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Backgrounder
Executive Summary

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How to Deal with Public Concerns About Health Insurance

Carrie J. Gavora

In recent months, the pressure on Congress to "do something" to deal with public concern over the supposed shortcomings of managed care and other features of the American health care system has been growing. The result has been a number of bills that would impose additional mandates requiring health plans to provide certain services, specify a set of "patient rights," and open up health care to more litigation by consumers.

Typically, in its well-meaning legislative effort to fix a problem, Congress will begin by misdiagnosing the problem. Then it will offer a solution that does very little to ameliorate public concerns and, worse, introduces new problems into the system.

The very fact that many lawmakers today think that the key to improving health care is for people to sue health providers should cause any sensible American to pause and wonder whether there is a better way. There is.

POSITIVE STEPS TO MEANINGFUL HEALTH CARE REFORM

To solve this problem, Congress needs to concentrate on the cause, not the symptoms. Three actions are needed:

ACTION #1: End the tax bias against family-owned and family-chosen health plans. Congress can take two simple steps to end much of the tax discrimination against family ownership of health insurance:

- Allow individuals who do not have access to employment-based health coverage to deduct 100 percent of their health care purchases. A refundable tax credit would be preferable, but this change would be a good first step to restoring tax fairness to working Americans.
- Allow individual workers in company-sponsored health flexible spending accounts (FSAs) to roll over, penalty free, the unused funds in these accounts at the end of the year. In addition, lawmakers should address deficiencies in the medical savings account (MSA) law passed two years ago as part of the Kennedy–Kassebaum Health Insurance Portability and Accountability Act (HIPAA), such as the cap on the number of accounts sold and

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the limits on larger employer group participation.

ACTION #2: Create an economical market for family-owned plans. Severe regulatory burdens on today's health insurance market make it difficult for families to exercise choice in a competitive health care marketplace. Consumer choice models like the Federal Employees Health Benefits Program (FEHBP) allow enrollees to choose from among a variety of health plans with minimal regulation or governmental interference. To apply this principle to the private sector, proposals should:

- Allow employers, providers, insurers, and consumer groups to band together in voluntary purchasing cooperatives called "HealthMarts." Small employers could enjoy the benefits of pooling risk and escaping onerous coverage mandates, while their employees could take advantage of the choices and affordability that competing health plans offer. This proposal could be improved by allowing individual purchasers to buy into a HealthMart.
- Allow associations to pool their members' resources to purchase health coverage, with federal protection from state regulation granted in the Employment Retirement Income Security Act (ERISA).

ACTION #3: Enhance health plan accountability. Once a family picks a health plan, the terms of that plan, like those of any other contract, should be enforceable under the law. There should be appropriate recourse for individuals who believe they have been harmed by decisions made by their health plan, or whose plan simply failed to deliver promised benefits. But it is important to understand that such legal recourse is a complement to effective choice and ownership, not a substitute for it. To promote plan accountability without expanding malpractice liability, policymakers can require plans that are covered under ERISA to diffuse patient concerns by:

- Disclosing in the health plan contract whether providers must clear specialist referrals or diagnostic test recommendations with plan administrators. If they must do so, plans should be required to disclose in the contract the methodology used by administrators in deciding whether to approve or deny benefit coverage.
- Notifying a patient up front, before treatment, whether a specific benefit is covered.
- Disclosing the reasoning behind determinations to deny coverage for specific benefits.
- Allowing meaningful external review of claims denials by independent medical doctors.

If a health plan continues to deny coverage after an external review deems the treatment necessary, it seems fair to allow the patient to take the case to federal court to receive some form of limited damages. Such measures would provide the right incentives for health plans that may not be acting in good faith to be more accountable to the patients they serve.

These are just the first steps on the road to effective health care reform, but they represent meaningful changes that can make coverage more affordable and consumer choice and health plan accountability more meaningful. They also offer Congress an opportunity to turn the tide of regulation and government mandates that now dominates efforts to improve the health care system. More critically, they offer families what they really want: control and ownership of their health coverage.

—Carrie J. Gavora is Health Care Policy Analyst at The Heritage Foundation.

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In recent months, the pressure on Congress to "do something" to deal with public concern over the supposed shortcomings of managed care and other features of the American health care system has been growing. The result has been a number of bills that would impose additional mandates requiring health plans to provide certain services, specify a set of "patient rights," and open up health care to more litigation by consumers.

Typically, in its well-intentioned legislative effort to fix a problem, Congress will begin by misdiagnosing the problem. Then it will offer a solution that does very little to ameliorate public concerns and, worse, introduces new problems into the system.

The very fact that many lawmakers think the key to improving health care is to encourage people to sue health providers should cause sensible Americans to pause and wonder if there is a better way. There is.

UNDERSTANDING THE PROBLEM

Americans are frustrated with the health care system, especially managed care, because they see covered services either being changed without their permission or being denied to them, and they have no recourse. They feel powerless. Understandably, families respond by demanding that plans be required to live up to their stated obligations and to meet reasonable standards of service in a civilized society.

Many in Washington assume that the only way to achieve this is through regulation and litigation, but this approach overlooks the root cause of this sense of powerlessness. In most economic relationships—say the purchase of a house, life insurance, or an automobile—consumers decide what they want and enter into contracts with a provider or seller. In order to stay in business, the seller must satisfy the customer. In the case of health insurance, however, most workers are bound by a contract entered into by two other parties (their employer and an insurer/managed care plan).

Unlike almost every other product or service they use, Americans with health coverage today do not own their health plan, and therefore do not control or choose the type of plan or the scope of benefits they want and need. The contract is drawn up between the employer and the health

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plan, not between the individual and the plan. The family does not own the contract, and the plan regards the *employer*, not the patient, as the "customer." Little wonder that the plan focuses on keeping costs down and satisfying the employer, not on satisfying the patient. Families will feel in control—and plans will be forced to satisfy their needs—only when people can choose and own their own health insurance plans.

Why does this unique and unsatisfactory situation persist? Why don't families simply enter into contracts with plans themselves, using the part of their compensation that employers currently earmark for health insurance? There are two reasons. The most important is the tax treatment of health care. The other concerns the shortcomings of the insurance market.

Today, millions of working Americans and their families are discriminated against by the tax code. The Internal Revenue Code provides large tax breaks to families obtaining health insurance through employer-purchased health plans by excluding the cost from employee income and payroll taxes. Not only does this policy place health coverage decision-making power with the employer rather than the health care consumer, but it also denies families the opportunity to own their health plans. Over 80 percent of uninsured Americans today work, but they either are not offered or cannot afford employer-sponsored health coverage. These families, who do not get their health insurance through their employer, must purchase insurance or treatment with after-tax income. More often than not, they go without health insurance because they simply cannot afford it.

Moreover, the current health insurance market is highly regulated, with thousands of state and federal laws mandating specific benefits, provider coverage, and pricing rules. The cost of insurance increases with each new requirement the government imposes, particularly in the individual market—virtually pricing low- and middle-income families out of health coverage in many states. It is folly to expect that further regulation of this already heavily regulated market will somehow enhance the quality of health care and protect patients. The market needs less regulation—not more—in order to bring costs down and offer consumers the health coverage they want. Assuming that this constricted market will function better if people can sue each other more easily is likewise unrealistic.

POSITIVE STEPS TO MEANINGFUL HEALTH CARE REFORM

To solve this problem, Congress needs to concentrate on the cause, not the symptoms. Three actions are needed:

ACTION #1: End the tax bias against family-owned and family-chosen health plans. Congress can take several steps to end tax discrimination against family ownership of health insurance. Two simple steps would end much of this bias:

- Allow individuals who do not have access to employment-based health coverage to deduct 100 percent of the cost of health care that they purchase on their own. Senators William Roth (R–DE) and Barbara Boxer (D–CA) and Representatives Bill Archer (R–TX) and Nancy Johnson (R–CT) all have proposed tax deductions for individual health care purchasers who are discriminated against by today's tax-favored status of employer-purchased health coverage. Although a refundable tax credit would be preferable, this change would be a good first step to restoring some tax fairness to working Americans.
- Allow individual workers in company-sponsored health flexible spending accounts (FSAs) to roll over, penalty free, unused funds in these accounts at the end of the year. FSAs are tax-free accounts that allow workers to set aside a portion of their wages to save for out-of-pocket costs, or for benefits not covered under an employer-provided health insurance package, including co-payments and deductibles. Families can also purchase

supplementary insurance coverage if they wish.

Both employers and employees may contribute to FSAs, up to specified limits, but current law does not allow the over 21.7 million Americans with FSAs to roll over any unused funds from one year to the next. Account holders must use all the funds in their account by the end of the year or forfeit the excess wages back to their employer. Representative David Dreier (R–CA) has introduced H.R. 3552 to allow people with FSAs to roll their account balances over from year to year. In addition, lawmakers should address deficiencies in the medical savings account (MSA) law passed two years ago as part of the Kennedy–Kassebaum Health Insurance Portability and Accountability Act (HIPAA), such as the cap on the number of accounts sold and the limits on larger employer group participation.

ACTION #2: Create an economical market for family-owned plans. Tax policies that level the playing field between individually purchased and employer-purchased health coverage, and that free resources so families can use those resources for health care, necessarily give people more choice. But the severe regulatory burdens on today's health insurance market dramatically reduce the opportunities for families to exercise choice in a competitive health care marketplace. At the same time, however, there are working consumer choice plans that Congress could model, such as the Federal Employees Health Benefits Program. The FEHBP allows over 9 million federal workers and retirees, including Members of Congress, their families, and staffs, to choose from among a variety of health plans with minimal regulation or governmental interference. More important, during open season, federal employees have the opportunity to leave a health plan they do not like and choose one that better meets their needs—the ultimate incentive for health plans to perform well. The following proposals would apply this principle to the private sector:

- Allow employers, providers, insurers, and consumer groups to band together in voluntary purchasing cooperatives, called "HealthMarts," to provide health coverage to workers in small and medium-sized firms. The concept, proposed by House Commerce Committee Chairman Thomas Bliley (R–VA), is to allow HealthMarts to contract with multiple insurers, with preemption from state mandated benefit laws (of which there currently are 1,062 nationwide), to provide a health insurance marketplace for employers. Small employers would enjoy the benefits of pooling risk, while their employees would take advantage of the choices and affordability that competing health plans offer. This proposal could be improved by allowing individuals to buy into a HealthMart.
- Allow associations to pool their members' resources to purchase health coverage, with federal protection from state regulation granted in the Employment Retirement Income Security Act (ERISA). H.R. 1515, championed by Representative Harris Fawell (R–IL), and its companion legislation, S. 729, introduced by Senator Tim Hutchinson (R–AR), would do just that, complementing the HealthMart proposal. H.R. 1515 offers small businesses the opportunity to pool their resources with those of other trade association members to purchase health insurance and qualify for the same federal protections, such as preemption from state mandated benefit and rating laws, that are granted to companies that pay directly for employees' health coverage (self-insured).

ACTION #3: Enhance health plan accountability. Once a family uses its power of choice to pick a health plan, the terms of that plan, like those of any other contract, should be enforceable under the law. There should be appropriate recourse for individuals who believe they have been harmed by decisions made by their health plan, or whose plan simply failed to deliver promised benefits. It is important, however, to

understand that such legal recourse is a complement to effective choice and ownership, not a substitute for it. A number of bills have been introduced that would expose managed care health plans now under ERISA to an open-ended liability and an explosion of costly litigation in cases of injury or death due to decisions made by health plans.

Under current law, a patient who is denied benefits by one of these ERISA health plans can recover the cost of the denied benefit or seek an injunction against the denial of the benefit. In addition, it is up to the judge whether or not to award attorney's fees and other "costs of action."[1] For example, if an ERISA health plan denies coverage of a doctor-prescribed magnetic resonance imaging (MRI) scan, the patient can hire a lawyer and go to court *before* the procedure and try to force the plan to cover the test. Or the patient can pay for the procedure out of pocket and then sue the plan for the cost of the MRI. These remedies are less than ideal because they do not guarantee compensation for all the costs faced by plaintiffs (such as attorney's fees and lost wages), even if the judge rules in their favor; as a result, patients with legitimate claims often are discouraged from filing a lawsuit. Moreover, current law permits actions only as a remedy for treatment costs, not for damages suffered.

Experience teaches, however, that introducing litigation into health care can be a slippery slope leading to expensive lawyer-driven litigation and to costly and unnecessary "defensive" medicine. When dealing with the murky areas of law governing ERISA preemption of malpractice laws, there are three issues Congress must take into consideration:

1. What costs should be recoverable in any litigation? Congress needs to evaluate current law and determine whether the remedies allowed under ERISA today are adequate. Then it should ask whether plaintiffs should have the right to sue for quantifiable losses other than the value of the denied benefit, such as guaranteed attorney's fees and lost wages.

2. How should "damages" be interpreted? This issue involves whether the scope of ERISA remedies should be broadened to include damages that are harder to quantify, such as compensation for pain and suffering, and punitive awards and, if so, whether there should be limits placed on those amounts. Lawmakers should be cautious, knowing that once subjective pain and suffering or punitive damages enter the picture, litigation could become a costly lawyers' bonanza.

3. Who should be liable? Policymakers also need to consider carefully who should be liable for payment of damages. Should it be the health plan, the doctor, or the employer? Or should it be some combination of the above? Exposing employers to litigation, for instance, will affect their willingness to offer insurance to their employees.

Experience suggests that Congress should think very carefully about these issues. Unlimited malpractice liability can have many unintended consequences. Take, for example, physician malpractice laws that place no limits on the type or amount of damages plaintiffs can claim. In attempting to protect themselves, doctors practice defensive medicine and order many unnecessary tests just to establish a record of having "done everything" for their patients. They are also concerned about frivolous lawsuits. When something goes wrong and patients file malpractice suits (as, it is estimated, one in eight people who have suffered from negligence do), only 50 percent end up receiving any compensation.[2] And those who do often receive exceedingly high awards that then drive up both the cost of malpractice pre-

1. "Employee Retirement Income Security Act," Title 29, "Civil Enforcement," U.S. Code, Chapter 18, Section 1132.

miums for doctors and the cost of health care for everyone.

Expanding medical malpractice liability to health plans and employers is not only a potentially costly option; it also fails to give patients and doctors what they want most: the flexibility and discretion to make sound medical judgments. Expanding liability would cause greater interference in the doctor-patient relationship by inviting health plan administrators (and lawyers) to be even more rigid about both the benefits provided and the doctors with whom they contract in order to protect them from future lawsuits. It also would cause many employers to avoid the threat of lawsuits by discontinuing insurance coverage, thereby adding to the number of uninsured families.

Congress needs to remember that in most instances (other than serious negligence cases), the best way for a patient to address dissatisfaction with how a plan functions is not to hire a lawyer, but to be able to leave that plan and join a better one. The ability to choose and switch is what holds other segments of the economy accountable. Real choice in health care would be a far more effective remedy than litigation for most grievances. In other words, most grievances caused by benefit denial could be remedied by creating a truly consumer-based marketplace for health insurance which allowed families to drop a plan that did not cover benefits they think they need. This would provide a strong incentive for health plans to act in good faith.

In cases where the patient's needs are immediate, or more serious from a medical point of view, the challenge for policymakers is to ensure that patients have adequate recourse when they believe the terms of the health insurance contract have been violated. Giving plaintiffs the tools with which to recover quantifiable losses, such as attorney's fees and lost wages, is a reasonable policy. But, as noted, allowing plaintiffs' lawyers unlimited discretion in pursuing open-ended damage awards is likely to cause costs to skyrocket—with little or no benefit realized by those who may have been injured. Therefore, the ramifications of expanding medical malpractice liability to health plans and employers should be weighed with great care.

Lawmakers can promote policies that clarify health plan contracts, and enhance plan accountability to patients without expanding malpractice liability, by requiring plans covered under ERISA to diffuse patient concerns in a number of ways. Only if these steps—combined with tax code changes and other efforts to enhance choice—fail to deal with most public concerns should Congress even consider expanding the opportunities for more litigation in any significant way. Specifically, ERISA plans should be required to:

- Disclose in the health plan contract whether participating providers must clear their specialist referrals or diagnostic test recommendations with plan administrators. If they must do so, require plans to disclose up front, in the contract, the methodology used by administrators in deciding whether to approve or deny benefit coverage.
- Notify a patient up front, before receiving any treatment, whether a specific benefit is covered.
- Disclose to patients the reasoning behind determinations to deny coverage for specific benefits.
- Allow external review of claims denials by independent medical doctors.

If a health plan continues to deny coverage after an external review deems the treatment necessary, it seems fair to allow the patient to

2. T. A. Brennan, L. L. Leape, N. M. Laird, *et al*., "Incidence of Adverse Events and Negligence in Hospitalized Patients," *New England Journal of Medicine*, Vol. 324 (1991), pp. 370–376.

take the case to federal court to receive some form of limited damages. Such measures would provide the right incentives for health plans that may not be acting in good faith to be more accountable to the patients they serve.

CONCLUSION

These are just the first steps on the road to effective health care reform, but they represent the sort of changes that can make coverage more affordable and consumer choice and health plan accountability more meaningful. They also offer Congress an opportunity to turn the tide of regulation and government mandates that now dominates efforts to improve the health care system. More critically, they offer families what they really want: control and ownership of their health coverage.

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