

Permanente Joins Campaign for Consumer Protection

Concerned about the torrent of new and often conflicting health care regulatory measures issuing from state legislatures, Kaiser Permanente and a unique coalition of health plans and national consumer groups launched a bid to seize the initiative with their own consumer protection campaign at a high profile Washington, DC, press conference in late September. The event featured the release of an 18-point set of proposed standards designed to bring major improvements to health care consumers while resulting in a reduced, less costly and more equitable regulatory regime for health plans and providers.

What sets the Kaiser Permanente standards apart from other recent health care industry proposals are the critical elements of scope, enforcement and sponsorship. Most important, the coalition came down heavily in favor of national standards, as opposed to state-by-state regulations, and in favor of legally enforceable standards, as opposed to voluntary ones. The coalition partnership between stakeholders who are often on opposite sides of regulatory issues—health plans/medical groups and consumer groups—was also expected to give added weight and credibility to the initiative. As Ron Pollack, President of Families USA, said, “These principles are a very constructive and real expression of care by the three HMOs. They are likely to lead to meaningful protections for health care consumers.”

The support of consumer groups may be especially important in light of the fact that one of the coalition’s target audiences was the 35-member Presidential Commission on Consumer Protections and Quality in the Health Care Industry (of which Kaiser/Group Health President and Chairman Phillip Nudelman is a member). The coalition directed a copy of the principles, with a cover letter, to the commission prior to its concluding its own work on a so-called “Consumers’ Health Care Bill of Rights,” hoping to influence the nature of those guidelines. Kaiser Permanente representatives also promised to work with interested legislators to craft bills based on the coalition’s principles.

The coalition, which began negotiating the standards among its members last February, also includes Group Health of Puget Sound (whose participation preceded its affiliation with Kaiser Permanente), and the Health Insurance Plan of New York. The consumer partners included Families USA and the American Association of Retired Persons (AARP), both of which are highly visible actors in state and national health care policy and regulatory affairs.

For Kaiser Permanente, negotiations over the principles were handled primarily through the Government Relations department, with oversight and input from members of the Health Policy Committee, whose membership includes senior Permanente Federation leaders, such as Executive Director Jay Crosson, MD, and the Associate Executive Director for Health Policy Development, Don Parsons, MD. According to Dr. Parsons, who participated directly in the negotiations, the issue of the integrity of the physician-patient relationship was always central to every discussion. “We struggled throughout the process,” said Dr. Parsons, “to ensure that the principles reflect our most fundamental values about the practice of medicine and that they would in no way interfere or influence those values or how decisions about medically necessary and appropriate treatment are made by physicians in consultation with their patients. It has always been our position that neither health plans nor the government should intrude upon these decisions, and we worked hard to ensure that these principles would not violate that commitment.”

The 18 proposed principles cover a broad range of consumer health issues, including accessibility of services, choice of health plans, confidentiality of information, continuity of care, and disclosure of information on experimental care, drug formularies, loss ratios, performance and quality measures, provider financial incentives, and other sensitive issues (see summary, page 58). Many of the proposed standards are already being met in some or all Kaiser Permanente Divisions and are already embodied in some states’ laws, while others would represent a stretch for the program in many divisions. It should be emphasized, however, that for the time being, the principles are just that: goals that have been endorsed by the program’s senior leadership. Some have already been implemented unilaterally; some have been adopted by particular divisions in accordance with state laws; some could be pursued programwide, with or without mandates; and others, such as choice of health plans, require federal legislation. In addition, it is likely that any legislative mandates based on the principles would call for phased implementation over a number of years.

A small number of the principles could only be implemented on a universal basis among all health plans in order to avoid adverse selection consequences. For instance, the proposal to submit to binding external decisions about coverage for experimental treatments—one of the top issues for consumers—could have serious cost consequences resulting in adverse selection by purchasers if implemented

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unilaterally or by only a few plans. In such a situation, plans that chose not to implement the principles could easily take unfair advantage of the more socially responsible plans that did implement them. The objective was to provide all parties the same level playing field in the interests of equity for all plans, their members, and their providers.

Significantly, the proposal does not include standards on one of the most difficult issues for both consumers and health plans and/or providers: member grievances and appeals. Those issues, which were included in Kaiser Permanente's original draft of principles, were taken "off the table" when the plans and the consumer groups failed to reach timely agreement, although all the parties promised to continue to work toward resolution of the sticking points. The coalition also decided to continue working on another vexing question: the appropriate government agency or agencies for oversight and enforcement of the proposed standards. At present, no federal agency is adequately equipped to take on the role, and it is likely that state regulators will jealously guard their prerogatives. Indeed, much of the oversight function might actually be done more efficiently at the state level, assuming common standards of monitoring and enforcement are observed.

To many observers, the most surprising aspect of the initiative is that a group of health plans and their medical group partners would embrace enforceable standards that even the most tough-minded consumer organizations could support. For several years, HMOs (including Kaiser Permanente) have been fighting a rear-guard battle against a growing tide of new consumer-supported health care laws and regulations at the state level. Before adjourning for last summer's legislative recess, state lawmakers passed a record 182 laws on managed care, up from 100 in 1996, according to the National Conference of State Legislatures. Forty states and Congress have passed length-of-maternity-stay laws in the last three years, and 37 states considered mastectomy-stay bills this year alone (though only seven passed).

The impact of the regulations on plans and providers is believed to be even greater than the numbers suggest since many of the measures were comprehensive "bills of rights" covering a broad array of health concerns. Already in 1997, such laws have been passed in 19 states compared with 13 states in 1995 and 1996 combined, and many other states, including California, are anticipating similar initiatives.

Congress is also likely to consider a health care "bill of rights" next year, based on the recommendations of the Presidential Commission.

In issuing their own consumer-supported standards and calling for national enforcement among all health plans, Kaiser/Group Health and HIP have moved well into the vanguard of the industry response to consumers' growing demands for safeguards. The more typical health plan strategy has been the approach exemplified by the American Association of Health Plan's "Patients First" initiative in early 1997, which embraced a number of consumer protection principles similar to those of the coalition, but specifically called for voluntary implementation.

Why did Kaiser Permanente and the other plans decide to step out front? Partly, said Steve Zatzkin, Senior Vice President for Government Affairs, because it is a role that the program is already familiar with as a result of earlier consumer-interest initiatives, such as last year's promulgation of principles and support for legislation on health plan coverage of emergency medical services (see *The Permanente Journal*, 1:1). That initiative, like the consumer protection principles, was largely motivated by an urgent sense that, as Zatzkin put it, "It's time to restore some trust in the American health care delivery system. But it can't be done unless virtually all plans are held accountable. If some plans are free to ignore the standards, then the whole phenomenon of managed care bashing is going to continue."

"We think national, enforceable standards will bring more consistency to the regulatory arena," added Zatzkin. "By acting nationally, we hope to create a level playing field for plans, greater equity for consumers and providers in different geographic areas, and less costly and burdensome regulation." Zatzkin said that in promulgating the principles, Kaiser Permanente is not trying to increase the level of regulation on itself or other plans, but to make regulation "more rational and less duplicative." Today, health plans are regulated by a vast array of various state insurance commissioners and corporations departments as well as by federal agencies like HCFA, the Federal Employees Program, the Labor Department and even the Defense Department (for CHAMPUS).

"We'd love to have all of these agencies singing from the same hymnal regarding health plan standards," said Zatzkin.

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Summary of Preliminary Statement of Principles for Consumer Protection

The health plans and consumer organizations involved in this effort have identified 18 consumer protection principles to promote quality health care and restore trust in the health care system. Below is a brief summary:

1. Accessibility of Services. To ensure access to quality care, health plans should:

- have enough physicians, specialists, and other providers to provide timely, appropriate care 24 hours a day, seven days a week;
- provide access to specialists, specialty care centers, and out-of-network referrals when necessary, and provide women members with direct access to obstetricians and gynecologists; and
- provide health care materials and services in a culturally and linguistically sensitive manner.

2. Choice of Health Plans. Individuals should be given a choice of health plans.

3. Confidentiality of Health Plan Information. There should be strong protections against improper disclosure by health plans of medical information.

4. Continuity of Care. Members should be allowed to choose their own primary care physician and change their primary care physician at any time. Health plans should promote preventive care, ensure that medical records are complete and available to members and their providers. Members who are being treated for a serious illness or are in the second trimester of pregnancy should be allowed to continue receiving treatment from their physician specialists for up to 60 days when their doctor's contracts are terminated by a plan or when, under their group coverage, they are forced to switch plans.

5. Disclosure of Information to Consumers. Health plans should provide consumers with the following information: a description of the coverage provided and excluded; how to obtain service; the names and credentials of the plan's physicians; a description of the method used to compensate physicians; the systems for managing the use of services; a description of restrictive prescription drug formularies; procedures for receiving emergency care and out-of-network services; use of arbitration; statistics on the numbers of members who leave the plan; and how to appeal decisions, file grievances, and contact consumer organizations or government regulatory agencies.

6. Coverage of Emergency Care. Health plans should cover emergency services, including services provided when a prudent layperson reasonably believes he or she is suffering from a medical emergency.

7. Determinations of When Coverage is Excluded Because Care is Experimental. Health plans should have an assessment process for reviewing new drugs, devices, procedures, and therapies. Plans should also have an external, independent review process to examine the cases of seriously ill patients who are denied coverage for experimental treatments.

8. Developments of Drug Formularies. Health plans that cover prescription drugs and use restrictive formularies should allow physicians to participate in the development of the formularies and provide for an exception process when nonformulary alternatives are medically necessary.

9. Disclosure of Loss Ratios. In order to allow consumers to learn what percentage of their premiums are paid out in medical benefits, health plans should uniformly calculate and disclose their loss ratios.

10. Prohibitions Against Discrimination. Health plans should not discriminate in the provision of health care services on the basis of age, gender, race, national origin, language, religion, socioeconomic status, sexual orientation, disability, genetic makeup, health status, or source of payment. Health plans should develop culturally competent provider networks. Health insurance reform should address discriminatory practices that discourage enrollment of high risk, high cost or vulnerable populations in health plans.

11. Ombudsman Programs. Health plans should cooperate with independent, nonprofit ombudsman programs that investigate members' complaints, help members file grievances and appeals, and provide consumer education and information.

12. Out-of-Area Coverage. Health plans should cover emergency and urgent medical care for members traveling outside the plan's service area within the United States.

13. Performance Measurement and Data Reporting. Health plans should meet national standards for measuring and reporting in areas such as quality of care, access to care, patient satisfaction, and financial stability.

14. Provider Communication with Patients. Health plans should not limit the exchange of information between health care providers and patients regarding the patient's condition and treatment options. Health plans should not penalize providers who advocate for their patients, assist patients with claims appeals, or report quality concerns to government authorities or health plan managers.

15. Provider Credentialing. Health plans should develop written standards similar to those used by the National Committee for Quality Assurance (NCQA) for hiring or contracting with health care providers and facilities. Health plans should not discriminate against providers who treat a dispropor-



tionate number of patients with expensive or chronic medical conditions.

16. Provider Reimbursement Incentives. Neither health plans nor provider groups should use financial incentives that encourage physicians or other providers to either overtreat patients or limit medically necessary care.

17. Quality Assurance. All health plans should implement comparable quality assurance programs consistent with nationally recognized standards and

provide for external review of the quality of care conducted by qualified health professionals who are independent of the plan and accountable to the appropriate regulatory agency.

18. Utilization Management. Health plans which manage utilization of services should ensure that their utilization management activities are administered by qualified health care professionals and the appropriately licensed providers evaluate the clinical appropriateness of adverse decisions. ❖



"Say Ah," by Evany Zirul, DO, MFA; PMGofMA.
Another piece of her work can be seen on page 40.