed in many states to bar consumer-controlled cooperatives.

Then during World War II, California industrialist Henry J. Kaiser set up two prepaid group health plans for his company's employees, known as Permanente Foundations. Unlike the health-care cooperatives, Kaiser's plans flourished — and served as the forerunner for what is today the country's largest HMO, Kaiser Permanente.

The Nixon administration saw in HMOs an appealing alternative to the liberal-backed national health insurance plans. Administration officials were sold on the idea by Paul M. Ellwood, today regarded as the father of managed care. Ellwood, a Minneapolis physician, argued that the traditional fee-for-services system penalized health-care providers who returned patients to health. He met with the administration's key health policy-makers on Feb. 5, 1970, to make his case for organizations to provide members comprehensive care for prepaid amounts. At that meeting Ellwood coined the phrase "health maintenance organizations." [19]

Financial and regulatory help were needed to put the idea into effect. The administration initially found money to help launch HMOs beginning in 1970, without specific congressional authorization, even as it was asking Congress to pass a law to promote the plans. The law enacted three years later — the Health Maintenance Organization Act of 1973 — provided more money, $375 million over five years, for grants and loans to help start up HMOs. [20] More important, the law required all businesses with more than 25 employees to offer at least one HMO as an alternative to conventional insurance if one was available.

At the same time, though, the act established requirements that proved to be regulatory obstacles to the growth of HMOs. It required HMOs to offer not only basic hospitalization, physicians' services, emergency care and laboratory and diagnostic services but also mental health care, home health services and referral services for alcohol and drug abuse.

These requirements, combined with the government's delay in promulgating regulations to implement the law, stunted the growth of HMOs, according to Starr's account. At the same time, the medical profession viewed the idea with skepticism or hostility. But Congress eased some of the burdens in 1976, and then provided another shot of money in 1978: $164 million over three years. [21] By then, HMOs were starting to take off in the market. At the end of the decade, HMOs had enrolled 7.9 million members — double the figure in 1970. Still, the number represented only 4 percent of the population and — as of the early 1980s — was expected to grow only to 10 percent of the population by 1990. [22]

In fact, enrollment in HMOs more than tripled over the next decade, reaching about 25 million in 1990. Despite a decade of rapidly rising health-care costs, HMOs had to keep fees down and provide good service in order to attract customers. Most faced business losses, and some went bankrupt. But they were generally regarded as successful in containing cost increases, enough so that traditional fee-for-service health plans began copying some of their practices, such as utilization review, where insurers scrutinized doctors' fees and practices.

Meanwhile, the once comfortable relationship between patients and doctors had become badly frayed. The growth of specialized medicine had weakened the bond with the old-style family doctors — who now likely as not called themselves "internists." The rise in doctors' income created a distance between an increasingly well-to-do profession and its patient-customers. And the increase in malpractice litigation led many physicians to adopt "defensive-medicine" practices to guard against the threat.

Managed-Care Backlash

The 1990s saw managed care reach a dominant position in the health insurance market. By 1993, most workers covered by employer-provided health insurance were enrolled in some form of managed care — either an HMO, a preferred provider organization (PPO) or a "point-of-service" (POS) plan. As of 1995, industry figures estimated a total of 150 million people nationwide were in a managed-care plan. Managed care was also credited with helping to bring down the rate of increase in health-care costs. But the decade also witnessed a growing backlash against managed care as many doctors chafed under cost-cutting pressures from HMO administrators, and many patients complained of delays in receiving — or outright denials of — needed medical care.

The consumer backlash against HMOs manifested itself most dramatically in court. A small number of HMO enrollees won whopping verdicts or settlements in suits claiming that their health plans had wrongfully denied or delayed necessary medical care. In California, the family of Helene Fox, who died of breast cancer after her HMO, Health Net, refused to pay for a bone marrow transplant, collected a $5 million settlement after a jury awarded her $89 million. In Georgia, Lamona and James Adams won a $45 million jury award in a suit that blamed Kaiser Permanente for the botched handling

of a bacterial infection that forced doctors to amputate their infant son's arms and legs; the company later settled for an undisclosed sum. [23]

A mid-decade survey produced statistical evidence of the consumer dissatisfaction with HMOs, at least in comparison with traditional fee-for-service health plans. The survey, conducted for the Robert Wood Johnson Foundation by researchers at Harvard University and Louis Harris and Associates, found that significantly more HMO subscribers than fee-for-service plan subscribers complained about their medical care.

The complaints came only from small minorities: For example, 12 percent of HMO subscribers said their doctors provided incorrect or inappropriate medical care, compared with 5 percent of fee-for-service plan subscribers. Still, the higher levels of dissatisfaction with HMOs prompted a cautionary note from the survey's director. "Consumers need to be aware that all health plans don't treat you the same way when you are sick," said Robert Blendon, chairman of the department of health policy management at Harvard's School of Public Health. [24]

Health-care providers were also voicing dissatisfaction with managed care. In one incident, Massachusetts internist David Himmelstein attacked the HMO that he worked for, U.S. Healthcare, in an appearance on Phil Donahue's nationally syndicated television program in November 1995. Himmelstein charged that the company rewarded doctors for denying care and forbade them from discussing treatment options with patients. The company — later acquired by Aetna — responded by terminating its contract with Himmelstein just three days after the TV show. But it reinstated him in February 1996 after a storm of criticism and also modified its contracts to permit doctors to discuss payment methods with patients.

Himmelstein's comments reflected the concerns that many doctors and hospital administrators had about managed care. "This is all about cost, not improving patient care," a doctor told *Wall Street Journal* reporter George Anders in a 1994 interview. "You survive in managed care by denying or limiting care," William Speck, chief executive of Presbyterian Hospital in New York, told Anders in June 1995. "That's how you make money." [25]

As the complaints escalated, state and federal lawmakers took up the issues. By mid-decade, hundreds of bills were being introduced in state legislatures around the country. The earliest legislation dealt with specific problems — like allowing women to select an ob-gyn physician as their primary-care provider, or prohibiting health-care plans from imposing "gag clauses" on physicians. Congress in 1996 passed a provision requiring health insurance plans to cover at least 48 hours of hospital care for new mothers — prohibiting so-called "drive-through maternity stays." [26]

By 1997, more comprehensive reform packages were being put together, both in state capitals and in Washington. Health insurers opposed most of the proposals. But they also responded in the market — for example, by making access to specialists easier, though typically for an added cost. [27] In addition, managed-care administrators and advocates sought to take credit for the continuing progress in taming the health-care-cost-increase monster. In a study released last summer, the AAHP claimed that the lower costs due to managed care had allowed more than 3 million people to have health insurance than would have had coverage without managed care.

"By driving down health-care inflation, health plans have provided a safety net, assuring more families access to affordable, high-quality coverage," AAHP President Ignagni said. [28] ■

CURRENT SITUATION

Reform Efforts

The managed-care revolution that Kaiser started in California for his workers now provides health insurance for around 70 percent of the state's residents. Predictably, Californians have also led the backlash against managed care — first in the courts and, for the past three years, in the political arena. But regulatory proposals have failed at the polls or been vetoed by the state's Republican governor, Pete Wilson.

Today, the fate of efforts to rein in managed-care companies in California remains uncertain even after a special task force appointed by the governor and legislators spent eight months trying to develop a consensus package of regulatory changes for the industry.

The 30-member task force — representing health-care providers, insurers, patients' groups, consumers, business and labor — issued a report in early January recommending the creation of a new state agency to regulate HMOs and the enactment of some 60 changes in the way managed-care plans operate. [29] Among the major steps endorsed by the panel:

- An "unbiased, independent, third-party" review process for resolving HMO members' complaints involving denials of medical care.
- Mandatory, standardized procedures for resolving consumer complaints, including a member's right to appear in person at a grievance hearing.
- Collection and publication of detailed information on members' complaints.

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Managed Care And Medical Technology: Implications For Cost Growth

Can managed care organizations control the use of innovative medical technologies better than fee-for-service systems can? A new study of gallbladder surgery shows little difference.

by Michael Chernew, A. Mark Fendrick, and Richard A. Hirth

ABSTRACT: Managed care health plans, particularly health maintenance organizations (HMOs), have been shown to reduce the level of health care spending. Their ability to constrain the long-term rate of health care cost growth is less certain and will depend largely on their ability to constrain the use of emerging medical technologies. Evidence from experience with one important medical technology, laparoscopic cholecystectomy, suggests no systematic difference between HMOs and the general population in the rate of growth in utilization following the introduction of new medical technology.

CONSIDERABLE EVIDENCE SUPPORTS the premise that managed care health plans, particularly health maintenance organizations (HMOs), reduce expenditures on health care services when compared with fee-for-service systems.[1] The evidence is mixed regarding the ability of HMOs to moderate health care cost growth. Joseph Newhouse reports that between 1976 and 19[illegible] HMO premiums rose as fast as those in other health care delivery systems, which suggests that HMOs reduce the level of health care expenditures, but not their growth rate.[2] More recent evidence suggests that health care cost inflation has moderated as HMO penetration has grown.[3] Moreover, some evidence indicates that the reduction in health care cost growth has been greater in areas with greater HMO penetration.[4] Despite considerable evidence that the level, ment, adoption, and diffusion of new medical technol[illegible]

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...ses in health care expenditures, surprisingly little is known ...how HMOs control the diffusion of new medical techniques.[5] A particular challenge for managed care plans is to control the use of medical technologies for which there is strong patient demand and controversy regarding the indications for use. Minimally invasive procedures represent one such class of technologies.

Minimally invasive procedures (for example, various types of endoscopic surgery in which access to the body is gained via incisions that are much smaller than those required by traditional techniques) allow physicians to accomplish the same objective as traditional techniques allow, but with much less morbidity. The revolution in the development of these procedures will have serious implications for the cost of health care.[6] Often, the new procedures are less expensive than the traditional procedures that they replace, which suggests the potential for significant cost savings. However, the introduction of minimally invasive techniques has led in many cases to an increase in the total number of procedures performed. Thus, the aggregate cost implications of using these techniques will depend on the extent to which the cost savings per case are offset by increased provision of services to persons who, without the new technology, would have consumed less costly care.[7] If the volume increase is large enough, the introduction of the new techniques may cause aggregate health care expenditures to rise, despite cost savings per case. Although increased volume may be justified if the new procedures are sufficiently attractive, the prevalence of insurance suggests that some patients may receive a service even if its benefits do not justify the cost.

This DataWatch provides a comparative analysis of how cholecystectomy rates in different types of delivery systems changed following the introduction of an important new surgical technique, laparoscopic cholecystectomy. Cholecystectomy is one of the most commonly performed surgical procedures. Use of the laparoscopic procedure exemplifies a trend toward minimally invasive techniques, and an examination of its use in HMO settings is particularly important. James Baumgardner presents a theoretical model suggesting that the use of technologies that reduce treatment-related morbidity, such as laparoscopic cholecystectomy, will be particularly difficult for HMOs to control.[8] Like many minimally invasive procedures, indications for its use are controversial and, to a large extent, subjective.[9]

About Laparoscopic Cholecystectomy

Cholecystectomy is the surgical removal of the gallbladder, usually performed to treat gallstone disease. Traditional open cholecystectomy involves cutting through the abdominal muscles to reach

the gallbladder and therefore results in a large scar, much discomfort, and lengthy recovery time—typically, a five-day hospital stay and a recovery period of several weeks.

Laparoscopic techniques drastically reduce the discomfort, the recovery time, and the scar, so much so that about 22 percent of laparoscopic cholecystectomies performed on Medicare beneficiaries nationwide between 1991 and 1994 were done on an outpatient basis.[10] Although traditional open cholecystectomy was considered very safe, the morbidity and mortality associated with the laparoscopic procedure are even lower.[11] In addition to reducing nonmonetary costs, laparoscopic cholecystectomy is less expensive per operation than open cholecystectomy, largely because of the reduced hospital stay and, possibly, reduced complication rates.

These improvements may make cholecystectomy attractive to vast numbers of mildly symptomatic persons. There also may be a large number of persons with asymptomatic gallstones, incidentally detected in connection with nonrelated services (such as imaging procedures), who may desire the procedure, although in this situation it appears that costs outweigh benefits.[12] Many insured patients who elect (or agree) to undergo laparoscopic cholecystectomy when the out-of-pocket cost is low might not have chosen to undergo the procedure if only open cholecystectomy were available or if they had to pay the full cost of the intervention. Hence, utilization management might be appropriate.

Laparoscopic techniques have diffused rapidly; nearly 100 percent of hospitals and surgeons adopted the techniques in the first year following their introduction.[13] Not surprisingly, the rate of open cholecystectomies plummeted during this period, as candidates for open cholecystectomies underwent the laparoscopic procedure instead.

Data And Methods

This study uses primary data collected from the administrative data systems of four HMOs and secondary data from five published studies to compare the impact of the introduction of laparoscopic techniques on cholecystectomy rates among selected populations. Three of the published studies examine the experience of populations with relatively modest HMO enrollment.[14] In 1991 the HMO penetration rates in two of these populations, Maryland and Connecticut, were 21.6 and 20.0 percent, respectively, and approximately 11 percent of both states' population were enrolled in Medicare.[15]

We compare the level of and growth in cholecystectomy rates reported in these populations with those experienced by six HMOs. Administrative data on enrollment and use of cholecystectomy, by age and sex, from four of these HMOs allow measurement of the

impact of laparoscopic innovation on cholecystectomy rates in those plans. In 1989 HMOs A, B, and D were group or staff models; HMO C was a mixed model. HMO C provided data for only those enrollees in plans that contracted with physician groups serving both HMO and non-HMO patients. HMO D changed to a mixed model by 1994, and much of the enrollment growth over the study period occurred in the network portion of the plan.

Two of the four HMOs were located in the Northeast, one in the Midwest, and one in the Mid-Atlantic region. HMOs A, B, and D provided data for their 1989 and 1994 experience. The earliest data supplied by HMO C were for 1990 and were not disaggregated into age and sex cells. In 1994 our data from these four plans covered a combined membership of approximately 1.3 million persons. Published cholecystectomy rates from U.S. Healthcare, an individual practice association (IPA)–model HMO, and Group Health Association (GHA), a staff-model HMO, during the period surrounding diffusion of laparoscopic cholecystectomy serve as two additional points of comparison.[16] The reliance on available data and published literature resulted in somewhat different study periods across plans. To address this problem, we explored the sensitivity of the findings to extrapolations of the data to a common study period.

The delivery systems studied serve populations with different demographic characteristics. The portion of the population that was female was 51.5 percent in both Maryland and Connecticut, and both states had a median age of between thirty and thirty-four. Two of the studies adjusted for shifts in population demographics over the study period. A third study did not, but given the size of the population studied and the brief study period, it is unlikely that major demographic shifts occurred that would substantially alter the reported increase in cholecystectomy rates.

The demographic data from the four HMOs from which we collected primary data reveal a gender mix and median age similar to those observed in the general population. However, the distribution of the HMO populations was weighted toward groups that were less likely to undergo cholecystectomy.[17] This demographic advantage deteriorated over the study period. For example, each HMO saw roughly a five-percentage-point increase in population between ages forty-five and sixty-five—the group most likely to undergo cholecystectomy.

Utilization rates in the four HMOs from which we collected primary data were adjusted for demographic shifts within the plans. Because we lack the primary data from other published studies, in which there were not dramatic demographic shifts over the study period, we cannot standardize all utilization rates to a common age and

gender mix.[18] However, cholecystectomy rates standardized to a common base are reported for the subset of plans for which this is possible.

Cholecystectomy Rates

In the general population and Medicare. The studies that examined systems with modest HMO enrollment indicate that the overall cholecystectomy rate, which had been steady or declining throughout the 1980s, rose noticeably after the introduction of the laparoscopic technique (Exhibit 1). During the brief adoption period, there was no indication of a change in the underlying incidence of disease. Pennsylvania Medicare data reveal about a 20 percent increase in utilization, and data from both Maryland and Connecticut reveal approximately a 30 percent increase in cholecystectomy rates following the introduction of laparoscopic techniques.[19] In the Medicare population, the average illness severity of cholecystectomy patients fell after the introduction of laparoscopic techniques.[20]

In HMOs. Five of the six HMOs (A, B, C, D, and Group Health Association [GHA]) support our *ex ante* hypothesis that cholecystectomy utilization rates in the HMOs were below those observed in the general population both before and after the introduction of laparoscopic techniques (Exhibit 2). In part, these lower rates reflect more favorable enrollment demographics. When adjusted to a

EXHIBIT 1
Rates Of Cholecystectomy (Open And Laparoscopic) Per Thousand, General and Medicare Populations, 1989–1992

Year	Maryland[a]	Connecticut[b]	Pennsylvania[c]
1989	1.69	1.76	4.6[d]
1990	1.84	1.88	–[e]
1991	2.16	2.26	–[e]
1992	2.17	–[e]	5.5[f]
Percent change, 1989–1992	28.4%	28.4%[g]	19.6%

SOURCES: See below.
[a] C. Steiner et al., "Surgical Rates and Operative Mortality for Open and Laparoscopic Cholecystectomy in Maryland," *The New England Journal of Medicine* 300, no. 6 (1994): 403–408. General population; adjusted for age. Outpatient procedures were not captured, but the authors suggest that very few if any were done in Maryland during the study period.
[b] Volume estimates are from R. Orlando III et al., for the Connecticut Laparoscopic Cholecystectomy Registry, "Laparoscopic Cholecystectomy," *Archives of Surgery* 128, no. 5 (1993): 494–499. General population. Rates are computed based on 1990 population estimates from the U.S. Census. Both inpatient and outpatient procedures were captured.
[c] J. Escarce, W. Chen, and S. Schwartz, "Falling Cholecystectomy Thresholds since the Introduction of Laparoscopic Cholecystectomy," *Journal of the American Medical Association* 273, no. 20 (1995): 1581–1585. Medicare population. Both inpatient and outpatient procedures were captured.
[d] Based on a 1986–1989 average.
[e] Not available.
[f] Based on a 1991–1993 average.
[g] Percent change computed from 1989 to 1991.

common base, utilization rates in the HMOs are higher than they were before adjustment, although in HMOs A, B, and C they remain below those in the general population (Exhibit 3). This finding is consistent with evidence that HMOs practice a more conservative style of care. Interestingly, in HMO D and U.S. Healthcare use of cholecystectomy was comparable to that in the general population.[21]

We can only speculate as to why this is so. U.S. Healthcare is the only IPA model in the study, which may provide an explanation. The evolution of HMO D to a mixed model is unlikely to account for this observation because when rates from 1989, prior to the growth in nonstaff products, are adjusted to a common population, they remain comparable to those in the general population. An alternative explanation might be that the market in which HMO D operates is less urban and thus potentially less competitive than the markets of the other HMOs.

In four of the six plans studied, the age- and sex-adjusted rates of growth in cholecystectomy utilization following the introduction of laparoscopic techniques exceeded those found in the general population. Three of these four plans provided us with the data necessary to adjust the rates to the demographic mix of the population at large. In one case, the growth in cholecystectomy rates falls to that observed in the general population when such an adjustment is made (Exhibit 3).

Adjusting to a common study period. Ideally, the study period

EXHIBIT 2
Rates Of Cholecystectomy (Open And Laparoscopic) Per Thousand In Health Maintenance Organizations (HMOs), 1989–1994

Year	HMO A[a]	HMO B[a]	HMO C[a]	HMO D[a]	Group Health Association[b]	U.S. Healthcare[c]
1989	0.96	0.82	–[d]	1.40	0.82	1.35
1990	–[d]	–[d]	1.43	–[d]	0.96	1.59
1991	–[d]	–[d]	–[d]	–[d]	0.99	2.01
1992	–[d]	–[d]	–[d]	–[d]	–[d]	2.15
1994	1.55	1.43	1.49	2.02	–[d]	–[d]
Percent change 1989–1994	61.5%	74.4%	4.2%	44.3%	20.7%[e]	59.3%[e]

SOURCES: See below.
[a] Age and gender were adjusted to reflect the demographic mix of the earliest available data from each plan. Both inpatient and outpatient procedures were captured.
[b] P. Strahm et al., "Laparoscopic Cholecystectomy: A New Technology Cost Analysis," *HMO Practice* 8, no. 2 (1994): 84–88. Both inpatient and outpatient procedures were captured.
[c] A. Legorreta et al., "Increased Cholecystectomy Rate after the Introduction of Laparoscopic Cholecystectomy," *Journal of the American Medical Association* 270, no. 12 (1993): 1429–1432. Both inpatient and outpatient procedures were captured.
[d] Not available.
[e] Percent change was computed from 1989 to 1992.

EXHIBIT 3
Health Maintenance Organization (HMO) Cholecystectomy Rates Per Thousand, Adjusted To The 1990 Demographic Mix Of Maryland

	1989 utilization	1994 utilization	Growth rate
HMO A	1.06	1.56	47%
HMO B	1.08	1.66	54
HMO D	1.75	2.31	32
Subtotal	1.24	1.85	50
HMO C	[a]	1.86	[a]
Total	[a]	1.85	[a]

SOURCE: Authors' calculations.
NOTE: The HMO rates reported here are standardized to the age and gender mix of Maryland according to the 1990 census.
[a] Not available.

would extend from 1989, before the introduction of laparoscopic techniques, to 1994, long after the transition to the new procedure. Unfortunately, our data spanned this entire time frame for only three of the nine systems studied. The most common shortcoming was study periods ending in 1991 or 1992. To assess the extent to which the findings reported from systems with shorter observation periods might inaccurately estimate the 1989–1994 growth in cholecystectomy use, we projected the growth rates that one might reasonably expect for the unobserved years.

Projection was based on two methods. First, growth rates from other plans for the missing years were examined to determine a reasonable range of growth for the missing periods. Second, the well-documented S-shaped adoption pattern that innovations typically follow was used to assess plausible changes in utilization for the unobserved periods.[22] The studies that provide data up to 1992 display a diffusion pattern consistent with this adoption curve.[23]

The projected change in cholecystectomy use between 1991 and 1994 is well below that which would be necessary to raise the growth in cholecystectomy rates in Maryland, Connecticut, and Pennsylvania Medicare above those observed in many of the HMOs. Likewise, any reasonable adjustment to HMO C or GHA is unlikely to alter the conclusion that the increase in cholecystectomy rates in these plans was well below that observed in the other HMOs, and in the case of HMO C, the increases were below those in the population at large.

Discussion

The data presented here tend to support the conclusions of Newhouse and colleagues, that HMOs do not systematically differ from the general health care system in how their practice patterns respond to emerging technology.[24] For this reason, one should view with caution recent experience that suggests that managed care, or

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managed competition, reduces cost growth. Attention must be paid to whether the reduction in cost growth reflects a true moderation in the underlying forces driving up expenditures, such as diffusion of medical technology, or whether it instead reflects transitional savings attributable to one-time price or efficiency gains.

Our findings also are consistent with models that conclude that HMOs will find it difficult to control the use of technologies that reduce the nonfinancial burden associated with care, such as minimally invasive therapies.[25] Because HMOs typically do not rely on patient cost sharing to stem use of services, it may be difficult for them to ration services that have strong consumer demand. For cholecystectomy, utilization control is difficult because of the large pool of potential candidates and the subjective nature of the indications for use.

The finding that certain HMOs responded differently than others to innovation should not be surprising. There is considerable evidence of practice pattern variations among HMOs.[26] Although HMO C did not implement any strategies particularly aimed at controlling cholecystectomy rates over this period, it operated in a very mature and competitive HMO market.

Physician group parameters. The physician group that served approximately half of HMO C's enrollees devoted considerable attention to determining the clinical threshold for performance of cholecystectomy after the introduction of laparoscopic techniques. In 1990 this group adopted informal parameters outlining when the procedure should be performed, which were designed to keep the clinical threshold for performance of cholecystectomy constant.

The actions of this physician group may reflect its philosophical commitment to monitor and control utilization. The group's actions also may be, in part, a response to the competitive environment in the health care market where the group is located. The medical director of the group contends that the cholecystectomy parameters that were adopted did not reflect incentives placed on the group by HMO C. However, it is worthwhile to note that the group was capitated for many of its patients (including those from HMO C), which created an incentive to reduce utilization. Surgeons in the group were blinded to each patient's insurer, which suggests that the conservative cholecystectomy rates may have held even for the patients covered by fee-for-service insurers.

The relatively constant cholecystectomy rate in HMO C illustrates two points. First, physician groups may be able to control the use of new technologies if attention is devoted to examining the merits of adoption and diffusion. Second, one method by which HMOs may control costs is to select conservatively practicing ph

sician groups. Even though HMO C was not explicitly involved in the development of the cholecystectomy parameters adopted by the physician group, its decision to contract with this group may have resulted in a lower rate of increase in cholecystectomy rates. Unfortunately, data from other plans in this market were not available, so we cannot determine the extent to which the experience of HMO C differs from that of the general population in its market.

Generalizability. One limitation of this study of a single technology is that the results may not be generalizable to the health care system as a whole. Although an increase in volume following innovation has occurred for other procedures, not all procedures that have experienced minimally invasive innovation have had such an increase in volume. For example, appendectomy, a generally nonelective procedure, has had relatively stable volume.

We analyzed practice patterns from a few large settings. It is possible that the experiences of other HMOs differed from those that we analyzed. It also is possible that insufficient managerial attention was paid to this one procedure to affect utilization because it represents a small portion of overall expenditures. However, cholecystectomy is one of the procedures monitored by the Health Plan Employer Data and Information Set (HEDIS), which is used by many large employers to evaluate HMOs. For this reason, HMOs have an incentive to track and monitor use of this procedure, perhaps even to a greater extent than other procedures.

Threshold for procedure. This discussion of case-mix differences highlights a critical issue arising in this type of study. The utilization rate for cholecystectomy depends largely on the distribution of illness severity and symptoms within the population and on the average threshold that patients and practitioners use to determine whether the procedure should be performed. Plans that exhibit a low utilization rate at any point in time may well have more patients at risk for the treatment if the threshold for treatment changes. These plans would naturally exhibit greater growth in utilization in response to innovation.

The fundamental observation that growth in cholecystectomy rates in HMOs after the development of a new technology exceeded that in the general population remains valid, even if the relatively greater increase in cholecystectomy rates in HMOs reflects a different distribution of patients near the initial surgical threshold. There still would be greater cost growth in the HMOs relative to the general population, if all else were held constant.

Patient backlog. It is also possible that the plan with the lower utilization rate prior to the innovation would accumulate a greater backlog of patients: those eligible for, but not treated with,

cholecystectomy. A drop in the treatment threshold may generate a temporary increase in rates as the backlog patients are treated. The plans that historically are more likely to perform the procedure would have a smaller backlog and therefore would exhibit a smaller increase. Such a pattern would tend to lead to greater growth in the HMOs that initially had lower utilization rates. However, given the rapid adoption and diffusion of this procedure, one would expect any backlog to have been eliminated by 1994, which suggests that our results remain valid.

Understanding the clinical implications of different thresholds is crucial to formulating a normative conclusion on how well different systems ration care. The data reported here do not indicate which cholecystectomy rate is appropriate. The reduction in procedure-related mortality and morbidity justifies some increase in volume. As Newhouse argues, the increase in health care costs may simply reflect consumer demand for advanced medical services.[27]

Despite the absence of fee-for-service incentives, the ability of managed care plans to constrain use of innovative services that appear beneficial to enrollees is not well understood. Given the important role that emerging medical technology plays in contributing to cost growth, more study is needed to understand the process of cost growth in managed care plans, and particularly to understand the manner in which these plans manage the adoption and diffusion of medical technology.

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Consumer Bill of Rights and Responsibilities

Report to the President of the United States

Prepared by Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997

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EXECUTIVE SUMMARY

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The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed by President Clinton on March 26, 1997, to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." As part of its work, the President asked the Commission to draft a "consumer bill of rights."

The Commission includes 34 members and is co-chaired by The Honorable Alexis M. Herman, Secretary of Labor, and The Honorable Donna E. Shalala, Secretary of Health and Human Services. Its members include individuals from a wide variety of backgrounds including consumers, business, labor, health care providers, health plans, State and local governments, and health care quality experts. The Commission has four Subcommittees: Consumer Rights, Protections, and Responsibilities; Quality Measurement; Creating a Quality Improvement Environment; and Roles and Responsibilities of Public and Private Purchasers and Quality Oversight Organizations. The Commission and its Subcommittees

meet monthly in public.

Following is a summary of the eight areas of consumer rights and responsibilities adopted by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

I. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans (1), professionals, and facilities.

This information should include:

- **Health plans:** Covered benefits, cost-sharing, and procedures for resolving complaints; licensure, certification, and accreditation status; comparable measures of quality and consumer satisfaction; provider network composition; the procedures that govern access to specialists and emergency services; and care management information.
- **Health professionals:** Education and board certification and recertification; years of practice; experience performing certain procedures; and comparable measures of quality and consumer satisfaction.
- **Health care facilities:** Experience in performing certain procedures and services; accreditation status; comparable measures of quality and worker and consumer satisfaction; procedures for resolving complaints; and community benefits provided.

Consumer assistance programs must be carefully structured to promote consumer confidence and to work cooperatively with health plans, providers, payers and regulators. Sponsorship that assures accountability to the interests of consumers and stable, adequate funding are desirable characteristics of such programs.

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(1) The term "health plans" is used throughout this report and refers broadly to indemnity insurers, managed care organizations (including health maintenance organizations and preferred provider organizations), self-funded employer-sponsored plans, Taft-Hartley trusts, church plans, association plans, State and local government employee programs, and public insurance programs (i.e., Medicare and Medicaid).

II. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

To ensure such choice, health plans should provide the following:

Provider Network Adequacy: All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day and seven days a week. If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers. Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members.

Access to Qualified Specialists for Women's Health Services: Women should be able to choose a

qualified provider offered by a plan—such as gynecologists, certified nurse midwives, and other qualified health care providers—for the provision of covered care necessary to provide routine and preventative women's health care services.

Access to Specialists: Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

Transitional Care: Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or through completion of postpartum care) to allow for transition of care. Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

Public and private group purchasers should, wherever feasible, offer consumers a choice of high-quality health insurance products. Small employers should be provided with greater assistance in offering their workers and their families a choice of health plans and products.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

To ensure this right:

- Health plans should educate their members about the availability, location, and appropriate use of emergency and other medical services; cost-sharing provisions for emergency services; and the availability of care outside an emergency department.
- Health plans using a defined network of providers should cover emergency department screening and stabilization services both in network and out of network without prior authorization for use consistent with the prudent layperson standard. Non-network providers and facilities should not bill patients for any charges in excess of health plans' routine payment arrangements.
- Emergency department personnel should contact a patient's primary care provider or health plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care.

IV. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

In order to ensure consumers' right and ability to participate in treatment decisions, health care professionals should:

- Provide patients with easily understood information and opportunity to decide among treatment options consistent with the informed consent process. Specifically,
    - Discuss all treatment options with a patient in a culturally competent manner, including the

option of no treatment at all.
    - Ensure that persons with disabilities have effective communications with members of the health system in making such decisions.
    - Discuss all current treatments a consumer may be undergoing, including those alternative treatments that are self-administered.
    - Discuss all risks, benefits, and consequences to treatment or nontreatment.
    - Give patients the opportunity to refuse treatment and to express preferences about future treatment decisions.

- Discuss the use of advance directives—both living wills and durable powers of attorney for health care—with patients and their designated family members.
- Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process.

To facilitate greater communication between patients and providers, health care providers, facilities, and plans should:

- Disclose to consumers factors—such as methods of compensation, ownership of or interest in health care facilities, or matters of conscience—that could influence advice or treatment decisions.
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options.
- Be prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients.

V. Respect and Nondiscrimination

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

VI. Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

In order to ensure this right:

- With very few exceptions, individually identifiable health care information can be used without written consent for health purposes only, including the provision of health care, payment for services, peer review, health promotion, disease management, and quality assurance.
- In addition, disclosure of individually identifiable health care information without written consent should be permitted in very limited circumstances where there is a clear legal basis for doing so. Such reasons include: medical or health care research for which a institutional review board has determined anonymous records will not suffice, investigation of health care fraud, and public health reporting.

- To the maximum feasible extent in all situations, nonidentifiable health care information should be used unless the individual has consented to the disclosure of individually identifiable information. When disclosure is required, no greater amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure.

II. Complaints and Appeals

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

Internal appeals systems should include:

- Timely written notification of a decision to deny, reduce, or terminate services or deny payment for services. Such notification should include an explanation of the reasons for the decisions and the procedures available for appealing them.
- Resolution of all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).
- A claim review process conducted by health care professionals who are appropriately credentialed with respect to the treatment involved. Reviews should be conducted by individuals who were not involved in the initial decision.
- Written notification of the final determination by the plan of an internal appeal that includes information on the reason for the determination and how a consumer can appeal that decision to an external entity.
- Reasonable processes for resolving consumer complaints about such issues as waiting times, operating hours, the demeanor of health care personnel, and the adequacy of facilities.

External appeals systems should:

- Be available only after consumers have exhausted all internal processes (except in cases of urgently needed care).
- Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized (2).
- Be conducted by health care professionals who are appropriately credentialed with respect to the treatment involved and subject to conflict-of-interest prohibitions. Reviews should be conducted by individuals who were not involved in the initial decision.
- Follow a standard of review that promotes evidence-based decisionmaking and relies on objective evidence.
- Resolve all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).

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(2) The right to external appeals does not apply to denials, reductions, or terminations of coverage or denials of payment for services that are specifically excluded from the consumer's coverage as established by contract.

VIII. Consumer Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage

consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. Such responsibilities include:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, health care providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

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PREAMBLE

Consumer Bill of Rights and Responsibilities

American consumers and their families are experiencing an historic transition of the U.S. system of health care financing and delivery. In establishing the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, President Clinton asked that it advise him "on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." As part of that effort, the President has asked the Commission to draft a Consumer Bill of Rights and Responsibilities.

This Commission includes 34 members from a wide variety of backgrounds including consumers, business, labor, health care providers, health plans, State and local governments, and health care quality experts. We hope our diversity of interests and backgrounds will make our recommendations more valuable to those who consider them.

This is an appropriate time to reexamine and reconsider the methods by which our Nation and the health care industry establish and protect the rights and identify the responsibilities of those people who use the health care system. The Commission believes it is essential to preserve those elements of the emerging system that have a positive impact on the quality of care as well as the cost and availability of health insurance coverage.

Development of a Consumer Bill of Rights and Responsibilities is an important step forward for all those involved in the health care system. Consumers, health care professionals, administrators of health care facilities, and those who operate health plans will benefit from a clear set of unifying standards. The

Consumer Bill of Rights and Responsibilities can help to establish a stronger relationship of trust among consumers, health care professionals, health care institutions, and health plans by helping to sort out the shared responsibilities of each of these participants in a system that promotes quality improvement.

The work of this Commission builds on the efforts of many others. The Commission reviewed dozens of proposals prepared and released by a variety of organizations (3) that have addressed the rights, responsibilities, and protection of consumers. We have heard public testimony from dozens of individuals and organizations. We are grateful for their contributions.

The Consumer Bill of Rights and Responsibilities charts a course for the continued enhancement of health systems and processes that serve to protect consumers and ensure quality. While the rights and responsibilities included in this report are intended to apply to all consumers and participants in the health care system, the Commission recognizes that the strength of these protections will grow over time as the capabilities of the health care industry become more sophisticated. Certain portions of the industry will require additional time to make these adjustments, but the Commission intends that the bulk of its recommendations be put in place within the next 3 years.

The Consumer Bill of Rights and Responsibilities was first drafted by the Subcommittee on Consumer Rights, Protections, and Responsibilities. The Subcommittee met in open session on seven separate occasions, and the Commission met six times during that same time period. The Subcommittee considered background papers on each topic, heard public testimony on most topics, and considered two or three drafts of each chapter. At each point in that process, the Subcommittee briefed the full Commission on its work and received feedback on those issues. The Commission also has considered draft chapters and revised drafts reflecting the input of its members. Throughout this process, the Subcommittee and the Commission have operated on a consensus basis that has allowed any member to place an issue before the respective body for consideration. The list of issues was refined to reflect the discussions of the Subcommittee and the Commission. The final product reflects the areas of overall agreement expressed by Commission members.

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(3) The Commission examined proposals by organizations including: the American Association of Health Plans, the American Association of Retired Persons, the American Hospital Association, the American Medical Association, the Campaign for Health Security, Citizen Action, Families USA, the Health Insurance Association of America, HIP Health Plans, the Health Policy Tracking Service, Kaiser Permanente, Kaiser/Group Health, the Midwest Bioethics Center, the National Association of Insurance Commissioners, the National Committee on Quality Assurance, the National Health Council, the Public Policy and Education Fund of New York, the Service Employees International Union, the Utilization Review Accreditation Committee, and many others.

Objectives of a Consumer Bill of Rights and Responsibilities

The Consumer Bill of Rights and Responsibilities is intended to accomplish three major goals.

First, to strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.

Second, to reaffirm the importance of a strong relationship between patients and their health care professionals.

Third, to reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

Guiding Principles for the Consumer Bill of Rights and Responsibilities

The work of the Commission was guided by the following principles:

All consumers are created equal. The work of this Commission in establishing a Bill of Rights and Responsibilities must apply to all consumers. This includes all beneficiaries of such public programs as Medicare, Medicaid, the Department of Veterans Affairs, and the Department of Defense, as well as Federal, State, and local government employees. It also includes all those who have private insurance, including those who purchase their own insurance, those who work for companies that have self-funded health plans, and those who work for companies that purchase insurance for their employees and dependents. And, finally, to the extent possible, these rights should be accorded to those who have no health insurance but use the health care system.

Quality comes first. The first question we asked ourselves in each circumstance was: Will this improve the quality of care and of the system that delivers that care? Sometimes this led us to reject policy options that we believe could hinder the progress our Nation has made toward a health care system that is focused on improving quality through accountable organized systems.

Preserve what works. There are elements of managed care and of indemnity coverage that must be changed to protect the rights of consumers. But there also are elements of each system that have improved quality and expanded access. We have tried to make sure that we preserve what works while we address areas that can and should be improved.

Costs matter. Although a comprehensive cost-analysis was not performed for this Bill of Rights and Responsibilities, the Commission has sought to balance the need for stronger consumer rights with the need to keep coverage affordable. We recognize that, in some circumstances, rights may create additional costs for employers; health plans; Federal, State, and local governments; and consumers. We also recognize that ultimately consumers can bear these costs in the form of lower wages, higher prices, higher taxes, or reduced benefits in other areas. The Commission believes some components of the Bill of Rights may also enhance the efficiency and effectiveness of the health care marketplace. While these efficiencies cannot be well calculated, they may help to offset some cost increases. The Commission has attempted to weigh these factors carefully and support recommendations that may prompt additional spending in cases where such spending may represent an investment in higher quality health care and better health outcomes.

Goals for Consumer Protection in a Quality-Focused Health Care System

A Consumer Bill of Rights and Responsibilities is, by its nature, a snapshot of what is needed at a particular time. The rights enumerated in this report are intended to move the health care system in a direction that is consistent with a system of health care delivery that is focused on obtaining the highest quality and best outcome for consumers and their families. In that light, the Commission has identified a series of goals for the continued reform of the American health care system that will maximize consumer rights in a system that focuses on quality.

Health coverage is the best consumer protection. A health care system that leaves more than 41 million Americans without health coverage cannot adequately protect the rights of consumers and their families. The fact that so many Americans live day in and day out without the security that health coverage provides is intolerable. Recent trends reported by the U.S. Census Bureau that the number of uninsured Americans rose by one million between 1996 and 1997 are cause for great concern. Moreover, the continued existence of a large group of Americans without health insurance increases the costs paid by those who have insurance as uncovered expenses are shifted to other purchasers. Efforts by Federal and State governments to expand the number of children who are insured are encouraging and should be strengthened. Similar efforts should be extended to other segments of the population so that all Americans are covered.

Consumers faced with catastrophic illness require assistance. Each year, an estimated 1,500 to 2,500 Americans lose their private health insurance coverage because their medical expenses exceed a lifetime limit included in their health insurance policy. Many of these consumers must exhaust their family

savings before becoming eligible for Medicaid or other forms of public assistance. This creates a tremendous hardship on these individuals and their families. Employers, health plans, and others should seriously consider taking steps to ease this burden by (1) eliminating or increasing lifetime limits, (2) expanding the use of high-risk pools to provide immediate coverage at the time consumers reach a lifetime limit, or (3) offering supplemental coverage for workers who wish to increase their limits.

Coverage must be made affordable for all consumers, employers, and other purchasers. The recent moderation in health care costs is promising and has been a contributing factor in the slowing of insurance coverage losses. Employers, health plans, and Federal and State governments should be applauded for their efforts to make coverage more affordable for more Americans. Recent projections for 1998 are less favorable. History makes clear that we cannot assume that costs will remain under control without continued cost containment.

Vulnerable groups require special attention. Many consumers are, for reasons beyond their control, more vulnerable than others to losing their coverage or experiencing significant gaps in their coverage. Individuals with mental or physical disabilities, low-income individuals, children, non-English-speaking consumers, and others require considerable attention by decisionmakers at all levels of the system. Enactment of the Americans with Disabilities Act of 1990, the Health Insurance Portability and Accountability Act of 1996, and the Mental Health Parity Act of 1996 were important steps to protect these consumers. Further steps can and should be taken.

Small purchasers need assistance. The owners of small businesses, the self-employed, and those who purchase insurance in the individual market continue to have great difficulty finding and maintaining affordable health care coverage. For a variety of reasons, insurance premiums are higher for small firms relative to the benefits they are able to purchase, and some small firms are unable to purchase insurance at all. In its final report, the Commission intends to offer several recommendations to help ameliorate some of these effects, including voluntary approaches for expanding insurance pools and for adjusting payment systems to reflect the greater risk inherent in small group and individual markets.

Consumer participation in clinical research. The national investment in clinical research has led to breakthrough advances in diagnosis, prevention, and treatment of illness and disability that have lengthened and improved the quality of life for millions of consumers while also achieving significant cost savings to the health care industry. Consumer participation in clinical research through their inclusion in clinical trials is vitally important not only to continued advancement and innovation in medical care but to the often life-threatening nature of the conditions affecting such consumers. The Commission encourages the ongoing efforts by researchers, health plans, employers, public purchasers, and others to resolve impediments to consumer participation in clinical trials and urges participants to reach agreement on an appropriate sharing of costs and responsibilities related to such trials.

The Commission does not, in this report, speak to the issues of implementation or enforcement of the Consumer Bill of Rights and Responsibilities. The rights enumerated in this report can be achieved in several ways including voluntary actions by health plans, purchasers, facilities, and providers; the effects of market forces; accreditation processes; as well as State or Federal legislation or regulation. In its final report to the President, the Commission intends to speak to the optimal methods for implementing and enforcing these rights through one or more of these approaches.

Finally, the Commission believes that the American people should have access to health care that is of high quality, evidence-based, safe, free of errors, and is available to all Americans regardless of ability to pay. Progress, over time, will require changes that must be made prudently, realistically, and with due regard to the needs of all stakeholders in the system. This Consumer Bill of Rights and Responsibilities specifies improvements that we believe are achievable now and in the next several years. It acquires even more meaning in the context of a broader overarching commitment to ensure that full access to high-quality health care will eventually be available to all Americans.

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Consumer Bill of Rights and Responsibilities

Report to the President of the United States

Prepared by Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997

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EXECUTIVE SUMMARY

Consumer Bill of Rights and Responsibilities

The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed by President Clinton on March 26, 1997, to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." As part of its work, the President asked the Commission to draft a "consumer bill of rights."

The Commission includes 34 members and is co-chaired by The Honorable Alexis M. Herman, Secretary of Labor, and The Honorable Donna E. Shalala, Secretary of Health and Human Services. Its members include individuals from a wide variety of backgrounds including consumers, business, labor, health care providers, health plans, State and local governments, and health care quality experts. The Commission has four Subcommittees: Consumer Rights, Protections, and Responsibilities; Quality Measurement; Creating a Quality Improvement Environment; and Roles and Responsibilities of Public and Private Purchasers and Quality Oversight Organizations. The Commission and its Subcommittees

meet monthly in public.

Following is a summary of the eight areas of consumer rights and responsibilities adopted by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry:

I. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans (1), professionals, and facilities.

This information should include:

- **Health plans:** Covered benefits, cost-sharing, and procedures for resolving complaints; licensure, certification, and accreditation status; comparable measures of quality and consumer satisfaction; provider network composition; the procedures that govern access to specialists and emergency services; and care management information.
- **Health professionals:** Education and board certification and recertification; years of practice; experience performing certain procedures; and comparable measures of quality and consumer satisfaction.
- **Health care facilities:** Experience in performing certain procedures and services; accreditation status; comparable measures of quality and worker and consumer satisfaction; procedures for resolving complaints; and community benefits provided.

Consumer assistance programs must be carefully structured to promote consumer confidence and to work cooperatively with health plans, providers, payers and regulators. Sponsorship that assures accountability to the interests of consumers and stable, adequate funding are desirable characteristics of such programs.

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(1) The term "health plans" is used throughout this report and refers broadly to indemnity insurers, managed care organizations (including health maintenance organizations and preferred provider organizations), self-funded employer-sponsored plans, Taft-Hartley trusts, church plans, association plans, State and local government employee programs, and public insurance programs (i.e., Medicare and Medicaid).

II. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

To ensure such choice, health plans should provide the following:

Provider Network Adequacy: All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day and seven days a week. If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers. Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members.

Access to Qualified Specialists for Women's Health Services: Women should be able to choose a

qualified provider offered by a plan—such as gynecologists, certified nurse midwives, and other qualified health care providers—for the provision of covered care necessary to provide routine and preventative women's health care services.

Access to Specialists: Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

Transitional Care: Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or through completion of postpartum care) to allow for transition of care. Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

Public and private group purchasers should, wherever feasible, offer consumers a choice of high-quality health insurance products. Small employers should be provided with greater assistance in offering their workers and their families a choice of health plans and products.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

To ensure this right:

- Health plans should educate their members about the availability, location, and appropriate use of emergency and other medical services; cost-sharing provisions for emergency services; and the availability of care outside an emergency department.
- Health plans using a defined network of providers should cover emergency department screening and stabilization services both in network and out of network without prior authorization for use consistent with the prudent layperson standard. Non-network providers and facilities should not bill patients for any charges in excess of health plans' routine payment arrangements.
- Emergency department personnel should contact a patient's primary care provider or health plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care.

IV. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

In order to ensure consumers' right and ability to participate in treatment decisions, health care professionals should:

- Provide patients with easily understood information and opportunity to decide among treatment options consistent with the informed consent process. Specifically,
    - Discuss all treatment options with a patient in a culturally competent manner, including the

option of no treatment at all.
  - Ensure that persons with disabilities have effective communications with members of the health system in making such decisions.
  - Discuss all current treatments a consumer may be undergoing, including those alternative treatments that are self-administered.
  - Discuss all risks, benefits, and consequences to treatment or nontreatment.
  - Give patients the opportunity to refuse treatment and to express preferences about future treatment decisions.

- Discuss the use of advance directives—both living wills and durable powers of attorney for health care—with patients and their designated family members.
- Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process.

To facilitate greater communication between patients and providers, health care providers, facilities, and plans should:

- Disclose to consumers factors—such as methods of compensation, ownership of or interest in health care facilities, or matters of conscience—that could influence advice or treatment decisions.
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options.
- Be prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients.

V. Respect and Nondiscrimination

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

VI. Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

In order to ensure this right:

- With very few exceptions, individually identifiable health care information can be used without written consent for health purposes only, including the provision of health care, payment for services, peer review, health promotion, disease management, and quality assurance.
- In addition, disclosure of individually identifiable health care information without written consent should be permitted in very limited circumstances where there is a clear legal basis for doing so. Such reasons include: medical or health care research for which a institutional review board has determined anonymous records will not suffice, investigation of health care fraud, and public health reporting.

- To the maximum feasible extent in all situations, nonidentifiable health care information should be used unless the individual has consented to the disclosure of individually identifiable information. When disclosure is required, no greater amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure.

II. Complaints and Appeals

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

Internal appeals systems should include:

- Timely written notification of a decision to deny, reduce, or terminate services or deny payment for services. Such notification should include an explanation of the reasons for the decisions and the procedures available for appealing them.
- Resolution of all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).
- A claim review process conducted by health care professionals who are appropriately credentialed with respect to the treatment involved. Reviews should be conducted by individuals who were not involved in the initial decision.
- Written notification of the final determination by the plan of an internal appeal that includes information on the reason for the determination and how a consumer can appeal that decision to an external entity.
- Reasonable processes for resolving consumer complaints about such issues as waiting times, operating hours, the demeanor of health care personnel, and the adequacy of facilities.

External appeals systems should:

- Be available only after consumers have exhausted all internal processes (except in cases of urgently needed care).
- Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized (2).
- Be conducted by health care professionals who are appropriately credentialed with respect to the treatment involved and subject to conflict-of-interest prohibitions. Reviews should be conducted by individuals who were not involved in the initial decision.
- Follow a standard of review that promotes evidence-based decisionmaking and relies on objective evidence.
- Resolve all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).

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(2) The right to external appeals does not apply to denials, reductions, or terminations of coverage or denials of payment for services that are specifically excluded from the consumer's coverage as established by contract.

VIII. Consumer Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage

consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. Such responsibilities include:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, health care providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

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PREAMBLE

Consumer Bill of Rights and Responsibilities

American consumers and their families are experiencing an historic transition of the U.S. system of health care financing and delivery. In establishing the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, President Clinton asked that it advise him "on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." As part of that effort, the President has asked the Commission to draft a Consumer Bill of Rights and Responsibilities.

This Commission includes 34 members from a wide variety of backgrounds including consumers, business, labor, health care providers, health plans, State and local governments, and health care quality experts. We hope our diversity of interests and backgrounds will make our recommendations more valuable to those who consider them.

This is an appropriate time to reexamine and reconsider the methods by which our Nation and the health care industry establish and protect the rights and identify the responsibilities of those people who use the health care system. The Commission believes it is essential to preserve those elements of the emerging system that have a positive impact on the quality of care as well as the cost and availability of health insurance coverage.

Development of a Consumer Bill of Rights and Responsibilities is an important step forward for all those involved in the health care system. Consumers, health care professionals, administrators of health care facilities, and those who operate health plans will benefit from a clear set of unifying standards. The

Consumer Bill of Rights and Responsibilities can help to establish a stronger relationship of trust among consumers, health care professionals, health care institutions, and health plans by helping to sort out the shared responsibilities of each of these participants in a system that promotes quality improvement.

The work of this Commission builds on the efforts of many others. The Commission reviewed dozens of proposals prepared and released by a variety of organizations (3) that have addressed the rights, responsibilities, and protection of consumers. We have heard public testimony from dozens of individuals and organizations. We are grateful for their contributions.

The Consumer Bill of Rights and Responsibilities charts a course for the continued enhancement of health systems and processes that serve to protect consumers and ensure quality. While the rights and responsibilities included in this report are intended to apply to all consumers and participants in the health care system, the Commission recognizes that the strength of these protections will grow over time as the capabilities of the health care industry become more sophisticated. Certain portions of the industry will require additional time to make these adjustments, but the Commission intends that the bulk of its recommendations be put in place within the next 3 years.

The Consumer Bill of Rights and Responsibilities was first drafted by the Subcommittee on Consumer Rights, Protections, and Responsibilities. The Subcommittee met in open session on seven separate occasions, and the Commission met six times during that same time period. The Subcommittee considered background papers on each topic, heard public testimony on most topics, and considered two or three drafts of each chapter. At each point in that process, the Subcommittee briefed the full Commission on its work and received feedback on those issues. The Commission also has considered draft chapters and revised drafts reflecting the input of its members. Throughout this process, the Subcommittee and the Commission have operated on a consensus basis that has allowed any member to place an issue before the respective body for consideration. The list of issues was refined to reflect the discussions of the Subcommittee and the Commission. The final product reflects the areas of overall agreement expressed by Commission members.

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(3) The Commission examined proposals by organizations including: the American Association of Health Plans, the American Association of Retired Persons, the American Hospital Association, the American Medical Association, the Campaign for Health Security, Citizen Action, Families USA, the Health Insurance Association of America, HIP Health Plans, the Health Policy Tracking Service, Kaiser Permanente, Kaiser/Group Health, the Midwest Bioethics Center, the National Association of Insurance Commissioners, the National Committee on Quality Assurance, the National Health Council, the Public Policy and Education Fund of New York, the Service Employees International Union, the Utilization Review Accreditation Committee, and many others.

Objectives of a Consumer Bill of Rights and Responsibilities

The Consumer Bill of Rights and Responsibilities is intended to accomplish three major goals.

First, to strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.

Second, to reaffirm the importance of a strong relationship between patients and their health care professionals.

Third, to reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

Guiding Principles for the Consumer Bill of Rights and Responsibilities

The work of the Commission was guided by the following principles:

All consumers are created equal. The work of this Commission in establishing a Bill of Rights and Responsibilities must apply to all consumers. This includes all beneficiaries of such public programs as Medicare, Medicaid, the Department of Veterans Affairs, and the Department of Defense, as well as Federal, State, and local government employees. It also includes all those who have private insurance, including those who purchase their own insurance, those who work for companies that have self-funded health plans, and those who work for companies that purchase insurance for their employees and dependents. And, finally, to the extent possible, these rights should be accorded to those who have no health insurance but use the health care system.

Quality comes first. The first question we asked ourselves in each circumstance was: Will this improve the quality of care and of the system that delivers that care? Sometimes this led us to reject policy options that we believe could hinder the progress our Nation has made toward a health care system that is focused on improving quality through accountable organized systems.

Preserve what works. There are elements of managed care and of indemnity coverage that must be changed to protect the rights of consumers. But there also are elements of each system that have improved quality and expanded access. We have tried to make sure that we preserve what works while we address areas that can and should be improved.

Costs matter. Although a comprehensive cost-analysis was not performed for this Bill of Rights and Responsibilities, the Commission has sought to balance the need for stronger consumer rights with the need to keep coverage affordable. We recognize that, in some circumstances, rights may create additional costs for employers; health plans; Federal, State, and local governments; and consumers. We also recognize that ultimately consumers can bear these costs in the form of lower wages, higher prices, higher taxes, or reduced benefits in other areas. The Commission believes some components of the Bill of Rights may also enhance the efficiency and effectiveness of the health care marketplace. While these efficiencies cannot be well calculated, they may help to offset some cost increases. The Commission has attempted to weigh these factors carefully and support recommendations that may prompt additional spending in cases where such spending may represent an investment in higher quality health care and better health outcomes.

Goals for Consumer Protection in a Quality-Focused Health Care System

A Consumer Bill of Rights and Responsibilities is, by its nature, a snapshot of what is needed at a particular time. The rights enumerated in this report are intended to move the health care system in a direction that is consistent with a system of health care delivery that is focused on obtaining the highest quality and best outcome for consumers and their families. In that light, the Commission has identified a series of goals for the continued reform of the American health care system that will maximize consumer rights in a system that focuses on quality.

Health coverage is the best consumer protection. A health care system that leaves more than 41 million Americans without health coverage cannot adequately protect the rights of consumers and their families. The fact that so many Americans live day in and day out without the security that health coverage provides is intolerable. Recent trends reported by the U.S. Census Bureau that the number of uninsured Americans rose by one million between 1996 and 1997 are cause for great concern. Moreover, the continued existence of a large group of Americans without health insurance increases the costs paid by those who have insurance as uncovered expenses are shifted to other purchasers. Efforts by Federal and State governments to expand the number of children who are insured are encouraging and should be strengthened. Similar efforts should be extended to other segments of the population so that all Americans are covered.

Consumers faced with catastrophic illness require assistance. Each year, an estimated 1,500 to 2,500 Americans lose their private health insurance coverage because their medical expenses exceed a lifetime limit included in their health insurance policy. Many of these consumers must exhaust their family

savings before becoming eligible for Medicaid or other forms of public assistance. This creates a tremendous hardship on these individuals and their families. Employers, health plans, and others should seriously consider taking steps to ease this burden by (1) eliminating or increasing lifetime limits, (2) expanding the use of high-risk pools to provide immediate coverage at the time consumers reach a lifetime limit, or (3) offering supplemental coverage for workers who wish to increase their limits.

Coverage must be made affordable for all consumers, employers, and other purchasers. The recent moderation in health care costs is promising and has been a contributing factor in the slowing of insurance coverage losses. Employers, health plans, and Federal and State governments should be applauded for their efforts to make coverage more affordable for more Americans. Recent projections for 1998 are less favorable. History makes clear that we cannot assume that costs will remain under control without continued cost containment.

Vulnerable groups require special attention. Many consumers are, for reasons beyond their control, more vulnerable than others to losing their coverage or experiencing significant gaps in their coverage. Individuals with mental or physical disabilities, low-income individuals, children, non-English-speaking consumers, and others require considerable attention by decisionmakers at all levels of the system. Enactment of the Americans with Disabilities Act of 1990, the Health Insurance Portability and Accountability Act of 1996, and the Mental Health Parity Act of 1996 were important steps to protect these consumers. Further steps can and should be taken.

Small purchasers need assistance. The owners of small businesses, the self-employed, and those who purchase insurance in the individual market continue to have great difficulty finding and maintaining affordable health care coverage. For a variety of reasons, insurance premiums are higher for small firms relative to the benefits they are able to purchase, and some small firms are unable to purchase insurance at all. In its final report, the Commission intends to offer several recommendations to help ameliorate some of these effects, including voluntary approaches for expanding insurance pools and for adjusting payment systems to reflect the greater risk inherent in small group and individual markets.

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The Commission does not, in this report, speak to the issues of implementation or enforcement of the Consumer Bill of Rights and Responsibilities. The rights enumerated in this report can be achieved in several ways including voluntary actions by health plans, purchasers, facilities, and providers; the effects of market forces; accreditation processes; as well as State or Federal legislation or regulation. In its final report to the President, the Commission intends to speak to the optimal methods for implementing and enforcing these rights through one or more of these approaches.

Finally, the Commission believes that the American people should have access to health care that is of high quality, evidence-based, safe, free of errors, and is available to all Americans regardless of ability to pay. Progress, over time, will require changes that must be made prudently, realistically, and with due regard to the needs of all stakeholders in the system. This Consumer Bill of Rights and Responsibilities specifies improvements that we believe are achievable now and in the next several years. It acquires even more meaning in the context of a broader overarching commitment to ensure that full access to high-quality health care will eventually be available to all Americans.

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Chapter One: Information Disclosure

Statement of the Right

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

This information should include:

- **Health plans (4):** Covered benefits, cost-sharing, and procedures for resolving complaints; licensure, certification, and accreditation status; comparable measures of quality and consumer satisfaction; provider network composition; the procedures that govern access to specialists and emergency services; and care management information.
- **Health professionals:** Education and board certification and recertification; years of practice; experience performing certain procedures; and comparable measures of quality and consumer satisfaction.
- **Health care facilities:** Experience in performing certain procedures and services; accreditation status; comparable measures of quality and worker and consumer satisfaction; procedures for resolving complaints; and community benefits provided.

Consumer assistance programs must be carefully structured to promote consumer confidence and to work cooperatively with health plans, providers, payers, and regulators. Sponsorship that assures accountability to the interests of consumers and stable, adequate funding are desirable characteristics of such programs.

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(4) The term "health plan" is used throughout this report and refers broadly to indemnity insurers, managed care organizations (including health maintenance organizations and preferred provider organizations), self-funded employer-sponsored plans, Taft-Hartley trusts, church plans, association plans, State and local government employee programs, and public insurance programs (i.e., Medicare and Medicaid).

Rationale

Value-based purchasing allows consumers to obtain greater value for their health care dollar by seeking higher quality care at the best price. To do this, consumers need accurate, reliable information that will allow them to assess differences in the quality and cost of health benefits plans, the health care providers who treat them, and the facilities and institutions that house them. Active and informed decisionmaking by consumers will improve the performance of the health care system, as providers seek to enhance their quality and reduce their costs in order to be more attractive to value-seeking consumers.

A more basic reason for providing consumers with information is an ethical one. Health plans, facilities, and professionals have an ethical obligation to inform consumers about how their actions can affect the consumer's life and health. Medical ethicists ground this obligation in the principle of respect for individual autonomy and individuals' right to make choices about how they receive medical care (Beauchamp and Childress, 1994).

This chapter provides a description of the types of information on health plans, health professionals, and health care facilities that should be made available to consumers either routinely or upon request. The Commission recognizes that much work remains to be done if all this information is to be readily available and understandable to consumers, specifically:

- *Detailed explanation is needed for certain types of information.* Some types of information are straightforward and require no further definition (e.g., the names, board certification status, and geographic location of primary care providers in a plan's network). Other types of information would benefit from the development of more detailed explanation, such as the care management information on clinical protocols, practice guidelines, and preauthorization and utilization review standards and procedures.
- *Standardized measures are needed for comparative purposes.* For the information intended to support consumer decisions regarding the choice of a health benefits plan, or choice of an individual provider or facility, standardized definitions will be needed to allow for "apples to apples" comparisons.
- *Ongoing development and promulgation of standardized measurement sets and instruments are needed for assessing satisfaction and quality.* The Commission believes that some of the most important types of information a consumer has a right to receive fall into the categories of consumer satisfaction ratings and clinical quality performance measures for health plans, health care professionals, and facilities. For all consumers to exercise this right, processes must be put in place to create standardized performance measures. In its final report, the Commission intends to address how such a process might be established so as to build on existing efforts, encourage ongoing innovation in quality measurement, and provide the best possible information to consumers at any given time to encourage quality improvement through market-based decisions.
- *Useful and appropriate reporting formats and processes are needed for consumers.* Although the Commission believes that consumers should have access to pertinent information, it recognizes that caution must be taken to provide information to consumers in useful formats (e.g., summary and detailed reports, printed copy, and Internet), at appropriate times (i.e., decision points), with assistance for vulnerable groups (i.e., those who are hearing impaired or non-English speaking). These issues also will be addressed in the Commission's final report.

Consumers should be able to obtain other information upon request as outlined below. Plans, providers, and facilities should inform consumers that such information is available and describe how it can be obtained.

Health Plan Information

Many consumers face a choice of health plans such as an indemnity plan, an HMO, a point-of-service plan, or a preferred provider organization. Consumers' choice of a health plan has a significant impact on consumers' ability to make other choices about facilities, health professionals, and treatment options. Even in cases where consumers do not have a choice of plans, they require information on the plan in which they are enrolled to use the available services effectively.

To the extent that a right to information creat disclosure requirements for health plans, these requirements should apply equally to all types of plans (including indemnity, HMO, PPO, and POS) regardless of sponsor (e.g., such government programs as CHAMPUS, VA, FEHBP, Medicare, and Medicaid and private plans including fully funded, partially self-funded, or fully self-funded plans). If the specific information required for disclosure does not exist, or is unavailable, the consumer should be informed.

The primary responsibility of providing consumers with health plan information falls upon the plans themselves. In the case of self-insured plans, this responsibility will rest with the plan sponsor unless it is delegated or contracted to a third-party administrator.

Within the category of health plan information, one can discern four principal subcategories of information: (1) benefits, cost-sharing, and dispute resolution; (2) health plan characteristics and performance information; (3) network characteristics; and (4) care management information.

A. Benefits, Cost-Sharing, and Dispute Resolution. Consumers should receive the following information about a health benefits plan:

- A general summary of all covered benefits, including:

- General limits on coverage, including any annual or lifetime limits, as well as limits forspecific conditions.
- Whether preventative services are covered.
- Whether a drug formulary is used and, if so, how decisions are made pertaining to inclusion of drugs, particularly new drugs (including a process to consider exceptions).
- How drugs, devices, and procedures are deemed experimental.

- Enrollee cost-sharing, including employee or beneficiary premium contributions, deductibles, copayments, and coinsurance.
- Type and extent of dispute resolution procedures available in the event of a dispute.

B. Health Plan Characteristics and Performance Information. Consumers joining or considering whether or not to join a health plan should receive information about:

- State licensure status, Federal certification, and private accreditation status (including publicly available reports).
- Consumer satisfaction measures.
- Clinical quality performance measures.
- Service performance measures (e.g., waiting time to obtain an appointment with primary care providers and specialists).
- Disenrollment rates (adjusted for involuntary disenrollment and other relevant factors).

Additional information that should be made available *upon request* includes:

- Number of years in existence.
- Corporate form of the plan (i.e., public or private; nonprofit or for-profit ownership and management).
- Whether the plan meets requirements (State and Federal) for fiscal solvency.
- Whether the plan meets standards (State, Federal, and private accreditation) that assure confidentiality of medical records and orderly transfer to caregivers.

C. Network Characteristics. It is important to provide consumers with information about the characteristics of the network and the procedures that govern its use. Consumers should receive:

- Aggregate information on the numbers, types, board certification status, and geographic distribution of primary care providers and specialists.
- Detailed list of names, board certification status, and geographic location of all contracting primary care providers; whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether facilities are accessible to people with disabilities.
- Provider compensation methods, including base payment (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withholds, etc.).
- Rules regarding coverage of out-of-network services, and applicable rates of cost-sharing.
- Information about circumstances under which primary care referral is required to access specialty care.
- Information about what options exist for 24-hour coverage and whether enrollees have access to urgent care centers.

Additional information that should be made available *upon request* includes:

- Detailed list of names, board certification status, and geographic location of all contracting specialists and specialty care centers; whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether facilities are accessible to people with disabilities.
- Detailed list of names, accreditation status, and geographic location of hospitals, home health agencies, rehabilitation and long-term care facilities; whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether they are accessible to people with disabilities.

D. Care Management Information. Information in this category that should be available *upon request* includes:

- Preauthorization and utilization review procedures followed.
- Use of clinical protocols, practice guidelines, and utilization review standards pertinent to a patient's clinical circumstances.
- Whether the plan has special disease management programs or programs for persons with disabilities. (This information should indicate whether these programs are voluntary or mandatory or if a significant benefit differential results.)
- Whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers.
- Qualifications of reviewers at the primary and appeals levels.

Health Professional Information

All consumers should receive information on:

- Whether the health professional's ownership or affiliation arrangement with a provider group or institution would make it more likely that a consumer would be referred to particular specialists or facility or receive a particular service.
- How the provider is compensated, including base payment method (e.g., capitation, salary, fee schedule) and types of additional financial incentives (e.g., bonus, withholds).

Consumers should receive *upon request* the following information on health professionals:

- Education, board certification, and recertification status.
- Names of hospitals where physicians have admitting privileges.
- Years of practice as a physician and as a specialist if so identified.
- Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity.
- Consumer satisfaction measures.
- Clinical quality performance measures.
- Service performance measures.
- Accreditation status (if applicable).
- Corporate form of the practice (i.e., public or private, nonprofit or for-profit, ownership and management, sole proprietorship or group practice).
- The availability of translation or interpretation services for non-English speakers and people with communication disabilities.
- Any cancellation, suspension, or exclusion from participation in Federal programs or sanctions from Federal agencies; any suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges.

Health Care Facility Information

Consumers should receive the following information from a health care facility:

- Corporate form of the facility (i.e., public or private; nonprofit or for-profit; ownership and management; affiliation with other corporate entities).
- Accreditation status.
- Whether specialty programs meet guidelines established by specialty societies or other appropriate bodies (e.g., whether a cancer treatment center has been approved by the American College of Surgeons, the Association of Community Cancer Centers, or the National Cancer Institute).
- The volume of certain procedures performed at each facility.
- Consumer satisfaction measures.
- Clinical quality performance measures.
- Service performance measures.

- Procedures for registering a complaint and achieving resolution of that complaint.
- The availability of translation or interpretation services for non-English speakers and people with communication disabilities.
- Numbers and credentials of providers of direct patient care (e.g., registered nurses, other licensed providers, and other caregivers).
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.
- Whether the facility has been excluded from any Federal health programs (i.e., Medicare or Medicaid).

Consumer Assistance Programs

Initial results indicate that consumer assistance programs support consumer needs for information on health plans, providers, and facilities. A loose patchwork of consumer assistance services currently exists in the public and private sectors. In the public sector, 14 State or locally based Medicaid programs now have established ombudsmen programs to assist beneficiaries with information needs. Some Medicare beneficiaries and people with chronic health problems have access to consumer assistance services through Information, Counseling, and Assistance (ICA) programs, long-term care ombudsmen programs, and protection and advocacy programs.

In the private sector, health plans often provide consumers with assistance services through customer and member service departments (Oxford Health Plans, 1997; Harvard Pilgrim Health Plan, 1997). Large group purchasers and labor unions often provide their employees with consumer assistance by organizing information on plans, educating employees about their rights, and intervening when employees have complaints about their plans (Darling, 1997).

While there are a number of sources that provide assistance to consumers, most programs target specific subpopulations and have limited funds, and hence provide a limited range of services. There are reasons to believe that consumers and other stakeholders would benefit from greater availability of consumer assistance programs that:

- **Inspire confidence.** Consumers want to know that they will be treated fairly.
- **Provide a safety valve.** Even in the best of systems, there will be individuals who fall through the cracks. Assistance programs provide a resource that can help such individuals resolve problems quickly and efficiently, often bridging communication failures between the consumer and the provider or health plan.
- **Foster collaboration.** Assistance programs should work with the array of available resources to best meet the needs of consumers.

The challenge to crafting assistance programs for health care consumers is to ensure that such programs are not duplicative, but rather that they supplement and complement existing resources.

With regard to consumer assistance, the Commission has not addressed issues of implementation. Specifically, this is not an endorsement or a requirement for any particular form of consumer assistance programs, but lays out desirable characteristics of such programs.

Implications of the Right

Obtaining the information listed above and making it available to consumers will not, by itself, equip consumers with the knowledge and abilities required to act on this information. Discussed below are some basic considerations in making this information useful to consumers and the implications of this for key segments of the health care industry.

Information Should Be Useful to Consumers and Cost-Effective to Obtain. Edgman-Levitan and Cleary (1996) have documented that consumers are able to evaluate critical information about quality. However, research on how consumers use information to make decisions suggests that too much information can be overwhelming. In its 1988 assessment of methods for communicating the quality of

medical care to consumers, the Office of Technology Assessment's Expert Advisory Panel concluded that "limiting information to only a few indicators of quality will probably be necessary [because] people can consider only a few items at any one time. Information is processed as a unit or chunk--a person's processing capacity has been estimated as being anywhere from four to seven chunks" (OTA, 1988). Ongoing research must be conducted to determine what is the most effective subset of information that consumers can use. Finally, while consumers clearly have a right to information, it must be understood that there are costs associated with collecting and distributing it. While providing information to consumers generates significant benefits for both the consumers and the health system as a whole, it is not necessarily inexpensive. Recognizing these costs, however, is not an argument for a "bare bones" approach to information disclosure. The failure to provide information also has costs. Well-informed consumers are the bedrock of an efficiently operating market. Without meaningful information, consumers are more likely to make choices that can result in less than optimal outcomes for themselves and there is less incentive for participants to strive for excellence. The challenge is to develop coordinated approaches to information collection and dissemination that will provide consumers the information they need to make decisions without imposing severe burdens on plans and providers.

Investments in Clinical Information Systems and Workforce Education and Training Will Be Needed. Greater investment in automated information systems will be necessary for health plans and providers to satisfy these information disclosure requirements, especially ones pertaining to product, facility, and provider performance and quality. The Commission is currently assessing barriers or impediments to investment in clinical information systems (e.g., inadequate data collection standards; confidentiality concerns; magnitude of capital investments required) and plans to speak to this issue in its final report. Responding to these increased information demands also has implications for the training and education of the health care workforce. There will be greater demand by health care organizations for individuals with particular technical and analytic skills (e.g., computer programming, engineering, data auditing, and statistics). Ongoing training and continuing education programs for practitioners and other workers whose work involves recording, compiling, or manipulating clinical and administrative data will also be needed to assure the completeness and accuracy of data and adherence to confidentiality safeguards.

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Chapter Two: Choice of Providers and Plans

Statement of the Right

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

To ensure such choice, health plans should provide the following:

Provider Network Adequacy: All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day and seven days a week. If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers. Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members.

Access to Qualified Specialists for Women's Health Services: Women should be able to choose a qualified provider offered by a plan—such as gynecologists, certified nurse midwives, and other qualified health care providers—for the provision of covered care necessary to provide routine and preventative women's health care services.

Access to Specialists: Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

Transitional Care: Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or through completion of postpartum care) to allow for transition of care. Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

Public and private group purchasers should, wherever feasible, offer consumers a choice of high-quality health insurance products. Small employers should be provided with greater assistance in offering their workers and their families a choice of health plans and products.

Rationale

The ability of consumers to exercise choice in the health care marketplace is associated with several desirable characteristics of a health care system.

- First, choice is associated with increased consumer satisfaction. In a survey of consumers receiving health care in both indemnity and managed care plans, individuals with a choice of health products report greater satisfaction with their plan and tend to rate both their health insurance product and their individual physicians of higher quality (Davis and Schoen, 1997).
- Second, the ability of consumers to choose among competing products is a hallmark of a healthy marketplace. Individual consumers are responsible for 34 percent of all direct expenditures for health care in the United States (Cowan et al., 1996). As the science of measuring and generating