

Health Care Consumer Protection and Physicians: Be Wary What You Ask For

Introduction

Suppose that your first patient of the morning greets you by asking how much you earned last year and what specific training and experience you have in treating her condition? What if she asks for a copy of the written protocol you intend to follow in treating her condition and for the opportunity to review your treatment plan beforehand? Before you even start the examination, what if she demands a complaint form that could be filed with the state Insurance Commissioner in case she's dissatisfied with the way she's treated?

Sound preposterous? It probably is. But those are the kinds of disclosures and protections state and federal legislators are being told that consumers need to be wise and happy patients. And who's responsible for planting such fantastic notions? It's probably not the culprits you'd expect. Nor would Oregon and Washington, where managed care systems have thrived for decades, seem likely fields for such ideas to take root.

Following several years of extensive health care reform efforts in Oregon and Washington, by 1997 both states moved their primary policy targets from containing costs and expanding coverage for the uninsured to the concerns of providers. While not a cataclysmic change, this shift occurred when physicians and other providers reacted to the heat they were feeling from care management strategies that sought better care for less money by demanding that government protect their clinical and financial interests. The rhetoric of consumer and patient benefit demonized managed care in the public eye, fanned "anti-managed care" sentiments, and undermined patient confidence—not just in insurance bureaucracies, but in physicians and other caregivers themselves.¹

This article summarizes recent health care consumer protection legislation in Oregon and Washington State. Both states modeled their legislation after proposals from the National Association of Insurance Commissioners (NAIC), the private association that represents state insurance regulators. But these models aren't just about "insurance." Because they strike close to the heart of the clinical practice of medicine, directly affecting the relationships between physicians and their patients and among physicians, they should be of considerable concern to physicians who care for patients and their profession. And because the managed care market is so advanced in these two states, what occurs in these legislatures should be instructive to physicians in other states where Permanente physicians practice.

National Patterns For Health Care Consumer Protection

The nation's health policy cauldron came to a boil in 1993-94 with President Clinton's push for enactment of his Health Security Act. Seeking a policy agenda (other than the President's) to support, the American Medical Association (AMA) developed a model state law that sought "strong policy positions calling for regulation of managed care plans to assure fairness to patients and providers." This strategy, called "Patient Protection" by the AMA (and "Physician Protectionism" by detractors), contained four elements:

- "Patient Protection" standards to assist consumers in making health plan selections. These standards encompassed issues like benefit coverages and exclusions, prior authorization and other review requirements, financial arrangements and provider contracting, and enrollee satisfaction.
- "Physician and Provider Fairness" standards addressing credentialing, involvement in medical policy development, contracting restrictions and medical information confidentiality.
- "Safeguards in Utilization Review" including federal standards for utilization review programs and for certain medical decisions.
- "Patient Choice" including mandatory "point-of-service" coverages for "limited access" plans, but also mandating that patients have a range of health plan options, including HMO and other managed care plans, available to choose from.²

Like viruses, these ideas spread quickly through state and federal legislative bodies. Although attacked by organizations like the Group Health Association of America (now the American Association of Health Plans), they were validated by other groups, including the National Association of Insurance Commissioners (NAIC). Spurred to reaction, NAIC shifted its emphasis from regulatory concerns over financial matters and insurance reform to consumer disclosure and protection activities into high gear.³

By 1996, NAIC had produced state "model" laws addressing most of the AMA's concerns, including quality assessment and improvement, managed care plan network adequacy, health carrier grievances, and utilization review. In addition, NAIC also focused on models involving health information confidentiality, data reporting, and consumer disclosures. These recommendations set a foundation for a state regulatory framework addressing consumer concerns with health care. At the urging of physicians and regulators, Washington State and Oregon jumped on this new regulatory bandwagon.

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BRUCE BISHOP, who has represented Kaiser Permanente's Northwest Division in the Oregon and Washington legislatures since 1987, is a lawyer in the Salem offices of Harrang Long Gary Rudnick, PC. He is a former Oregon legislative staffer, a graduate of Hastings College of the Law (J.D., 1973) in San Francisco and of Pacific University (B.A., 1968) in Forest Grove, Oregon.



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Northwest states could have joined—or even led—other parades. In contrast to NAIC’s state regulatory approach, the National Committee for Quality Assurance (NCQA) offers a nongovernmental approach to improving health services through a voluntary accreditation program for health care systems. As explained to a Washington State legislative committee in January 1997:

NCQA’s mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality.

We do not see ourselves as a replacement for government oversight of health plans. Instead, we view our work as complementing the function of government by empowering purchasers, both private and public, individual and commercial, with information to guide choice based on both cost and quality. Absent reliable information on health plan quality, purchasers and consumers will buy on price alone.⁴

While covering many of the same issues as the NAIC model laws, the NCQA accreditation process focuses on six categories of standards for managed care systems, including quality improvement, physician credentialing, members’ rights and responsibilities, preventive health services, utilization management, and medical records.⁵

By early 1997, Kaiser Permanente also had drafted detailed reform principles that addressed a blend of consumer and provider protections reflecting both NAIC regulatory and NCQA accreditation approaches. Kaiser Permanente’s recommendations address access, choice of health plans, confidentiality, continuity of care, health plan disclosure, emergency care, experimental treatment, drug formularies, loss ratios, grievances, nondiscrimination, out-of-area coverage, performance measurement and data reporting, provider communication with patients, provider credentialing and statutory contract rights, provider reimbursement, quality assurance, and utilization management.

Northwest Cycles of Health Care Reform

Over most of the past decade that this author has tracked state health care legislation in the Pacific Northwest for Kaiser Permanente, public officials’ concerns with health and medical care issues have focused principally on two facets—cost and access, and they’ve responded with market or regulatory strategies.

In the 1980s, both Oregon and Washington had elaborate “health planning” systems that relied heavily

on certificate-of-need programs and health care cost reporting systems to control health care costs.⁶ By the end of the 1980s, market strategies had moved to center stage, and most regulatory controls were shelved, either directly by repeal of their authorizing laws or indirectly by limiting the fiscal resources available to operate them. Whether these regulatory programs had worked or not, they were largely replaced with concerns about access to services, particularly for the uninsured.

More recently, Washington State and Oregon have gained national reputations for enacting and implementing innovative health care reforms. In 1987, for example, Washington established its Basic Health Plan (BHP), a state-funded program to subsidize health coverage for low-income residents. In 1989, Oregon created the Oregon Health Plan (OHP), substantially increasing the number of Oregon families eligible for Medicaid while also mandating that all employers provide health benefits coverage.⁷ In 1993, Washington adopted a landmark “managed competition” reform to achieve universal coverage; Oregon obtained federal approval to make its expanded Medicaid program a reality. Both of these reform strategies relied heavily on managed care, particularly group, staff, and independent practice model HMOs. In fact, it’s probably safe to say that neither state could have advanced its expanded health care access programs without such delivery systems being both well-established and willing participants.

The Washington State Experience

Washington State’s recent health policy ventures help to illustrate how provider and purchaser conflicts can affect state health policies, swinging them from one extreme to another. The state reached its apex as a health policy innovator in 1993, when the Health Services Act massively overhauled the state’s systems for delivering and financing medical care. This law, in many respects, attempted to blend both market and regulatory approaches and, by and large, garnered support from most health care interest groups in the state. When, during the summer and fall of 1994, national health care reform efforts failed and major changes in federal and state legislative control occurred, Washington State’s reforms fell from favor, particularly with the business community, which objected to the law’s expectation that all employers would be required to offer health benefits to employees and their families.

After Washington health policymakers in 1995 dismantled the 1993 reforms, they left in place two features believed to be popular. The first involved making individual health coverage more accessible. The



second required that health plans offer “every category” of licensed providers’ services. While they had been minor matters in legislative debates initially, both of these surviving issues took on new significance when the 1997 Washington legislature turned to protecting patients and providers.

In 1996, a Washington Deputy Insurance Commissioner active in the NAIC’s deliberations on new managed care regulations announced that the office was considering the adoption of new administrative policies regulating managed care. To get input on the rules, three panels were created, one including health care providers; one including purchasers and consumers; and one including health insurers and health plans. Using the NAIC model laws as a starting point and meeting independently, the groups were invited to adapt the NAIC models to their liking. By fall, it was evident that the process was unworkable, and with the legislature’s 1997 session approaching, this administrative venture fizzled.

In January, legislative attention turned to HB 2018, a proposal that touched most of the areas of managed care and health care consumer protections embraced by the AMA and the NAIC models. Although it started its legislative life as a “marketplace stabilization” proposal that attempted to modify the state’s individual market reforms, it quickly attracted other amendments. Within the first month, the legislation also addressed utilization review, grievance procedures, and provider network requirements for health carriers. Subjected to extensive wrangling throughout the session, the legislation was approved and sent to Governor Locke. Instead of accepting the legislative compromises, the governor vetoed most portions of the law, including the new requirements for managed care disclosures and standards. His veto message noted:

“I have vetoed sections 101 through 108 and section 111, which create standards for grievance procedures, utilization review and access plans for health carriers. Those sections “deem” compliance with the national organization standards of the National Commission on [sic] Quality Assurance (NCQA) to be sufficient to meet the standards contained in the bill. This would be a direct violation of *Woodson v. State*, 95 Wn.2d 257 (1980), which prohibits delegation of legislative power to nongovernmental entities ... I am not opposed to looking at the use of national standards on these issues in a constitutional manner.”

Just recently, the Washington Insurance Commissioner’s office has published a notice that it’s

intending to gear up its rulemaking apparatus this fall to address managed care issues, indicating that there will be at least one more round of discussions on the topic.

The Oregon Experience

Oregon’s health care reforms, while often controversial, generally have been less battered by political wind changes than Washington’s. From its legislative origins in 1989, OHP efforts to expand health coverage have generally enjoyed broad support from health care interests⁸ and legislators in both parties.⁹ In 1992, the Bush Administration refused to grant Oregon the waivers necessary to launch the OHP expanded Medicaid program, citing concerns that its proposed “prioritization” of benefits could be detrimental to the disabled. Early in 1993, however, the Clinton Administration concluded otherwise, allowing the program to become operational in 1994.

During the 1995 legislative session, one of the most contentious legislative debates over health care policy was spearheaded by the Oregon Medical Association. The OMA introduced its version of “patient protection” legislation as SB 979 and proposed that the state regulate matters involving medical service contracting, enrollees’ changing primary care physicians, mandatory “point-of-service” coverages, grievances and appeals, use of medical records for peer and utilization review purposes, and the setting of utilization review standards. Although it became law, the bill was poorly drafted¹⁰ and probably has had little substantive impact on or been of any discernible benefit to patients or providers. Nonetheless, this law formed the foundation for Oregon’s debates in 1997 to protect consumers of health services.

In the fall of 1996, while three significant ballot measures affecting health care issues were being debated—the tobacco tax, provider compensation, and provider category mandates¹¹—the Oregon Department of Consumer and Business Services circulated draft legislation on health care consumer standards. This proposal authorized the department to set standards and disclosure requirements for managed care plans by administrative rule. When the 1997 Oregon Legislature convened in January, the DCBS bill (SB 96) was only one of several offered to the legislature. In the group were legislative proposals from at least three individual legislators, including SB 21, sponsored by State Senator Jeannette Hamby (R-Hillsboro); from Oregon’s medical and nurse associations, and from a national organization of women legislators. To reconcile these various proposals, the leaders of the two legislative committees responsible for health care issues agreed to convene a work group

composed of providers, employers, consumers, and insurers, asked the state Insurance Commissioner and OHP Administrator as co-chairs of the group to draft legislation, and gave the group eight weeks for the task. In response to this "opportunity," the work group proceeded to chew over a plateful of health care consumer protections, ultimately producing amendments that became SB 21.

If one measures a legislative strategy's success by the number of votes it generates, this process worked. Once the work group had finished its deliberations, the amended bill was considered briefly in committee and by the Senate and House, gaining unanimous approval without amendment. Signed into law by Governor Kitzhaber before the legislature even adjourned its regular session, SB 21 became Chapter 343, Oregon Laws 1997. In July, an advisory committee, composed of many of the same interests as participated in the legislation's development, was convened to make recommendations on implementation rules necessary to make the law work. These rules will be the subject of public hearing this fall.

Why "Consumer Protections" Matter to Physicians

Despite the different outcomes in 1997 between Washington's and Oregon's consumer protection legislation, the substance of both states' bills are remarkably similar.

For example, both bills contained language adopting a "prudent layperson" standard for health plan coverage of emergency medical services. (This provision was one of the few not vetoed in the Washington bill.) Similarly, both bills addressed consumer grievance and appeal practices, utilization review practices, and provider network disclosure requirements.

1. *Utilization Review.* In Washington's HB 2018, the legislature established standards for "utilization review," defined as the:

"... prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to a patient or group of patients."

As drafted, this provision would apply not just to "utilization review" activities by insurers and other "nonprovider" organizations but to physicians and medical groups as well. Among other requirements that would have become Washington law had the Governor not vetoed these provisions would have been a mandate that: "Review organizations shall maintain a documented utilization review program description and written utilization review criteria

based on reasonable medical evidence.... Review organizations shall make pertinent criteria available upon request to the participating provider involved in a specific case under review."¹²

While this language was probably intended to "protect" physicians from nonphysician reviewers, it intrudes as well on most physician decisions, consultations and referrals.

Oregon's SB 21 also sets "utilization review" standards, although they are definitionally limited to insurers and agents to whom they've delegated such reviews. The Oregon law requires that:

"Any patient or provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee."¹³

The law does not specify procedures that must be followed for such appeals.

2. *Physician "Gag" Clauses.* Considerable national attention has occurred in recent years over insurer contracts with physicians that prohibit (or "gag") physicians from discussing certain treatments with their patients. Oregon's SB 21 specifies in section 15 that insurers not "terminate or otherwise financially penalize a provider for":

"(1) Providing information to or communicating with a patient in a manner that is not slanderous, defamatory, or intentionally inaccurate concerning:

- (a) Any aspect of the patient's medical condition;
- (b) Any proposed treatment or treatment alternatives, whether covered by the insurer's health benefit plan or not; or
- (c) The provider's general financial arrangement with the insurer.

(2) Referring a patient to another provider, whether or not that provider is under contract with the insurer. If a provider refers a patient to another provider, the referring provider shall:

- (a) Comply with the insurer's written policies and procedures with respect to any such referrals; and
- (b) Inform the patient that the referral services may not be covered by the insurer."

Again, while these provisions are undoubtedly motivated by the desire to protect physicians from undue interference in their medical decisions from insurers' cost-containment strategies, they may also have the effect of requiring physicians to discuss with patients a number of matters involving contracts the physician and/or medical group has, not only with insurers but with other physicians as well.

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3. *The Adequacy of Provider Networks.* A third example of the ways state “consumer protection” standards may affect physicians’ professional practices involves “network adequacy,” a topic addressed by both Oregon’s and Washington’s 1997 legislation. Sections 109 and 110 of Washington’s HB 2018 (provisions vetoed by the Governor) only would have directed that a study be conducted on the need for network adequacy requirements and specified the topics to be addressed. Section 111 (also vetoed) would have required “access plans” to address network issues, by providers’ “... license, certification, and registration type and by geographic location....” Oregon’s network adequacy requirements are contained in SB 21’s section 3 and require disclosure to enrollees of: “Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available, and a description of any limitations on the ability of enrollees to select primary and specialty care providers.”¹⁴

The development of specific requirements for satisfying these requirements is one of the tasks that will be addressed in rulemaking this fall.

Conclusion

Who’s better off now that Oregon and Washington State health policymakers have addressed consumer protection and managed care standards? In all frankness, Washington’s citizens probably are because that state’s legislation was nullified by its Governor’s veto pen while Oregon’s law is just beginning to take shape. Whether either state’s ventures in this area will take to heart the physicians’ credo to “Do no harm” remains to be learned. The risks seem great that state legislative decisions like Oregon’s and Washington’s attempts to protect health care consumers will end up falling far short of their intended goals, creating unexpected results and burdening physicians with more regulation. ❖

References

1. For example, an article in the newsletter of the Multnomah County Medical Society, describing Oregon’s 1995 “patient protection act,” was headlined “New law takes stab at managed care.” (The Scribe, August 4, 1995.) Blurring important differences between providers and patients, the Oregon Medical Association claimed that the law would “set up basic rules

about how patients and physicians are treated in managed care.” Similar salvos were being fired at managed care in the general media.

2. American Medical Association, “Patient Protection Act - Model State Legislation,” memorandum from Kelly. C. Kenney, Assistant Director, Department of State Legislation, to State Legislation Contacts, June 30, 1994.

3. At least in part, this was probably done to shore up state insurance regulators’ oversight over health plans, since some versions of federal health reform being debated in 1994 would have transferred many regulatory responsibilities from state to federal officials.

4. National Committee for Quality Assurance, “Statement for Work Session on Managed Care Regulation,” from Stephen N. Lamb to Senator Alex Deccio, Chair, Senate Health and Long Term Care Committee, January 14, 1997.

5. Ibid.

6. In fact during this period, Washington had one of the few hospital rate-approval mechanisms in place in the country.

7. Interestingly, physician-legislators spearheaded both of these initiatives. The BHP’s “father” was then-State Senator, now U. S. Representative Jim McDermott, MD. The OHP was championed by then-State Senate President, now Oregon Governor, John Kitzhaber, MD.

8. Key and consistent supporters of the Oregon Health Plan have included provider organizations like the Oregon Medical Association and the Oregon Association of Hospital and Health Systems; business interests, including Associated Oregon Industries; and health carriers, including Kaiser Permanente and Blue Cross and Blue Shield of Oregon.

9. Designed by then-Senate President John Kitzhaber, a Democrat, the Oregon Health Plan was sustained by Senator Greg Walden, a Republican, in 1993, during the time that Kitzhaber left the Senate in 1992 and became Governor in 1995. Ironically, Walden had opposed the Oregon Health Plan in 1989; as a first-term minority-party state representative, Walden unsuccessfully attempted to strip the “employer mandate” from the Plan. That feature of the plan was abandoned entirely in 1995, after Congress failed to allow states to require employers to offer health benefits.

10. For example, SB 979’s provisions on “medical service contracts” refer to “the other party” to the contract without ever defining who such parties are. Similarly, the law subjected insurers’ contracts with providers to enforcement by state insurance regulators, but provider contracts between physicians or between hospitals and physicians were enforceable only in court, resulting in virtually no additional protection for contracting providers.

11. Ballot Measure 44 proposed to increase tobacco taxes substantially in order to maintain and expand the Oregon Health Plan. Ballot Measure 35 proposed to prohibit certain types of provider compensation arrangements, possibly including “capitation.” Ballot Measure 39 proposed to require “all categories” of health care providers be available through all health plans. Oregon voters approved the tobacco tax, but rejected the other two measures.

12. HB 2018, State of Washington, 1997 Regular Session, section 102.

13. Section 4, subsection (2)(c).

14. SB 21, section 3, subsection (5)(L).

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