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Who Is Holding Whom Accountable For Quality?

A review of current and emerging accountability mechanisms for quality care in managed care systems.

by Alice G. Gosfield

PROLOGUE: In the first half of 1996, some thirty-three states enacted laws to provide consumers of managed care health services with stronger protections. These laws involved such issues as access to specialists, “gag rules,” emergency care, appeal rights on wrongful denial of care, and maternity length-of-stay requirements. And a bipartisan bill to bar health maintenance organizations from imposing “gag rules” on physicians’ ability to share full treatment information with their patients nearly passed in the closing days of the 104th Congress. These and other “anti-managed care” laws are but one mechanism—albeit a controversial one—available to improve accountability for quality of care within the managed care sphere. Here, author Alice Gosfield neatly lays out the range of techniques now used for holding managed care accountable.

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ABSTRACT: The debate over accountability for managed care quality is occurring everywhere, from Congress and state legislatures to courtrooms and boardrooms. This paper reviews a variety of today's techniques for holding managed care answerable for quality, ranging from those grounded in the law to more market-based approaches, including accreditation and commerce in data about plan performance. Today, there is some dissonance between purchasers' rhetoric about quality and their actual buying behavior. Eventually the discussion of accountability for quality may really be joined when the baby boomers become the consumers of this system and not just its financiers.

THE EXTENT TO WHICH managed care as both an industry and a technique for providing health care services is answerable for the quality it produces is of increasing concern. Accountability in managed care entails a wide range of issues, from plans' responsiveness to customers' complaints, press reports, and purchasers' demands on the one hand, to direct legal controls over managed care behavior on the other.

Responsibility for those activities for which a managed care entity or health plan may be held accountable is spread across a web of relationships. A managed care organization—whether a true health maintenance organization (HMO), an insurance company, or a self-insured plan offering a plan of managed care benefits—contracts with a network of providers, from individual physicians to highly intricate integrated delivery systems. Each contributes to the presence or absence of quality. How the managed care entity is held accountable for the actions of its constituent parts depends on a variety of control and evaluation techniques. Some techniques are grounded in law or legal principles, while others reflect different mechanisms of control or measurement.

Some accountability mechanisms have emanated from the industry itself. These are found primarily in the self-regulatory systems of managed care contract provisions, which govern the providers that directly produce clinical quality, as well as through managed care accreditation programs, which began as voluntary efforts of the industry but now are increasingly linked to regulation. Regulation—primarily at the state level—both establishes threshold qualifications for managed care entities to do business and prohibits undesirable behavior. It is flourishing in a variety of formats as managed care spreads from coast to coast.

Perhaps the most dramatic public example of managed care accountability for quality comes in the form of tort verdicts. Liability for damages resulting from lawsuits over bad outcomes for patients not only penalizes the entity held responsible but also sends a chilling effect through the industry. This in turn stimulates risk-management behavior in those who seek to avoid similar problems.

Besides responding to directly imposed accountability, the health care market exercises its own influence when purchasers vote with their dollars and their feet by selecting plans that demonstrate the value-driven behavior buyers increasingly demand. In response, the managed care industry is generating a plethora of data to demonstrate its clinical integrity in providing vital health care services. Some of these, such as single-company report cards, are the industry's own efforts to demonstrate its capabilities on these fronts. Others, such as accreditation status reports, Health Plan Employer Data and Information Set (HEDIS) measures, new performance measures, and cross-plan report cards, increasingly represent joint efforts between the industry and purchasers to make managed care plans more accountable.¹

A related concern is the extent to which one type of managed care accountability for quality will predominate. Answering to multiple masters, some of whom are sending mixed messages, presents both operational and strategic problems for managed care organizations that seek to perform well. Whether regulation and external controls will stifle market innovation is a typical industry concern, whereas those who would impose controls are worried about whether there is a baseline of quality below which managed care should not be permitted to operate.

This paper examines the principal mechanisms of accountability for quality currently in play, including two grounded in the law (case law and state and federal regulation) and two that are based in market competition (self-regulation through accreditation, reporting programs, and contractual controls over provider networks; and market influences in purchasing choices, demand for data, plan advertising, and press reports). It then considers some of the questions raised regarding the impacts of these techniques and what the future may bring for these efforts.²

Case Law

To date, the case law holding managed care organizations liable for bad outcomes to patients has been relatively limited and somewhat equivocal in its teachings. Although high-profile cases, such as *Fox v. Health Net*, which resulted in an \$89.9 million verdict, and *Ching v. Gaines*, with a \$3 million result, have garnered significant attention in the lay press, the visibility of these cases is not commensurate with their significance to the lawyers who are working on these issues.³ The legal community has seen the courts' inexorable trend toward confirming managed care organizations' legal responsibility for the care provided to patients. Predicated on traditional theories of ostensible agency, *respondeat superior*, and corporate negligence,

more and more cases hold that because of the direct relationship between the managed care organization and the individual (the health care provider) who caused the harm to the patient, the managed care organization can be held liable.⁴

Other cases have attempted a frontal assault on the utilization controls and financial incentives that also characterize managed care. These have been considerably less successful. Although lawsuits based on these claims have proceeded past the summary judgment stage, the number of instances in which verdicts have been assessed and upheld on appeal is decidedly small.⁵ Two principal cases are most often discussed in this context. In *Wickline v. State*, the patient was discharged after four days' postoperative hospitalization. She suffered the amputation of her lower leg and won a \$500,000 jury verdict when she sued the plan for premature discharge; the verdict was later overturned on appeal.⁶ In *Wilson v. Blue Cross of California*, the family of a discharged psychiatric patient who committed suicide sued not the hospital or physicians but the insurer and the utilization review company.⁷ In both cases, the courts held that managed care organizations could be held liable as a matter of law, but in neither case were damages ultimately imposed. Other cases confronting the financial incentives of managed care under a variety of theories have not fared as well in the courts or have been settled before a trial verdict.⁸

Confusing the accountability which courts would otherwise impose, the Employee Retirement Income Security Act (ERISA) has had surprising effects. Because ERISA was designed primarily to make retirement plans accountable to their pensioners, the remedies available to aggrieved claimants are limited to the benefit that the plan should have provided. When the matters at issue are only dollars in a bank account, this system, which preempts state law on the same issues, makes sense. In the context of health care services, however, where the benefit may be access to the hospital or the right to have a procedure performed and paid for, the so-called benefit determination has ancillary consequences that may have a direct impact on a patient's health. For about five years the case law fairly consistently held that where the plan denied benefits and patients were thereby harmed, there was no remedy in state court (that is, punitive tort damages), and often there was no consideration as to the propriety of the plan's decision.⁹ This situation has begun to change very recently, and the ultimate outcome is as yet unknown.

In 1995, in *Dukes v. U.S. Healthcare*, instead of challenging the benefit denial (the omitted services that led to the harm), the plaintiffs complained that the managed care organization had an ongoing responsibility to select and then monitor the performance of its contracted

“Regulation has emerged as a significant force for managed care accountability for quality.”

network of physicians; based on a failure to perform this duty effectively, the managed care organization should be held liable.¹⁰ The Third Circuit Court of Appeals agreed, finding not only that the managed care organization could be held liable for the actions of its contracted physicians, but that this obligation had absolutely nothing to do with benefit determinations and was therefore not preempted by ERISA. The case was remanded for trial in state court. An increasing number of cases have followed this line of reasoning.

Taken together, managed care organizations’ legal responsibility for the quality results of their contracted physicians is more and more obvious. Whether a direct judicial challenge to financial incentives or utilization controls eventually will succeed remains to be seen. Nonetheless, malpractice carriers are reporting both increases in these types of complaints and new ones focusing in particular on the actions of the primary care gatekeepers in determining access to specialty services and other ancillary and provider services.¹¹

Managed care organizations respond to verdicts in an *ad hoc* fashion, which sometimes depends upon the relationship of the plan management to its counsel and still further upon the type of counsel. Whether managed care organizations change their overall behavior in response to case law has not been reported to date, in part because there is such lag time from the harm suffered by the patient, to the filing of the lawsuit, to the determination of the interlocutory (preliminary) issues, then to the trial (if the case survives a motion for summary judgment), and then finally to appellate court decisions, which provide the real guidance to the industry. Given this extraordinary delay and isolated impact, regulation has emerged as a significant force for managed care accountability for quality, across an expanding spectrum of concerns.

Regulation

The most fundamental accountability technique at the state level has been the establishment of basic requirements for a managed care organization to be licensed to do business. States vary greatly in the extent to which they regulate for quality in that process. Some states impose access and availability requirements on clinicians. A minority now require some type of external quality audit and will deem this standard to be met based on accreditation by a recognized entity. Still others require certain types of quality-relevant data re-

porting.

A more recent and growing phenomenon is the extent to which states are now looking below the level of the licensed HMO itself to those who do business with it, particularly where those entities assume financial risk for care.¹² Establishing the predicates for risk assumption by the new entities emerging to do business with plans—including physician organizations, physician/hospital organizations, and integrated delivery systems—is beginning to proliferate nationally. Although much of the focus to date has been oriented to maintaining the financial viability of these entities to assure continued consumer access to services, in some states, notably Pennsylvania, there has been much attention to credentialing and quality issues and the extent to which an HMO maintains direct responsibility for the delegated actions of its constituent provider networks.

The link between regulation and previously unregulated initiatives also is more evident. Incorporating accreditation into regulation has taken a variety of forms, but in its most extreme manifestation in Florida, accreditation is a cost of doing business. There, HMOs cannot be licensed unless they are accredited.

■ **Anti-managed care laws.** It is, however, in the arena of the so-called anti-managed care laws that regulatory accountability has been most aggressively imposed.¹³ These laws are always the result of a concerted lobbying effort by aggrieved parties who are seeking redress for perceived inequities or, sometimes in the case of managed care, direct injury. The first enactments so labeled were predominately “any-willing-provider” statutes. These laws cut at the selective nature of the networks by requiring them to accept as providers any members of the designated categories who were both willing to accept the plan’s rates of payment and able to meet its initial criteria. Proponents of these laws argue that they protect quality by ensuring patients access to their chosen provider. Managed care organizations counter with the position that a major virtue of managed care is a network selected on the basis of quality. There are disputes about the extent to which quality-based judgments truly drive provider selection and termination. As physicians seek to develop their own organizational structures to enter the competitive fray, the popularity of any-willing-provider statutes seems to be on the wane. Some speculate that this reflects the realization that when physicians manage their own networks, they behave more like managed care organizations and want to be selective themselves.

The new anti-managed care laws address different issues. In some ways, they speak to concerns over the secrecy that has charac-

terized much in the business of managed care. Anti-gag clause provisions—requirements to disclose to patients physician financial incentives, utilization review criteria, and clinical practice guidelines—are all examples of this type of law. The quality nexus here lies in whether those who are choosing a plan or contracting with it understand the full scope of the implications of the relationship.

Other legislative and regulatory approaches deal with the way in which benefits are provided when care management is seen as impinging on quality. Examples include postpartum length-of-stay mandates, required direct access to obstetrician/gynecologists, point-of-service mandates, and regulations that require that circumstances in which a reasonable layperson would believe he or she is in need of emergency care should be recognized as emergencies by the plan, even if in hindsight the situation was not urgent.

Managed care organizations have demonstrated vocal and defensive reactions to some of these efforts, including public relations campaigns by some to distinguish themselves from others that engage in such undesirable behavior. At the same time, however, some managed care plans decry the fact that certain of these controls cut at the “proprietary” or “trade secret” aspects of how they do business. These anxieties are decidedly overblown. Plans all know each other’s techniques. They all operate within a large middle pathway, and there are virtually no trade secrets about managing care to be had in the industry. Whether the mechanisms that “manage” care should be held confidential has been called into question in many corners of the industry. Can accountability proceed in the face of secrecy? Recent trends in state-level initiatives seem to indicate public distrust of this position and the belief that quality is undermined in an environment that is not open.

■ **Federal government accountability.** At the federal level, where the Medicare and Medicaid populations are primarily at issue, the record of the government regarding plan accountability for quality has been spotty. Twenty years ago, when managed care was still described as “alternative delivery systems,” Congress’s decision to stimulate HMO development represented a pioneering initiative. Some quality controls were imposed through federal qualification. As the market has moved far beyond the world of 1973, the role of the federal government has been fairly weak. The peer review organization (PRO) program has been the principal federal approach to quality control in Medicare hospitals, but its reach also extends to Medicare HMOs.¹⁴ The program has been subject to broad-based criticism and major refurbishing in the fee-for-service sector. But PROs have been essentially irrelevant to the managed care world, although administratively burdensome. Although federal qualifica-

tion continues to be of interest to some plans, the power of the “dual-choice” option has been undermined by the greater strength of the market’s move toward managed care.¹⁵

As part of the quality concerns associated with managed care generally, the federal system has recently shifted its energies into new sorties pertaining to fraud and abuse. Most of the fraud enforcement has been focused primarily at plans’ marketing tactics or misstatements regarding federal dollars to be collected, with so-called intermediate sanctions imposed as a result. The two primary regulatory initiatives include the managed care “safe harbor” regulations issued under the federal antikickback statute and the physician incentive plan regulations.¹⁶ The safe harbor regulations specify those limited transactions that the government believes may tend to induce referrals in exchange for economic benefit but will not be seen as violating the antikickback statute. The managed care safe harbors are for the most part superfluous from a quality perspective, focused as they are on the potential for overutilization—hardly the primary risk in managed care systems. They predominately address the right of providers to discount their services to obtain business from plans.

The physician incentive plan regulations define the thresholds of financial risk assumed by physicians in Medicare managed care plans beyond which those plans must provide special protections to safeguard against underservice. In that sense, they are a quality-accountability mechanism. Whatever their motivation—and they are mandated under several sections of the law, including the Stark amendment as well as the Medicare HMO qualification provisions—their original publication was roundly derided by the industry as heavy-handed and the premises upon which they were based, out of date.¹⁷ The government originally announced a 28 May 1996 implementation date, which was pushed back to 1 January 1997. Revised regulations were issued one day before the effective date.

Perhaps the most creative federal accountability efforts can be seen in the rising concern among federal prosecutors for managed care underservice as a form of false-claims liability. Since the submission of a single false claim is punishable by between \$5,000 and \$10,000 per item claimed plus triple the charges, false claims in managed care in the form of underservice are likely to be a far more significant prosecutorial issue in the future. A recent settlement in the Eastern District of Pennsylvania demonstrates this approach’s potential for translating a fundamental quality failure into a false claim. A major nursing home chain paid a \$565,000 settlement to avoid the costs and risk of litigation in a case in which the U.S. attorney charged that failure to care for patients (primarily by not

feeding them sufficiently) allowed bed sores to develop and the resulting open wounds to fester. Seeking reimbursement from Medicare for the services provided amounted to a false claim, since the services that would have prevented these problems are intrinsic to providing skilled care and obviously were not rendered. The settlement agreement required the nursing home to adhere to the Agency for Health Care Policy and Research (AHCPR) guidelines for treatment of decubitus ulcers.¹⁸

Whether in the data about quality submitted to produce federal payments or in applications to obtain Medicare payments, these false-claims cases undoubtedly will increase over time. Combined with the now almost traditional uses of the mail fraud and conspiracy statutes, federal fraud and abuse prosecutions will be a developing arena for managed care quality accountability.

Accreditation

The process of accreditation traditionally has been a technique to differentiate qualified performers from those that cannot meet the accreditation standards. Whether in the hospital context or even in the accreditation of health care professionals, these initiatives are usually self-regulatory and emerge from the industry itself. In the managed care arena, the inception of accreditation was similar but has now moved in a different direction.

There are now five accrediting bodies that play a significant role in the managed care world. They appear to be directed at different segments of the industry, although because of the relative novelty of their implementation, the lines are blurring in both the entities available to be accredited and the extent to which each accrediting body stays within its own bailiwick.

First, the National Committee for Quality Assurance (NCQA) focuses primarily on state-licensed managed care plans that provide comprehensive benefits to defined populations. The NCQA also has recently begun a process to certify credentialing-verification organizations and has issued standards for behavioral health organizations. Second, the Accreditation Association for Ambulatory Health Care (AAAHC) focuses primarily on ambulatory care delivery sites, including clinics and ambulatory surgery centers. Third, the Utilization Review Accreditation Commission (URAC) has two accreditation programs—one for utilization review entities and one for provider networks. The network standards have been the subject of some volatility; they were issued, revised, and reissued after URAC purchased a preferred provider organization (PPO) accreditation program. The utilization review program is far more established than is the network review. Fourth, The Medical Quality Commis-

sion (TMQC) surveys medical groups and individual practice associations that provide care in a capitated or prepaid setting. This group's base of strength is in California, so the extent to which its influence will expand nationwide is not yet known. Fifth, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recently relaunched a network accreditation program.

All of the accreditation organizations encourage their approved subjects to market their accredited status. Accreditation itself is intended to demarcate a different level of performance, but the sheer numbers of NCQA-surveyed managed care organizations—the NCQA has now surveyed about half of the HMOs in the country—by comparison with the newer programs makes it difficult to assess the extent to which the public perceives any differences among the accreditation programs or their significance.

The real power of the accreditation process is in its link to purchasing opportunities. Where employers, or state agencies on behalf of their employees, mandate accreditation for a plan to be offered to their subscriber population, plans will move to make themselves more accountable by seeking accreditation. Apparently, only major employers have used this mechanism to a significant degree, although it is now beginning to filter down to smaller and middle-size employers too. Nonetheless, when the NCQA put its accreditation status list on the World Wide Web, it received between 5,000 and 6,000 hits per month. Information about quality performance is escalating in both quantity and quality as a means of motivating plan behavior and quality performance.

Performance Measurement

Data reporting is developing as a major technique of accountability. Starting with HEDIS 2.0, which has now been clinically intensified in the newer version of HEDIS 3.0, employers, business coalitions, and others began asking plans to report their performance in terms of the common measures that HEDIS encompasses. This project, which was created to eliminate the disparate requests for proposals and other data demands directed at plans, has now been joined by the separate efforts of the Foundation for Accountability (FACCT), an organization primarily of consumer and purchaser representatives seeking to develop new performance measures for managed care, especially those that are “patient centered.”¹⁹ With a HEDIS version specifically for Medicaid as well, plans are asked to report a growing number of measures. There is debate over the quality of some of the measures themselves, the cost to and capacities of the plans to produce the information, and the validity of the data reported.

“Those in the know routinely report that plans will turn themselves inside out to be able to report ‘good’ HEDIS data.”

Other data-generating enterprises also are emerging. In its recently issued *Quality Compass*, the NCQA is now selling a database that links accreditation status with plan-reported HEDIS data. In the NCQA national cross-plan report card, HEDIS data were validated externally from the plans themselves. Business coalitions and state agencies all around the country are offering disparate comparative data not only about plans but now extending to individual physicians, hospitals, and networks.

As for other types of information, consumer satisfaction data are burgeoning throughout the industry both in response to purchaser requests and because plans are seeking to attract buyers. Although these data undoubtedly are relevant to quality, in that access and availability of care as well as doctor/patient interactions directly affect the ability to get proper services, they probably have less meaning in clinical terms than their prominence would appear to indicate. Outcomes data, while frequently described, are not evident in their purest form. While there are, within HEDIS data and the FACCT measures, some statements that reflect patients' perceptions of treatment impact, this is not the same as true clinical outcomes, which remain a sought-after goal.

There are unquestionably problems with plans' capabilities to report data. Anecdotally, those in the know routinely report that plans will turn themselves inside out to be able to report “good” HEDIS data. These data apparently come at the expense of other parallel quality initiatives. Whether FACCT measures will stimulate the same behavior, whether the plethora of measures eventually will undermine their validity, and whether there is any way for purchasers to distinguish the quality of one set of measures from another (if such distinctions exist) cannot yet be determined, given the remarkable pace of developments in this aspect of the industry.

Contractual Provisions

As the newer forms of accountability flourish, the plans still relate to their networks of contracted providers in a way that seeks to hold them accountable while enhancing the position of the plan itself in a competitive environment. Beginning with credentialing, selection, and then termination of providers based on quality factors, the plans are more conscientious today than they were five years ago on these issues. Requiring providers to adhere to the plan's own quality-control

techniques in the form of clinical practice guidelines is also a reported mechanism. Although 87 percent of HMOs surveyed have said that they use clinical practice guidelines as a technique for monitoring quality, what they understand “guidelines” to be is questionable. The data appear to show that preventive health guidelines are often used to determine provider compliance; more process-oriented guidelines are not as evident.²⁰

Contract anti-gag clauses have been amended and expunged in the wake of widespread press reports about the pernicious potential of these provisions. On the other hand, provider access to the detailed requirements of all of the systems by which their quality is measured and to which they are required to adhere remains variable throughout the country.

Observations

As a purely cost-driven market appears to be fading into at least rhetorically a more value-oriented context, the role of quality in managed care purchasing has risen to the fore. The primary dilemma for plans has been the discontinuity between the rhetoric they hear in the press and state-legislated anti-managed care laws contrasted with the actual purchasing behavior of employers. The significance of quality-data dissemination, whether comparative or intrinsic, as a factor in plans' accountability for quality will depend directly on the extent to which purchasers act on what they see, recognizing that sometimes quality costs more.

One element of the system that is essentially invisible but appears to have great influence and thereby may undermine this type of accountability is the employee benefit industry, which advises employers on how to deal with the plans. Consultants differ in the extent to which they advise based on quality concerns or even perceive the quality implications of their advice (“just tell them you’ll pay 10 percent less in premium”). Evidence as to their accountability is elusive. Similarly, whether the actuaries who set the rates for plan premiums take into account quality-relevant factors (such as clinical practice guidelines) rather than utilization alone is also unknown.

Nonetheless, the American public has begun to examine more closely the inner workings of managed care. Much of the stimulation for this has come from horror stories in the popular press about managed care gone awry. With the burst of new quality-data initiatives on the scene, some of the more sensational journalistic endeavors have given way to more thoughtful pieces that contribute to the individual consumer’s understanding of the choices he or she faces in choosing a plan and of the more restricted managed care setting. Some of these press activities are seen by the industry as having

undermined managed care credibility; this in turn has led to public relations efforts on the part of the American Association of Health Plans as well as to plans' advertising the ways in which they do not engage in the criticized behavior. More plans tout their freedom of choice, preventive services, lack of gatekeepers, centers of excellence, and emphasis on customer satisfaction, not to mention physician satisfaction, with claims about their quality stated in sweeping terms.

Advertising aimed at the individual consumer is one manifestation of managed care accountability. However, because most plan purchasing decisions are made by employers, and the options they offer to their consumer constituencies are narrowing, consumer choice increasingly will be asserted at the level of the care system, the physician network, or the individual doctor. The question of whether plans' accountability for the quality of their care will come to full fruition will depend in part on how closely employers can match their choices to their subscribers' desires. Some of the expressed concern about managed care quality reflects patients' dissatisfaction with plan selections that were made without a full understanding of the systems that produce the cost-saving effects employers seem to prize. One result of this dissonance is agitation for state regulatory controls, which are then enacted hastily in response to primarily anecdotal evidence.

Physicians and other providers have tried to make plans accountable through legislative techniques as well, although recently they have begun developing their own competing plans and stronger provider networks have emerged. Interestingly, however, some recent data demonstrate that while physicians in developing managed care markets are sometimes suspicious of the plan controls they see in the California model, in that state's most evolved managed care markets some of the physician groups that are taking risk have themselves produced hospital utilization at 40 percent below the rates of their California managed care peers.²¹

The fundamental conundrum in any discussion of managed care quality, however, is whether we have a common definition of what we mean. Whether freedom of choice and open access to services represent quality is certainly subject to debate. The primary obstacle to solving the conundrum is a dearth of clear data to compare the quality of the traditional systems, to which many cling because it is familiar and therefore "the standard of care," with the quality of the newer forms of managing care, about which information is only now beginning to appear.

The emerging system of managed care accountability for quality is one of checks and balances. Buyers claim to exercise their pur-

chasing power in a way that makes known their concerns, and plans respond to the competitive threat. Individual consumers exercise some choice regarding their physicians and make known their grievances and dissatisfactions, which are then totaled up and compared. State regulators respond to constituency demands by curbing some of the approaches decried by practitioners, fearful both of their own exclusion from participation and their financial well-being as well as of the potential impact on their patients' health. The federal government seeks to protect the vulnerable populations for which it must advocate in the market, with dual strategies of fundamental requirements for plans to participate and chilling-effect regulations to punish misbehavior—all while Congress considers various types of anti-managed care legislation. Along the way, the courts decide individual facts and circumstances measured against legal principles of precedent based on an earlier reality.

■ **Is this working?** Since we have no common definition of what we are trying to accomplish in the move to managed care, where you stand on whether it is working depends on where you sit. In this transitional era the techniques in use today are fairly rudimentary and developing. They undoubtedly will become more sophisticated. What of the future? The greatest increase in accountability for managed care quality may lie in the inevitable health care needs of the baby boomer population. Today, they are merely financing the new approaches but are less often their immediate beneficiaries. Given their numbers and their purchasing power, demand for quality will likely increase when they themselves must use the managed care system they only pay for today.

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The author is a member of the board of directors of the National Committee for Quality Assurance (NCQA). The opinions here are exclusively the author's and should not be attributed to the NCQA in any way whatsoever. A version of this paper was presented at the Kaiser Permanente/Health Affairs conference, "Health Care Quality in a Time of Transition," in Washington, D.C., 16 September 1996.

NOTES

1. The Health Plan Employer Data and Information Set (HEDIS), a system of performance measures, now in its third iteration, was developed and published under the auspices of the National Committee for Quality Assurance (NCQA).
2. For a more detailed consideration of all these issues see, A.G. Gosfield, *Guide to Key Legal Issues in Managed Care Quality* (New York: Faulkner and Gray, 1996).
3. *Fox v Health Net* (Ca. Super. Ct., December 1993); and *Ching v Gaines* (Ca. Super. Ct., November 1995).
4. "Ostensible agency" is the theory that the treating physician is perceived by the patient as the agent for the plan, and his actions are then attributed to the

plan as having been on its behalf. See, for example, *Boyd v Einstein*, 574 A2d 1229 (Pa. Super., 1988). *Respondeat superior* is a principle, primarily in employment relationships, that the employer is responsible for the actions of the employee. See *Schleier v Kaiser Foundation Health Plan*, 876 F2d 174 (DC App., 1989).

5. The motion for summary judgment is that point at which the defendant tries to convince the judge that there is no need for a trial because as a matter of law the managed care organization cannot be held liable.
6. *Wickline v State*, 239 Cal. Rptr. 810 (1986).
7. *Wilson v Blue Cross of Southern California* (1990 Cal. Lexis 4574).
8. See *Teti v U.S. Healthcare* [1989 WL 143274 (E.D. Pa.)]; *Anderson v Humana*, 24 F 3d. 889 (7th Cir., 1994); and *Bush v Dake* (Mich. Saginaw County Ct., 1989).
9. See, for example, *Corcoran v Blue Cross of Louisiana*, 965 F2d 1321 (5th Cir.) *cert den* 113 S.Ct 812 (1992); and *Kuhl v Lincoln National*, 999 F2d 298 (8th Cir., 1993).
10. 1995 WL 361723 (3d Cir., Pa.).
11. L. Kertesz, "Data Signal Managed-Care Suits on Rise," *Modern Healthcare* (20 May 1996): 17.
12. D. Krane, "Assumption of Insurance Risk: Current Issues Affecting Managed Care Organizations," in *Health Law Handbook*, 1996 ed., ed. A.G. Gosfield (New York: Clark Boardman Callaghan, 1996), 71–88.
13. See R.L. Roth, "The Little Red Hen Syndrome: States and 'Anti-Managed Care' Laws," in Gosfield, *Guide to Key Legal Issues in Managed Care Quality*, 133–158.
14. This is the program under federal law that uses physician peer review organizations (PROs) across the country to monitor the quality of care provided primarily under Medicare and recommend sanctions, including exclusion from Medicare, for those hospitals and physicians who provide poor quality. 42 *U.S. Code*, sec. 1320c *et seq.*
15. The "dual-choice" option refers to the statutory requirement that where an employer offers a health benefit plan and a federally qualified HMO is available in that area, both plans must be offered.
16. *Federal Register* on safe harbor regulations, see 61 (25 January 1996): 2122. The physician incentive plan regulations, originally published at *Federal Register* 61 (27 March 1996): 13430, were significantly revised and reissued by the end of the same year. *Federal Register* 61 (31 December 1996): 69034 .
17. On the Stark amendment, see 42 *U.S. Code*, sec. 1395nn *et seq.* On the Medicare HMO qualifications, see 42 *U.S. Code*, sec. 1395mm(i).
18. The AHCPR was charged with the responsibility to publish national clinical practice guidelines. See 42 *U.S. Code*, sec. 299b-1; and Institute of Medicine, *Guidelines for Clinical Practice: From Development to Use*, ed. M.J. Field and K.N. Lohr (Washington: National Academy Press, 1992).
19. It is beyond the scope of this paper to consider these differences, but patient-centered measures look to patient surveys and interviews as a primary technique to determine the outcomes of care. This is a new and developing concept.
20. M. Gold et al., "A National Survey of the Arrangements Managed-Care Plans Make with Physicians," *The New England Journal of Medicine* (21 December 1995): 1678–1683.
21. J.P. Robinson and L.P. Casalino, "The Growth of Medical Groups Paid through Capitation in California," *The New England Journal of Medicine* (21 December 1995): 1684–1687.