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FOREWORD

FROM HERO TO GOAT: MANAGED CARE IN THE 1990s

THOMAS L. GREANEY*

For health care law and policy, the 1990s can be characterized as the decade of managed care. The phenomenon of payors strongly influencing health spending and utilization decisions spread rapidly. As this was happening, the landscape of legal relationships and regulatory controls witnessed a dramatic change as well. By the mid-nineties, health care premiums, which had been spiraling out of control for years and had provoked calls for comprehensive changes in the system, came under control. However, managed care was not to leave the playing field as the hero that had successfully forced a long-overdue rationalization of health care delivery and payment. Instead, its fate was more akin to a veteran first baseman who allows a ground ball to go through his legs and denies baseball's most worthy and long-suffering fans their one chance in a lifetime of winning the World Series.¹ In the view of many consumers and lawmakers, managed care became synonymous with interference with physician discretion, restrictions on patient choice and profiteering by insurance companies. The legal fallout was extensive administrative regulation and numerous judicial decisions directed at constraining managed care.

As background for Saint Louis University's Symposium on Managed Care, this essay offers a brief historical sketch of the managed care era and presents three perspectives for considering future directions. The excellent articles that comprise the Symposium offer the reader a rich understanding of the legal and policy issues that face judges and lawmakers today.

A Brief History of Managed Care in the 1990s. At the outset of the decade, most observers heralded managed care as the solution to spiraling costs and a guarantor of quality. The Clinton health reform proposal made managed care the centerpiece of a comprehensive federal program designed to reshape the structure of health care insurance and delivery in America. After

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1. Specific names of historical antecedents to the text have been withheld at the request of the Buckner family and Boston Red Sox.

the demise of the Clinton Plan, most states chose not to adopt wide-ranging reforms, and instead contented themselves with the success of managed care in containing costs. Some incremental change appeared at the federal level as well, with legislation such as the Kennedy-Kassebaum bill ensuring to some extent portability of insurance and limiting some unpopular insurance practices. With increased reliance on risk sharing by providers and selective contracting, the need for efficient means of delivering services was apparent and “integration” became the watchword of the industry. Providers integrated horizontally and vertically, and various forms of integrated delivery systems appeared in almost every community. For most policymakers and economic analysts, this was a natural progression toward rationalizing a delivery system long out of touch with market forces. Legal doctrine began to accommodate these changes. Judicial decisions and administrative rules in diverse areas including ERISA, antitrust, malpractice, tax-exemption, fraud and abuse and Medicare law reflected a consensus that provider cooperation and integration was necessary in the new era of managed care.

However, the gears of legal and institutional change shifted abruptly in the mid-nineties. Growing dissatisfaction among consumers and providers with the constraints imposed by managed care, together with legal regimes that seemed to protect payors from accountability, fostered the so-called “managed care backlash.”² A torrent of state legislation targeting the shortcomings of managed care was quickly enacted. At the same time, many of the institutional arrangements that had grown up to support the new world of provider and payor integration began to fall apart. For example, “disintegration” of unsuccessful PHO’s, bankruptcies of IPA’s, and unwinding of mergers became commonplace. Finally, many of the legal doctrines that had previously supported managed care were reexamined; judicial and administrative law developments reflected increasing skepticism about the practices and performance of the industry.³

An Economic Perspective. The economics of managed care offers some insight into the underlying causes of the above described changes. Most fundamentally, managed care represents only one of several players that jointly

2. A large literature has developed on the managed care backlash. See Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395 (2001); David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 MILBANK Q. 35 (2001); Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 J. HEALTH POL. POL’Y & L. 931 (1999); Marc A. Rodwin, *Backlash As a Prelude to managing Managed Care*, 24 J. HEALTH POL. POL’Y & L. 1115 (1999); Alain C. Enthoven et al., *Consumer Choice and the Managed Care Backlash*, 27 AM. J.L. & MED. 1 (2001).

3. See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Policy in Health Care*, HEALTH AFF., Mar.-Apr. 2002, at 185 (discussing influence of backlash on judicial decisions in antitrust).

determine medical spending decisions. Patients, the ultimate consumers of health services, demand care and influence provision of services by their buying decisions. It is well known, of course, that their choices are shaped by forces such as moral hazard resulting from insurance coverage and imperfect information owing to the technical and complex nature of health services. Choice is also subject to the influence of agency relationships. Patients' access to care and selection of providers is limited by the choices made by their employers. Employers shop and choose insurance coverage on behalf of their employees and share in the cost of paying for that coverage. However, the menu of plans ultimately presented to employees is usually severely limited. The managed care entity may select a limited array of providers and influence consumers' choices with controls including financial incentives such as capitation or measures such as utilization reviews and deselection of physicians. Finally, providers of care, especially physicians, strongly influence spending decisions through their advice to patients, selection of treatment modalities and referrals.

Plainly the cumulative effect of these somewhat imperfect agency relationships reduces the likelihood that the market is satisfying consumer preferences. Appreciation of the separation between spending decisions and the "consumer" also underscores the fundamental dilemma facing managed care. Economizing on costs inevitably entails some intrusion on medical decision-making. As Haavi Morreim described it,

[V]irtually every medical decision is a spending decision, and third parties can control their costs only by controlling, or at least by influencing, actual decisions about patient care. . . . Plans regard themselves as entitled to determine what they will pay for, and physicians believe that they themselves, not business managers or even medical directors, should decide what is best for patients.⁴

The inevitability of joint payor/provider/consumer decision making in health care does not mean that, left unimpeded, the market will produce a smooth, efficient, or satisfying result for the parties. Yet it does suggest that advocates for managed care and market-based health care policies must do a better job in focusing on the infrastructure necessary to support workable competition in the industry and to correct abuses that undermine its legitimacy in the eyes of the public.

A Political Perspective. The managed care era was characterized by shifting political coalitions. Initially, managed care enjoyed the support of liberals and conservatives as a market based alternative to command and control regulation. The Clinton Administration's Health Security plan sought to build a centrist coalition behind sweeping structural changes that would rely

4. E. Haavi Morreim, *Battling for Control of Health Care Resources*, 7 INDEP. REV. 237, 238 (2002).

on managed care principles. However, the legislation foundered on the strong opposition of much of the insurance industry, which feared an aggressive, federal regulatory hand in the form of large quasi-public intermediaries would come to impose on it unacceptable regulatory constraints.⁵ While organized medicine did not support the Clinton reforms, its opposition was relatively muted.⁶ After the demise of the Clinton reforms, however, the legislative agenda of medicine changed dramatically, with the American Medical Association (“AMA”) actively supporting widespread legislative interventions to deal with managed care (including, ironically, many that the Clinton reforms would have imposed).

Looked at from the perspective of politics, it is clear that during the nineties the medical community allied with consumer groups to focus on issues of quality, choice and safety that were implicated by evolving managed care arrangements. The union of these “previously antagonistic forces” found significant success at the state level.⁷ The resulting “devolution” of policy making from federal to state governments may have produced opportunities for the well-organized local apparatus of medical interest groups to achieve policy objectives vital to their economic and professional interests.⁸ While the efforts to enact a federal “patients’ bill of rights” appears stalled as of this writing,⁹ proposals to control managed care have found receptive audiences at the state level.¹⁰

Managed care may be faulted for the shortcomings that invited a strong response from the political and legislative processes. An investigation by the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services revealed a startling failure to report adverse actions against

5. See HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* (1996). For an argument that the political campaign against the Clinton reform relied on dubious premises, see James Fallows, *A Triumph of Misinformation*, *ATLANTIC MONTHLY*, Jan. 1995, at 26.

6. In fact some medical groups supported reform, while the AMA gave mixed signals. See JOHNSON & BRODER, *supra* note 5.

7. Louise Trubek, *Public Interest Lawyers and New Governance: Advocating for Healthcare*, 2002 *WIS. L. REV.* 575, 586 (2002). See also Carl F. Ameringer, *Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Authority*, 5 *DEPAUL J. HEALTH CARE L.* 187, 192 (2002) (“collaborative activities between physicians and consumers at the state level . . . furthered the political agenda of organized medicine”).

8. See Ameringer, *supra* note 7, at 192 n.29 (summarizing evidence that relative to managed care, physicians are better organized at the state level than at the federal level).

9. On the merits of a patients bill of rights, see George J. Annas, *A National Patients’ Bill of Rights*, 338 *New Eng. J. Med.* 695 (1998) (supporting). *But see* David A. Hyman, *Regulating Managed Care: What’s Wrong with a Patients’ Bill of Rights*, 73 *S. CAL. L. REV.* 221 (2000) (opposing).

10. See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failures*, 85 *CORNELL L. REV.* 1 (1999).

physicians to the National Practitioner Data Bank.¹¹ The OIG observed several explanations for this phenomenon including managed care's abandonment of its role in clinical oversight and their emphasis price in lieu of quality. As Clark Havighurst summarized the quality shortcomings of managed care, "[M]ost plans are not rigorously selective in their choice of subcontractors Managed care today means little more than subcontracting and capitation."¹²

In addition, it should be recalled that many in the insurance industry vigorously opposed not only the Clinton reforms but also less intrusive reforms. As Alain Enthoven described managed care's role: "Some health plans have resisted market-improving legislation, in part because they may benefit from market imperfections that allow them to attract healthy populations while avoiding the sick. The industry generally has not supported responsible multiple-choice arrangements."¹³

The managed care backlash was driven both by public dissatisfaction with waiting times and access to physicians, but perhaps more importantly by the perception of inadequacies in care attributable to managed care.¹⁴ In addition, the absence of choice of health plans may have contributed to public attitudes. An important factor driving opinion on managed care is not just the type of health plan people are enrolled in, but also the extent to which they have a choice in the matter. The results of a national survey indicate that persons without choice at enrollment are substantially less satisfied with their plan and with managed care in general than are persons with choices.¹⁵

Legal Perspectives. Managed care's performance has been shaped in part by the legal framework in which it operates. Markets need information, mobility and accountability to function properly. We have learned that health markets are deficient in many of these areas and many legal reforms have been proposed to ameliorate these failures. These include measures to support risk pooling, encourage choice for employees, prevent risk selection and insure that core coverage is not denied to consumers. Moreover, the legal system is charged with preventing managed care from externalizing its costs. As Marc Rodwin has put it, "Backlash is unlikely to disappear until the industry matures and thoughtful regulatory authority protects the public, and the industry from

11. During a nine-year period, eighty-four percent of MCOs *never* reported an adverse event. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, MANAGED CARE ORGANIZATION NONREPORTING TO THE NATIONAL PRACTITIONER DATA BANK: A SIGNAL FOR BROADER CONCERN, at i (2001).

12. Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 11 (2000).

13. Enthoven & Singer, *supra* note 2, at 935.

14. Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF. July-Aug. 1998, at 80.

15. Atul A. Gawande et al., *Does Dissatisfaction With Health Plans Stem From Having No Choices?*, HEALTH AFF. Sept.-Oct. 1998, at 184.

itself.”¹⁶ However, many of these reforms have been stymied by a variety of institutional and legal impediments. Most notably, the piecemeal regulatory system fostered by shared federal and state responsibilities and ERISA operates to fragment and thwart reform efforts. Whether the nation will have the benefit of multiple laboratories of experimentation, a cacophony of conflicting and ineffective regulation, or gridlock, remains an open question.

The Symposium. This Symposium issue brings together some of the nation’s foremost legal authorities who address many of the topics mentioned in this essay. This outstanding group of scholars, practitioners and government officials critically analyze the key legal, social and economic issues that will influence the future of managed care.

The Center for Health Law Studies also owes a debt of gratitude to Mary Ann Jauer for her tireless work in putting together the arrangements for the authors’ presentations in the Spring and to the editors of the *Saint Louis University Law Journal* for their excellent work in editing the contents of this volume.

16. Rodwin, *supra* note 2, at 1124. For the view that quality control is unlikely to be advanced through state law and tort litigation, see Richard Kronick, *Waiting for Godot: Wishes and Worries in Managed Care*, 24 J. HEALTH POL. POL’Y & L. 1099 (1999).