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The public is clearly concerned about the state of the current health care system. When the private health insurance market turned away from the relatively unfettered and generous indemnity health insurance system to embrace the more restrictive and cost-conscious managed care system, patients worried that they would be denied needed medical services. Their suspicions have been fueled by high visibility denials and law suits. The public's worries have motivated lawmakers at both the state and federal level to introduce hundreds of bills over the past few years designed to provide patients with health care protections and rights. Most of the legislation that has been introduced or enacted attempts to regulate managed care organization; the ten "Patients' Bill of Rights" and managed care reform initiatives up for consideration in Congress this session regulate health plans exclusively.[1]

Critics have targeted the managed care organizations (MCOs) for reform because these companies constitute the visible face of America's new health care system. Because patients' access to health care services is mediated almost entirely through their managed care organizations, they perceive the MCO as the decision maker responsible for coverage

1. H.R.719.IH, 106th Cong., 2d sess. (1999); S.374.IS, 106th Cong., 2d sess.; S.6.IS, 106th Cong., 2d sess.; S.240.IS, 106th Cong., 2d sess.; H.R. 358.IH, 106th Cong., 2d sess.; S.300.IS., 106th Cong., 2d sess.; S.326.IS, 106th Cong., 2d sess.; H.R.448.IH, 106th Cong., 2d sess.; S.24.IS, 106th Cong., 2d sess.; H.R.216. IH; 106th Cong., 2d sess.

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decisions and therefore the villains in denials. If legislative attempts to provide patients with specific rights and protections remain narrowly focused on managed care organizations, the aim of reform will not be achieved. With narrowly focused reforms, there is no way to ensure patients are really guaranteed appropriate, cost-effective care. Scrutiny must be expanded to include those whose impact on health care coverage decisions, though less visible, is equally significant. In particular, employers must be brought into the equation. Employers exert a powerful influence on the health care industry because 64 percent of nonelderly working Americans get health insurance through their jobs (EBRI 1998b). This means that, to a large extent, employers control the type, amount, and quality of health insurance available to an individual.

While managed care organizations have done some egregious things, at times using crude denials to reduce costs, in many cases they only act as agents carrying the messages of employers and others. It is infeasible to expect insurers to be able to reform the health system when they are only one part of it and often lack authority or power. Effective protections for health care consumers will only be possible when all major players, including employers, are identified and held accountable.

Evolution from Passive Purchaser to Active Participant

Over the past decade, employers have emerged as the most powerful single force behind the health care revolution. Before the mid-1980s, employers acted primarily as passive purchasers of health insurance. But, as the cost of private health insurance per enrollee rose by 218 percent between 1980 and 1993, they maneuvered to take an active role in the health care industry (PPRC 1996). Unwilling to accept meekly the burden of mounting health care expenditures, business joined with health care reformers and initiated the drive to control costs.

Employers use health insurance as a tool to attract skilled employees and to keep them healthy, productive, and satisfied. The government encourages this practice with a substantial tax incentive designed to lower employers' cost of offering this benefit. But, as the price of health insurance went up and the cost of providing it absorbed an ever-greater proportion of business's bottom line, these positive incentives came into tension with a growing need to contain costs. An illuminating statistic is that employer spending on private health insurance rose from $61 billion in 1980 to $262.7 billion in 1996 (EBRI 1998a).

In the last five to ten years, employers initiated several strategies to control the costs of health insurance premiums. A few employers, particularly small businesses, felt their bottom line was so eroded by health insurance costs that they stopped offering health insurance benefits to their employees entirely. Others chose to limit coverage to current employees only, thus ending the tradition of providing insurance for employee dependents and retirees. A 1998 survey by William Mercer found that only 36 percent of employers offer coverage for retirees, down from 62 percent in 1986 (Mercer 1999). Employers also set limits on their health care expenditures by shifting a greater percentage of premium and copay costs to the employee and by increasing deductibles. These cost-containing measures provided some relief for employers, but they were too localized to stem the rising tide of national health care costs. Substantive savings were not realized until the business community embraced managed care.

The crucial step of the health care revolution unfolded when employers, who had long seen health insurance as a sort of sacred cow of business services, a product over which they had no control, finally began to apply standard business practices to the purchase of health insurance. Most large employers are accustomed to measuring outputs and assessing whether the value derived therefrom is worth the expenditure, and they wanted to make the same calculation when they purchased health insurance. The decentralized structure of the traditional indemnity insurance system was not conducive to providing the necessary output measures of quality, cost efficiency, or health status outcomes for the services they offered, so employers looked for an alternative and settled on managed care.

The incipient managed care industry was an appropriate match for cost-conscious employers. The managed care system was better able to meet the needs of the business community in two respects. First, it controlled expenditures by shifting from inpatient to outpatient treatment, placing strict controls on the use of medical services, and by offering financial incentives to physicians and hospitals for cutting services and costs. Second, the managed care industry was actively attempting to improve health care quality by setting practice guidelines and monitoring treatment with utilization reviews and by developing objective health outcome measures. This attempt on the part of the managed care industry to provide employers with objective information also served to stimulate the growth of the now influential quality measurement industry.

Once employers discovered the cost-saving potential of the managed

care system, they rapidly turned away from traditional indemnity plans. This trend was spearheaded by Allied Signal Inc., which in 1988 moved all its employees from indemnity insurance into a Cigna health maintenance organization (HMO). By 1991, Allied Signal demonstrated the cost-saving potential of managed care when it reported a 23 percent cut in health insurance expenditures (Wojcik 1991). Businesses further contained health insurance expenditures by restricting their employees' health insurance choices to managed care plans. At the same time, entrepreneurial managed care organizations capitalized on this new trend and rapidly increased their market share by initially sacrificing profits and "shadow pricing" to undercut the prices offered by traditional indemnity companies. Between 1984 and 1998, the proportion of employees in the United States enrolled in some form of managed care plan increased from 5 percent to 85 percent (Kuttner 1999). This illuminates the employer community's pivotal role in pushing managed care to the forefront of health care reform.

Another significant, and largely ignored, employer cost-saving measure dovetailed with the growth of managed care. During the 1980s, a rapidly expanding number of companies began to take advantage of a loophole in the Employee Retirement Income Security Act of 1974 (ERISA), which allowed companies who self-funded an insurance plan to avoid most state insurance regulations. The ERISA legislation regulates the administration of employee benefit programs. Although the regulations are very detailed and specific for pension plans, they are imprecise for health plans. This lack of specificity created what amounts to a "no-regulators-land" for employers who set up self-funded health insurance plans for their employees.

Self-funding has the advantage of giving employers much greater control over the quality, cost, and distribution of health care coupled with the additional savings associated with avoiding state regulations. Employers quickly moved to capitalize on the potential cost savings, and by 1995, most large employers and 25 percent of employers overall had created self-funded, mostly managed care, plans (EBRIa 1998).

Continued Employer Influence

Employers as a group did not revert to disinterested purchasers after the initial push toward health care cost containment and the adoption of managed care. As purchasers, employers continue to have a powerful, yet largely invisible influence on managed care organizations and the health

care services they provide. During the 1990s, most employers significantly increased their level of direct involvement in the administration of the health care benefits plans in order to maintain control over costs. There are two primary mechanisms that employers use to control the medical services given to employees by a managed care organization.

First and most importantly, employers set the financial framework within which the administrating MCO must allocate health care services. One of the cost-saving advantages of managed care is that it allows businesses to establish a prospective budget for health care expenditures. Once employers determine what they are willing to contribute to each employee's health care expenses per month—known as per member/month (PMPM)—the contracting managed care company has to find a way to allocate health care services within that budget. Clearly, the amount of coverage provided will be tied to the PMPM. Employers as a group have kept a tight reign on PMPM budgets. Consequently, when the price of health care services goes up and the PMPM rate does not, managed care organizations have been forced to limit or eliminate coverage for some services. These limits are often the underlying cause of denials of service to policy holders.

Second, the employer's influence on managed care organizations occasionally even extends to coverage decisions about specific medical services. Employers are increasingly using their new role as insurer to customize the coverage package for the particular needs of their employees. Sometimes this means that contentious denials of care can be traced back to a decision made by the employer, not the managed care organization administering the contract.

For example, some employers explicitly deny coverage for certain types of treatments. A suit was filed against Bodine Aluminum because the company negotiated a health insurance contract that did not cover high dose chemotherapy (HDCT) for breast cancer although it did cover HDCT for other forms of cancer. In another incidence, a man covered by the Railroad Employees National Dental Plan (a self-funded plan) had inpatient surgery to remove a tumor in his jaw. His damaged jaw was grafted with synthetic material. The patient's claim for reimbursement was denied because under the terms of his plan, although bone grafts were covered, synthetic grafts were specifically excluded by the dental plan.

Westinghouse chose to exclude some vaccinations from its benefits package. In particular, the plan would only pay for two of the standard three hepatitis B vaccination series. This unusual benefit denial remained

even after physicians, consumers, professional organizations, and the state insurance commissioner wrote letters of protest. The public might suspect that the managed care organization was responsible for refusing to pay for the third shot but, in reality, the responsible party was the employer. The reason cited by Westinghouse was that the contract they negotiated with one union did not specifically agree to coverage for the three shots.

Employers have also made specific coverage decisions that reflect particular moral values. For example, the Catholic Diocese of Pittsburgh purchased a pharmacy benefit plan that explicitly excludes coverage for oral contraceptives, even if those contraceptives have been prescribed for noncontraceptive reasons (i.e., abnormal vaginal bleeding). There are no exceptions to this policy.

The courts are beginning to recognize the role of employers in health care allocation decisions, and to hold them accountable. In a 1998 survey of employers by William Mercer, 19 percent of employers with twenty thousand or more employees have been named in at least one legal action related to medical care provided through one of their health plans (Mercer 1999).

Recommendations

In the fervor of the managed care backlash, reformers largely fail to recognize how subtle is the question regarding who actually bears responsibility for denials of care. If the goal of health system reform is to secure access to the highest quality of care, then we need to think of patient rights and protections in a more expansive way. Employers should be held accountable in the same way that we are now demanding accountability from managed care organizations.

Reform initiatives should be directed toward employers in two major areas of patient rights: quality and choice. Employers are in a unique position to influence advances in the quality of health care. They can encourage managed care organizations to provide the highest quality of care by only contracting with plans that have been accredited by the National Committee for Quality Assurance, and by collaborating with health plans to set specific health improvement goals for employees. In addition, employers should make payments to managed care organizations contingent upon performance measures.

Choice of product is essential in our market-based health care system. The public should encourage mandates requiring employers to offer their

employees a choice of health plan. In addition, employers need to require that the managed care organizations they contract with provide performance outcome information to help employees make an informed choice of plan.

In conclusion, despite the pervasive perception by the public that it is solely the managed care companies that are limiting care and denying benefits, the reality is that the managed care organization is often used more as administrator, not as benefits designer or decision maker. True rights and protections will be achieved only when the employer, the man behind the curtain, is revealed as the puppeteer of the managed care wizard of Oz.

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