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# REGULATING HMOs: CREATING AN ETHICAL FRAMEWORK FOR COST-EFFECTIVE HEALTH CARE

ANNANDALE-ON-HUDSON, N.Y.--As Health Maintenance Organizations (HMOs) become the dominant mode of health care delivery in the United States, complaints about the system increase, along with calls for federal reforms. In response, regulators are seeking solutions to the conflicts that arise when cost containment and patient services collide.

In ***Regulating HMOs***, a new Public Policy Brief from The Jerome Levy Economics Institute, Senior Scholar Walter M. Cadette examines the key conflicts the system creates and outlines solutions regulators should consider as reforms are debated.

"The ethical problems of HMO medicine flow from its very design," Cadette says."Every dollar of revenue is also a potential dollar of profit if it is not spent on direct patient care." Reforms, he contends, should focus on disclosure, so that patients can make informed decisions about their health care providers, and on "muting the conflict between medical and business criteria in care decisions."

Cadette's proposals include the

- Amending the 1974 Employment Retirement Income Security Act (ERISA), to ensure that health plans can be held liable when decisions adapted for cost reasons do serious harm
- Striking gag clauses from physician contracts and obliging health plans to disclose just how they practice cost-conscious medicine
- Rethinking the concept of "purchasing cooperatives," which at a minimum would supply consumers with objective comparative information on health plans and their style of practice
- Creating a third-party appeals mechanism, which not only helps to protect consumers from unfair denials of claims, but also would help to cut the costs incurred through continuing claims disputes, financing of unpaid hospital receivables, and other overhead
- Shifting the decision-making power balance back to physicians; making utilization review the province of physicians, in effect, to declare utilization review to be the practice of medicine

"Managed care's ability to control health care costs will be tested as never before in coming years," predicts Cadette. Further, with the aging of the baby boomers and advances in medical technology, the pressure for earnings combined with the system's built-in financial incentives to undertreat pose a mounting danger that patient welfare will be compromised, he says. "In this setting, it is especially important that people have an opportunity to exercise choice in purchasing health insurance, that they understand the consequences of cost-conscious choices, and that they are fully apprised of the financial incentives under which their physicians work," Cadette says. "It is also especially important that health plans be held accountable and that patients have an opportunity to prevail in disputes with health plans when the merits of their cases can be shown."

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