SPECIAL ARTICLE

Managed Care Patient Protection or Provider Protection? A Qualitative Assessment

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PURPOSE: Opponents of managed care regulation allege that a patient's bill of rights, in reality, represents provider protections motivated by the desire to curtail the economic onslaught of managed care. This claim is assessed through a large qualitative study of state managed care patient protection laws.

METHODS: State laws were reviewed and categorized, and regulators in each state were surveyed, to determine the pattern and content of relevant enactments as of the end of 2001. In 2002, six states were selected for in-depth case studies to reflect a range of market, demographic, and legal characteristics. In each state, 16 to 24 key informants were interviewed, including provider advocates, physician practices, health plan managers, regulators, patient advocates, and various industry observers. Additional interviews were conducted from a national perspective, for a total of 138 interviews. Interviews were semistructured, and interview notes were analyzed using qualitative techniques.

RESULTS: These laws are directed primarily to patients' rights and only secondarily to providers' interests. Enactment of these laws was rarely attributed primarily to provider advocacy. Instead, providers aligned with consumers, or the impetus came from legislators or regulators. There was little evidence that these laws, collectively or individually, have had much effect on providers' economic concerns. Health plans are still free to form and shape networks as they see fit, subject to competitive constraints. Provider due process laws might suppress deselection to some extent, but most subjects thought these laws only marginally restrain health insurers from removing providers who they no longer want.

CONCLUSION: Managed care patient protection laws do not advance a self-interested provider agenda that disables features of managed care that are beneficial to consumers. Instead, these laws appear to embody a convenient alignment of interests among providers, patients, and lawmakers. **Am J Med. 2004; 117:932–937.** ©2004 by Elsevier Inc.

As part of the "backlash" against managed care, states and federal agencies have enacted a plethora of laws since the mid-1990s aimed at restraining the perceived excesses of gatekeeping, utilization management, and other cost-containment efforts (1–3). Some critics allege that these laws, known as a patient's bill of rights or managed care "patient protection laws," in reality are provider protections because they are motivated by the desire of physicians and hospitals to curtail the economic onslaught of managed care (4,5). Thus, critics accuse providers of co-opting legislative and regulatory processes to gain professional and economic advantages that they were not able to secure more legitimately in the marketplace. Although these gains are not necessarily at the expense of the public interest, the broader public interest may be served only secondarily.

To assess the validity of these claims, this article reports the results of a large qualitative study that assesses a broad range of effects from state managed care patient protection laws. The article focuses on portions of these state laws that relate most directly to provider interests, as well as considers how patient protection laws as a whole have affected provider interests.

METHODS

Initially, state managed care patient protection laws were reviewed and categorized in all 50 states, as of the end of 2001, to determine the pattern and content of relevant enactments (6). Then, in 2002, six states (Table 1) were selected for in-depth case studies following a systematic review of all 50 states. In each state, 16 to 24 confidential interviews were conducted with key informants representing a range of perspectives, including provider groups, health plans, government regulators, patient advocates, and various industry observers. In addition, a focus group was conducted with 9 experienced health care lawyers from across the country, and 12 interviews

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Table 1. Characteristics of the Six States Selected for In-depth Case Studies

State	Size	Location	HMO Penetration	Strength of Legislation
Iowa	Small	Midwest	Low	Weaker
Louisiana	Medium	Southwest	Low-medium	Medium
Michigan	Large	North-central	Higher	Medium
New Jersey	Large	Eastern	Higher	Stronger
Texas	Large	Western	Medium	Stronger
Virginia	Medium	Southeast	Low-medium	Medium-strong

HMO = health maintenance organization.

were conducted at the home offices of four of the largest national health plans. The total of 138 interviews consisted of 29 health plans or insurance industry groups, 26 provider groups (e.g., medical societies, hospital associations, and physician practices), 12 patient advocates, 11 insurance agents, 32 human resource managers or employer representatives, 9 regulators, and 19 other market participants or observers (including health care lawyers and industry analysts). All subjects gave verbal consent, and the study protocol was approved by the Wake Forest University School of Medicine Institutional Review Board.

The medical society participated in each state. A convenience sample of two to three physician groups (including at least one primary care and one specialty group) were selected in each state using the Medical Group Management Association directory. The total of 14 physician groups ranged in size from 13 to 1200 physicians, and included seven multispecialty groups, four single-specialty groups (anesthesia, cardiology, neurology), and three primary care groups.

Interviews were semistructured, following field-tested interview guides that were developed through consultation with a panel of expert reviewers. Lines of inquiry included the following: what was the impetus for these laws; what problems were they intended to address; how prevalent were these problems prior to these laws; have these laws worked to improve, correct, or avoid these problems; have these laws caused problems; do regulators actively enforce these laws and do health plans comply; and are changes related to these laws primarily in direct response to these laws or, instead or in addition, in reaction to market forces?

Detailed interviewer notes were coded systematically to identify relevant themes, which were then tabulated according to four categories of interview subjects: insurers, providers, employers/agents, and others (including patient advocates and market observers). For each theme, opinions and reported behaviors within each group and state were triangulated with those noted in other groups and states to determine the extent of convergence or divergence in views and reported behaviors.

RESULTS

State Enactments

State enactments are dominated by patient rights provisions, such as external review, direct access to specialists, and the prudent layperson standard for emergencies. These exist in almost all (42 to 47) of the 48 states that have any such laws (Table 2). Any-willing-provider laws, however, exist in only about half of states (n = 26), and in most of these (n = 17) the law applies only to a few designated classes of providers, such as pharmacists, rather than to physicians or hospitals generally. A similar pattern was seen for antidiscrimination (or "freedom of choice") laws. Although more common, existing in 35 states, many of these states (n = 16) apply the law to only a few categories of alternative practitioners or allied health professionals, such as chiropractors or physician assistants, rather than to physicians generally or to a long list of provider classes. Moreover, most of these laws were not included with the general package of patient protection laws but instead were enacted earlier, often in the 1980s.

More typically included in a patient's bill of rights are due process protections for excluded physicians, which exist in 32 states (Table 2). However, only half of these laws give physicians an opportunity to dispute the grounds for exclusion or termination; the other half require only that notice or an explanation of reasons be given, with no right to dispute the reasons.

Impetus for Enactment

Only 10% (5/50) of interview subjects thought that widespread or systemic abuses of a serious nature led to these laws. Only in Texas was this view heard more than once, although still not from a majority of subjects. Elsewhere, even patient and provider advocates admitted that they were unable to document serious systemic abuses. Rather than serious and widespread abuse, subjects noted, in equal proportions and across all states and interview groups, that three different concerns led to enactment of these laws.

First, some subjects said that news media gave a great deal of attention to a few "horror stories" or isolated cases of especially bad behavior or outcomes re-

Table 2. Selected Managed Care Laws

Type of Law	Description	No. of States	Variations	Study States
Provider Focused				
Any-willing-provider	Restrict the ability of health plans to engage in selective contracting by requiring plans to accept all providers, within defined categories, who are willing to accept the health plan's payment and participation terms.	26	17 are for limited categories	Limited version only, in New Jersey, Texas, Virginia.
Antidiscrimination	Prohibit health plans from excluding entirely certain designated classes of providers from their networks (although health plans do not have to include all willing members of these provider classes).	35	16 are for limited categories	Limited version in Iowa and New Jersey. Broad version in Texas and Virginia.
Due Process	Require notice, explanation, or opportunity to respond for providers who are excluded or "deselected" from networks.	32	16 provide only notice or reason	Weaker versions in Michigan and Virginia. Stronger version in New Jersey and Texas.
Patient Focused				
External Review		42	2 are nonbinding	
Access to Specialists		42	25 are for obstetricians/ gynecologists only, or for special conditions	
Prudent Layperson		47		

lated to managed care. This view was most common among national insurers (4 of 5), and heard more frequently in New Jersey (5 of 9) and Texas (4 of 7), two states with stronger versions of these laws. Second, subjects noted that regulators or legislators had received many routine complaints from patients and providers about managed care, reflecting a general unhappiness with network restrictions and utilization management, but not necessarily pointing to any patient injuries; instead, regulators and others believed that patients and providers simply did not like what managed care was about and how it worked because they were not used to dealing with these obstacles and restrictions. A third explanation, encountered most often in Iowa (7 of 9), was that there were not many problems or complaints in the particular state, but state officials were responding to problems elsewhere or general national trends to prevent problems from arising locally.

Only a minority (6 of 34) of subjects thought patient advocates were a driving force for enactment of these laws, and even then, subjects usually said that consumer organizations acted in concert with physicians. Only patient advocates themselves frequently pointed to patient advocacy as a driving force for enactment, but just as often they also pointed to one of several other sources. More than a third (13 of 34) of subjects saw physicians as a driving force for patient protection laws, but most said that this was done mainly to protect the economic interests of physicians rather than out of an overriding concern for patient safety. The general sentiment was that providers "hated" managed care and were looking for any way they could "beat back" the "onslaught" of payment denials, reductions, and delays. This view prevailed more among providers and their representatives (7 of 10) than among other groups. Only among insurers was this view also heard frequently, but insurers just as frequently thought that these laws were driven by patients' interests or by lawmakers' political opportunism that appealed to the public's interests. Among all groups of subjects, almost half thought that legislative or regulatory actors were the main force behind adoption of these laws. Overall, the prevailing view was best captured by 2 patient advocates in Texas (which was among the first states to enact a full slate of these laws), who said that these laws were the result of a "harmonic convergence of common interests," or a "Perfect Storm," in which multiple forces aligned from different directions, all pushing for a common or overlapping set of protections.

Inclusion of Providers

Laws that promote the inclusion of providers in managed care networks include any-willing-provider laws, antidiscrimination (or "freedom of choice") laws, and provider due process protections. Because these laws are so varied (Tables 1 and 2), this section examines the cumulative or overall effect in each state on providers' ability to join managed care networks, rather than separately analyzing each component law.

Overall, the vast majority (23 of 31) of interview subjects from all groups and most states said that providers face no problems joining managed care networks, as long as they are willing to accept the payment terms. Subjects noted that managed care networks are broad and becoming broader, and that most insurers have decided for business reasons to adopt an any-willing-provider approach, rather than a selective contracting approach, to forming their networks. Interview subjects noted, however, that provider selectivity still exists in some markets and for some types of providers. For instance, health maintenance organizations (HMOs) that are founded by a particular hospital organization or physician group tend to remain more aligned with their founding provider organizations than their competitors. Also, Texas subjects said that health plans contract selectively with hospitals in larger cities, where there are many hospitals from which to choose. Subjects in several states noted that health plans are more selective in contracting with some or all specialists.

The views of providers were basically the same as those of insurers on these questions. Providers were somewhat more likely to point out pockets of selectivity, but, for the most part, they did not say they had trouble joining the networks they wanted, apart from not liking the payment terms. Moreover, there was general agreement that patient protection laws do not influence the level of provider selectivity, nor do they deter health plans that want to from being more selective, as long as they "dot their I's and cross their T's." Health plans noted that these laws still allow health plans to exclude coverage for particular services (e.g., acupuncture) even if the service is one in which the protected category of provider (acupuncturist) specializes.

In states that require insurers to give their reasons for excluding particular providers, subjects explained that any reason will suffice, such as the network is full or no additional capacity is needed. In Texas, the only study state with substantive review of these reasons, subjects said that physician peer reviewers are not inclined to disagree with the business reasons of health plans, and they rarely disagree with reasons based on professional competence.

Termination of Providers

The due process protections noted above apply primarily to situations where providers' managed care contracts are terminated by health plans—that is, to "deselection" rather than nonselection. Across all the study states and all groups of subjects, the vast majority (27 of 31) said that provider deselection occurs rarely and is not a major problem. No physicians or other provider subjects pointed to deselection as a problem area.

When insurers do terminate providers, subjects said that this is usually for administrative concerns or sometimes for quality concerns, but not because a particular provider is a high utilizer. Many subjects noted that insurers are doing more provider profiling, but subjects generally explained that this information is used for feedback or persuasion, or in the context of rate negotiations, and not to exclude high utilizers.

For the most part, the general range of views about deselection did not vary according to the content of due process laws in different states. Most subjects (22 of 31) thought that patient protection laws do not deter deselection, but some said that these laws can make it more difficult to remove providers. Several subjects noted that laws requiring reasons for termination effectively eliminate the ability of health plans to engage in "no cause" terminations. Moreover, some lawyers and health plans thought that, once a reason is given, the insurer has to be prepared to prove it, even if it is a purely business reason, such as the network being full. Several health plans stated that they often choose to institute "corrective measures" rather than go through the due process steps needed to document and defend a termination.

The prevailing view, however, was that provider due process laws do not create major barriers to terminating providers, for either business or quality reasons. Several subjects noted the "big loophole" that, even where the law prevents no-cause terminations, it still allows no-cause nonrenewals of provider contracts that are not "evergreen" (i.e., contracts that terminate automatically unless they are mutually renewed or renegotiated). Where the law requires only reasons for terminations, sometimes this applies only if providers request a reason, which they often do not because doing so might trigger mandatory reporting to the National Practitioner Data Bank if the reason given is based on quality concerns. Where reasons are required, subjects said that any reason will do. Even when the law gives providers an opportunity to rebut this reason, some subjects thought that the law applies only where health plans choose to give a reason, and therefore that no-cause terminations are still permissible (although it may be that subjects were thinking of situations where providers opted for no-cause termination by not requesting a reason). Lawyers commented that the general common law is a stronger influence on due process activities than are these statutory requirements; for instance, they advise health plans to use these protections even when they are not required by statute or regulation to protect the health plan if the provider decides to sue.

Managed Care Regulation Generally

There was widespread agreement that many providers have gained more bargaining leverage in recent years in their negotiations with health plans, but the dominant view among all groups of interview subjects was that this is due to market forces rather than to any legal or regulatory influence. Informed subjects pointed to employers' and workers' desires for broader networks, and to the shift in enrollment from tightly controlled HMOs to preferred provider organizations, point-of-service plans, and non–gatekeeping HMO models. These market pressures, rather than patient protection laws, were seen as primarily responsible for insurers dropping capitation payment, expanding their networks, and lessening the intensity of utilization management. (Further details from this part of the study are reported elsewhere [7].)

Interview subjects who represent providers' interests were somewhat more likely than others to attribute some positive effects to these laws. Half of provider subjects who commented on the global effects (8 of 16) said that these laws had no, or only minor, effects, but the other half thought that these laws had improved the environment for providers. However, most of those who saw positive effects attributed improvements to a mix of market and legal forces, and only a few providers thought that laws were partially responsible for providers' increased market power. Even when laws were seen as helpful, providers often pointed to laws other than the patient bill of rights. Instead, they attributed improvements to more recent enactments regarding prompt payment and fair business practices, or to longer-standing requirements that health plans maintain adequate provider networks and pay providers' normal charges when members are justified in seeking care outside the network.

DISCUSSION

Patient protection laws did not advance a self-interested provider agenda that disables features of managed care that are beneficial to consumers. Instead, these laws embody a convenient alignment of interests among providers, patients, and lawmakers. This conclusion is broadly consistent with findings from other similar studies (8–11), one of which concluded that patient protection laws are a "curious mix of consumers' rights, provider protections, and patient protections" (12). Securing the purely economic interests of providers was not seen, even by insurers, as the dominant motivation for these laws. Accordingly, there is little evidence that these laws have had much effect on providers' economic concerns. A quantitative analysis performed in a different part of this investigation found improvements in specialists' satisfaction with practice and attitudes about managed care in states that initially adopted these laws, but this effect lasted only a few years and was greatly diminished in states that adopted these laws after 1997. This qualitative investigation suggests that improvements in physicians' attitudes in response to these laws were isolated and short-lived because most health plans voluntarily adopted many of the protections required by these laws, independent of their enactment, in response to market forces or the public backlash against managed care (7,13–15). Although providers' bargaining power against health plans has increased in recent years (16,17), this was attributed mainly to market conditions rather than to these legal provisions.

These improvements in providers' economic interests do not mean, however, that providers are content with the current situation. Instead, important issues remain regarding such matters as billing practices and the authority under the antitrust laws to engage in collective bargaining. However, these issues are more nakedly economic concerns of providers, rather than issues that intertwine providers' interests with patients' rights. As several subjects noted, managed care patient protection laws succeeded in "cooling the rhetoric" of providers' claims that managed care practices were making it impossible to maintain acceptable standards of professionalism. Therefore, lawmakers can now evaluate more clearly providers' legislative and regulatory initiatives for what they are: claims about being treated unfairly in the marketplace and about the need for government intervention to correct market defects.

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