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Informing, Claiming, Contracting: Enforcement in the Managed Care Era

*Louise G. Trubek**

INTRODUCTION

Patient and consumer protections are “in play” at the state level.¹ Dubbed “patients’ bill of rights,” the impetus for these initiatives is to correct the imbalance that occurs when the incentives for cost containment in managed care organizations (“MCOs”) negatively impact patients’ health care quality and access. This group of protections includes substantive requirements in the health insurance policy between the MCO and the purchaser (continuity of care), procedural processes (internal grievance and external review systems), and provider contract clause requirements (gag clause prohibitions).²

Patient protections are legislative enactments that delegate crucial enforcement decisions to other institutions. A new enforcement regime for patient protection legislation is emerging that reflects the current health care environment and is consonant with societal trends. Health care delivery is becoming organized predominantly as a market-based system utilizing

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1. This article discusses state patient protections. Federal enactments and proposals will not be discussed. It should be noted, however, that at the federal level, enforcement mechanisms similar to those noted in this article are being proposed. Medicaid, for example, is proposing requiring “report cards” and beefed up grievance procedures; this is a clear result of the activity in the commercial market. See Medicaid Managed Care; Regulatory Program to Implement Certain Medicaid Provisions of the Balanced Budget Act of 1997, 63 Fed. Leg. 242-55 (1998). The Department of Labor has established Employee Retirement Income Security Act (“ERISA”) rules requiring grievance systems that closely parallel state systems. See 29 C.F.R. § 2560.503(b). Issues involving medical record privacy and the uninsured and underinsured remain consumer and patient issues. These issues will not be addressed in this article.

2. This set of protections has been enacted in many states. Several competing bills are pending in Congress as of this date. The specific protections have been critiqued for responding to anecdotes without adequate documentation and for missing the mark of actually protecting consumers. See David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409 (1998).

MCOs.³ MCOs rely on cost-containment devices such as capitation, risk-sharing, and limited provider networks.⁴ These devices deliberately create tension between the goal of cost containment and the goals of optimal quality and access.⁵ This organizational structure is layered on top of a jerry-built payment and regulatory system. The financing system continues to rely on government programs, employee benefit plans, and individual purchases. Regulation is split between state and federal agencies, and diverse health plans have multiple benefit packages and procedures.⁶

This complex health care environment interacts with societal trends: growth of technology, complicated perceptions about lawyers, evolving techniques for management, and privatization of traditional government functions. Development of the internet has allowed consumers to be informed quickly; flowering of health websites is astounding.⁷ The public view of the legal system and the role of lawyers is problematic. There is a negative view of the ability of lawyers and legal processes to assist the poor and minorities, and there is skepticism about the speed and fairness of litigation.⁸ Nonetheless, the public still believes that "in spite of its problems, the American justice system is still the best in the world."⁹ There is an emphasis within large orga-

3. See Alain C. Enthoven, *Why Managed Care Has Failed to Contain Health Costs*, 12 HEALTH AFF. 27, 29 (Fall 1993); see also Rand E. Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1075 (1981). Wisconsin uses "managed care plan" in place of "managed care organization." Wisconsin modified its Health Management Organization ("HMO") statute, WIS. STAT. § 609 (1998), in 1998, to include a broader definition for managed care organizations; it maintains a definition of HMOs under WIS. STAT. § 609.01(2) (1998).

4. Wisconsin defines a "managed care plan" as "a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with or employed by the insurer offering the health benefit plan." WIS. STAT. § 609.01(3C) (1998).

5. See Barbara C. Colombo & Robert P. Webber, *Regulating Risk in a Managed Care Environment, Theory v. Practice, The Minnesota Experience*, 8 ANNALS HEALTH L. 147 (1999).

6. The complexity in the system is partly caused by ERISA with its preemption issues and by the lack of mandated standard benefit packages.

7. See Francis H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 IND. L. REV. 1019, 1020 (1998).

8. See Linda Greenhouse, *47% in Poll View Legal System as Unfair to Poor and Minorities*, N.Y. TIMES, Feb. 24, 1999, at A-2; see also Carrie Menkel-Meadow, *The Trouble with the Adversary System in a Postmodern, Multicultural World*, 38 WM. & MARY L. REV. 5, 8 (1996).

9. See Greenhouse, *supra* note 8.

nizations on managerial systems as a means for complying with public policy initiatives. One example is the internalization of statutory employment discrimination standards into corporate policies and procedures.¹⁰ Finally, some government functions are contracted out to private self-regulatory agencies who have technical expertise in and intimate knowledge of the regulated industry. This technique, most prevalent in dynamic industries, is termed “audited self-regulation.”¹¹

States are pivotal in implementing patient protection legislation through the creation of new enforcement mechanisms that supplement traditional insurance remedies and processes.¹² As a consequence of these innovations, the roles of the actors in the health care system are re-envisioned: redefining regulators’ purpose, expanding consumer participation, complicating MCOs’ functions, and shifting physician responsibilities. In describing these broader patient protection trends, this article focuses on Wisconsin’s experience. Wisconsin first enacted a health maintenance organization (“HMO”) regulatory structure in 1983.¹³ This was successful in creating extensive HMO penetration; 1.6 million people are now enrolled in Wisconsin HMOs.¹⁴ In 1997, the Legislature enacted Act 237, entitled “Managed Care Consumer Protection Act,” with a primary effective date of January 1999.¹⁵ In Summer 1998, the Office of the Commissioner of Insurance (“OCI”) commenced writing rules that were issued for comments in December 1998.¹⁶ A rulemaking hearing was held in December 1998; there was extensive participation and disagreement from speakers representing consumer groups, profes-

10. See Lauren Edelman, *Legal Environments and Organizational Governance: The Expansion of Due Process in the American Workplace*, 95 AM. J. SOC. 1401 (1990).

11. For a description of “audited self-regulation,” see Administrative Conference of the United States, *Recommendation 94-1, The Use of Audited Self-Regulation as a Regulatory Technique*, 1994-1995 A.C.U.S. 1, 1.

12. For a discussion of traditional insurance remedies in the life and health context, see WILLIAM F. MEYER, *LIFE AND HEALTH INSURANCE LAW* §§ 2:65-2:77 (Supp., Sept. 1998).

13. 1983 Wis. Legis. Serv. 27 (West). At that time, the state also initiated Medicaid managed care for AFDC recipients and converted the state employees’ health care system into a managed care program. See Louise G. Trubek, *Making Managed Competition a Social Arena: Strategies for Action*, 60 BROOK L. REV. 275, 280 (1994).

14. See Patricia Simms, *Manuals on Dealing with HMOs*, WIS. ST. J., Feb. 22, 1999, at 1A.

15. 1997 Wis. Legis. Serv. 237 (West).

16. Wis. OCI, *Managed Care Plans, Proposed Order of the Office of the Commissioner of Insurance Repealing and Creating a Rule* (to be codified at ch. Ins 9 Wis. ADM. CODE) (proposed Nov.-Dec., 1998) (hereinafter *December Proposed Rules*).

sional organizations, and insurers.¹⁷ OCI decided not to issue this set of rules and is rewriting proposed rules for hearings in Spring 1999, anticipating final issuance in Summer 1999.¹⁸

The difficulty in implementing a legislative vision for patient protection is evidenced by Wisconsin's experience in proposing rules and the subsequent debate following the passage of its managed care act. A new regulatory regime is required to reflect consumer and patient concerns in such an environment. This article describes three evolving enforcement mechanisms: informing consumers, encouraging disputes, and influencing contracts. The discussion includes an analysis of effects of the mechanisms on actors in the health care regulatory arena. It concludes with an assessment of the actors' adaptations.

Informing Consumers

Information has become an important enforcement tool in the new health care system. The development of credible private systems with national scope, the desire of consumers for information, and the availability of such information have resulted in substantial changes in the roles of regulators, consumers, and MCOs.¹⁹ An emerging system for development and dissemination of health information is dubbed "data-driven quality assurance" ("DDQA"). Collection of data, preparation of comparative "report cards," and distribution of data and comparative guides are components of DDQA.

There are several private organizations that are now developing DDQA programs; the National Commission on Quality Assurance ("NCQA") is the most active. Private certification is promoted through NCQA based on the provision of data indicating compliance with its standards.²⁰ Cost, quality, and access statistics are among the data gathered. This information is based on standards developed by NCQA in a consensus process. NCQA develops systems based on this process to measure and

17. See Written Testimony from OCI Rulemaking Hearing (Dec. 17, 1998) (materials on file with author).

18. The discussion of rules in this paper is based on the proposed rules of December 1998. The final set of rules is expected to be approved with an effective date in early Fall 1999. These rules are available from the Wisconsin Office of the Commissioner of Insurance <http://badger.state.wi.us/agencies/oci/oci_home.htm>.

19. For a discussion of the Missouri experience, see Gretchen Garrison, *House Bill 335-Managed Care in Missouri*, 66 UMKC L. REV. 775, 778 (1998).

20. See Barry R. Furrow, *Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos*, 43 VILL. L. REV. 361, 371 (1998).

compare HMOs on quality indicators, dubbed the Health Plan Employer Data and Information Set (“HEDIS”). NCQA has begun to release comparative quality of care analyses based on the HEDIS information.

Wisconsin now statutorily requires quality assurance standards.²¹ Proposed Wisconsin rules include reliance on private accreditation systems; they implement quality assurance by requiring HEDIS filings by MCOs.²² Because the statute has been expanded to define MCOs broadly, many additional health plans will be required to collect data and perhaps seek NCQA certification. An official of OCI indicated that it intends to take this data and develop comparative charts to be distributed to consumers.²³

DDQA systems allow state health insurance regulators to rely on non-governmental systems. These new administrative systems are termed “audited self-regulation.”²⁴ Audited self-regulation allows a wide group of people to be involved in a system that responds to changes in markets and technology faster than agency rulemaking processes. As John Jacobi points out, the involvement of state legislatures and regulators is important in providing a public regulatory backup to ensure that standards continue to be met by state MCOs. Moreover, regulatory oversight allows interested parties that are not part of the private system to intervene.

Consumers trust that these national systems of private accreditation are legitimate and accessible and that they encourage a broad market because of their national scope. DDQA in health care empowers consumers to use their buying power to influence the health system and allows them to participate in monitoring the effectiveness of legislative protections.²⁵ The use of the internet can spread information widely, allowing the development of quality information comparisons between MCOs. DDQA allows consumers to monitor the quality of the MCOs by demanding NCQA certification as a bottom line requirement

21. See WIS. STAT. § 609.32 (1998)

22. See December Proposed Rules, Ins 9.39, *supra* note 16.

23. See Comments of Eileen Mallow, Interagency Coordinating Council Minutes, (Dec. 8, 1998) (materials on file with author); see also notes of Louise G. Trubek, Interagency Coordinating Council Minutes (Dec. 8, 1998) (materials on file with author).

24. See Furrow, *supra* note 20; see also John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705 (1997).

25. For an insightful discussion on the use of DDQA, see Jacobi, *supra* note 24.

for enrollment, by comparing the certified plans, and by insisting on higher standards.

DDQA systems also encourage MCO compliance with quality standards by allowing them to participate in the consensus process at the national level. MCOs incorporate the quality measures that are subsequently reinforced by legislation and rules. DDQA encourages internal compliance systems within MCOs, forcing them to create quality evaluations to ensure that these standards are met.

DDQA systems thus change the roles of regulators, consumers, and MCOs; there is a complex interaction between these actors and the private accreditation organizations. Regulators function by using DDQA to monitor quality. MCOs internalize these systems in order to get approval by DDQA agencies, thus improving their outcomes. Reliance on DDQA systems, however, requires careful monitoring to guarantee the fairness and credibility of the system. Consumers and regulators must conduct constant oversight.²⁶

Encouraging Disputes

There is increasing reliance on individual consumer disputes with MCOs as a method to enforce patient protections.²⁷ Creating and encouraging consumer claims can achieve the goals of different actors: regulators monitor MCO response, patients redress their wrongs, MCOs discover gaps in their services, and health care professionals strengthen their bargaining positions. Two dispute handling processes that are "catching on" are internal grievance hearings and independent external review. In grievance procedures, patients file a written statement describing their disagreement with an MCO decision. Decisionmakers are designated to review the disagreement; often there is a hearing before a decision is rendered. The reviewers are primarily health care professionals.²⁸ These grievance processes are re-

26. See Claudia Schlosberg, *Privatizing Government Regulation of Publicly Funded Health Plans: The Limits of Private Accreditation* (visited Mar. 2, 1999) <www.healthlaw.org/Accredit.html>; see also Jacobi, *supra* note 24.

27. For general discussion of the importance and role of grievance procedures in managed care systems, see Eleanor D. Kinney, *Consumer Grievance and Appeal Procedures in Managed Care Plans*, A.B.A. HEALTH L. SEC. NEWSL. at 17; see also Louise G. Trubek, *supra* note 13; Louise G. Trubek, *The Social HMO for Low-Income Families: Consumer Protection and Community Participation*, 26 SETON H. L. REV. 1143 (1996).

28. "Health care professional" is the phrase preferred by my colleague, Dr. John Peterson. It is meant to cover a wide variety of people who provide services for pa-

quired by statute or rule and are overseen by state insurance commissioners.²⁹ The independent external review systems usually hear “appeals” from the grievance process. These systems consist of panels developed by independent review organizations and certified by insurance regulators. The panels are primarily health care professionals selected from a national pool. The findings of the panel are binding on the MCO.

Wisconsin has been a leader in the creation of elaborate internal MCO grievance procedures; they are required by statute.³⁰ In the recent “Managed Care Consumer Protection Act,” the use of appeals systems for complaints regarding prescription drugs and devices and experimental treatment was expanded to include all health care plans.³¹ The proposed rules also expanded the use of grievances to include oral grievances and require more prompt decisions on urgent care issues. HMOs had been required annually to report only the number of grievances and reversal rates. The proposed rules require more extensive and detailed reporting by MCOs to enable purchasers, consumers, regulators, and media to obtain more information about who is using the process and for what claims.³²

There is now a move in Wisconsin to enact an independent external review system. Many states have recently enacted such systems. They generally are compulsory for MCOs, use physicians and other experts as decision makers, and can be used for most complaints. In addition, they usually require “exhaustion” of the internal grievance process.³³ A collaboration of groups, including the Medical Society of Milwaukee County, the American Association of Retired Persons (“AARP”), and the Center

tients. It maintains the concept of “professionalism” and is used in lieu of “health care provider.”

29. See Jane Perkins, Kristi Olson, and Lourdes Rivera, *Making the Consumer's Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction*, Los Angeles, CA: National Health Law Program, 1996, p. 5. See Kinney, *supra* note 27. In Wisconsin, information on total number of grievances filed and the reversal rates must be filed annually by every HMO. See WIS. STAT. § 609.15 (1998). For a comparative analysis of HMO grievance reports, see Sara E. Zeman and Louise G. Trubek, Center for Public Representation, Inc., *Improving Managed Care: HMO Grievance Data and Consumer Participation* (Revised, June 15, 1999) <http://www.law.wisc.edu/pal/griev_data.htm>.

30. See WIS. STAT. § 609.15 (1998).

31. See WIS. STAT. § 632.853 (1998).

32. See December Proposed Rules, Ins 9.32(7)(c), *supra* note 16.

33. For a useful description of external review, see Karen Pollitz et al., *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, Henry J. Kaiser Family Foundation (Nov. 1998).

for Public Representation, Inc. ("CPR") are supporting the enactment of independent external review in the current legislative session.³⁴

Both internal grievance and external review systems require regulatory oversight, even though the actual conducting of reviews occurs in non-governmental agencies. The internal grievance systems are within MCOs, and external reviews are primarily provided by panels from independent organizations who contract with government agencies. The panels performing external reviews, as in the internal grievance systems, consist primarily of experts from the health care system. There remains an important regulatory function in overseeing the grievance and review systems: setting standards, requiring detailed complaint reporting, and ensuring consumer assistance.

These extensive disputing systems require that consumers act on their own behalf; ideally, this is a flowing process. Consumers create a dispute by claiming an "injury." As technology systems and information access evolve, consumers will develop new claims that can be heard in the disputing process. This echoes the "informed consumer" encouraged by the information system discussed above. For example, the addition of drug and device and experimental treatment provisions in Wisconsin's 1997 Managed Care Consumer Protection Act reflected increased consumer knowledge about potential denials of service.

These disputing systems also internalize complaint information and norms within MCOs.³⁵ Health care professionals and administrators within MCOs learn about the disputes and incorporate the outcomes into their organizational procedures. These systems encourage a management approach to disputes, and these interpretations become de facto patient protections. In this regard, the external review is crucial in allowing outside information and expertise to influence the actions of the MCO. MCOs are likely to incorporate the information within their systems as part of quality control.

Decision makers in these dispute systems are primarily health care professionals, especially physicians; this is an effort to keep the process within the health care system. The result can

34. The collaboration is entitled Collaboration on Healthcare Consumer Protection ("CHCP"). Also involved are the Wisconsin Nurses Association, Wisconsin Society for Podiatric Medicine, State Medical Society of Wisconsin, and the Medical College of Wisconsin. See Julie Sneider, *Group Pushes for More HMO Reforms*, BUS. J., Jan. 29, 1999, at 21.

35. See Edelman, *supra* note 10.

strengthen the role of health care professionals in their relationships with patients and MCOs. Health care professionals can serve as advocates in creating the disputes that are heard in the process. Health care professionals also serve as reviewers of disputes. Both these roles maintain the importance of health care professionals within the system.³⁶ The dispute process, therefore, can be valuable in maintaining health care professionals' credibility as advocates for patients fighting against poor quality in MCOs.³⁷

Influencing Contracts

The contract between the physician and MCO is emerging as a crucial mechanism for construction of the health care system. Legislative initiatives are regulating these contracts: requiring or prohibiting certain clauses, allowing public disclosure, and encouraging third-party enforcement.³⁸ These legislative provisions influencing private contracts are a useful intervention in a market-based system. Regulators, however, now must confront issues of access and enforcement of these legislative interventions in the physician-MCO contracts.

Recent revisions of Wisconsin's Managed Care Consumer Protection Act contain two major sections that create requirements concerning the physician-MCO contract. The first section deals with what are often termed "gag clauses." One provision prohibits contracts that "limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options."³⁹ Another provision prohibits the MCO from penalizing a provider or terminating its contract "because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee."⁴⁰

36. Kinney argues that physicians now have split loyalties that undermine their ability to fight for consumers in MCO disputes. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301, 319 (1996).

37. See Robert I. Field, *New Ethical Relationships Under Health Care's New Structure: The Need for a New Paradigm*, 43 VILL. L. REV. 467, 492 (1998).

38. The contracting process also has important public policy consequences in the selection and deselection of providers based on their provision of services to uninsured and high-cost chronic patients. See Andrew B. Bindman et al., *Selection and Exclusion of Primary Care Physicians by Managed Care Organizations*, 279 JAMA 675 (1998).

39. WIS. STAT. § 609.30 (1998).

40. See *id.* at § 609.30(2).

The second major restriction deals with continuity of care. The length of the contract is directly regulated, and there are medical conditions outlined that require the physician to provide treatment even if the contract with the MCO has been terminated. Further, the payment for these services is also outlined in the statute.⁴¹ In Wisconsin, substantial debate on access to the contracts emerged in the rulemaking process. The initial proposed rules required that physician-MCO contracts be filed with OCI.⁴² There was substantial objection by MCOs to public access, and they requested a requirement that contracts be held as proprietary and confidential.⁴³ CPR, a nonprofit public interest law firm, suggested that there be a provision that a consumer could demonstrate "good cause" to OCI and then be allowed access.⁴⁴ CPR supported a public access provision so that private enforcement by consumers and patients could be facilitated and encouraged.

The ability of consumers and health care professionals to expand private enforcement remedies using contract provisions is currently at issue. One view is that enforcement should be through the insurance regulators and health care professionals only. A contrary view is that consumers and patients should be able to use contracts as a tool to assert their protections arising from legislation. New remedies might be based on the melding of public and private enforcement.

There is potential for physicians and consumers to bring private right of action claims stating that they have rights based on patient protection statutes and regulations.⁴⁵ There is also the potential to use private contract theories of third party beneficiaries, linking standing issues in state regulations to private contracts.⁴⁶ It also has been suggested that the tort of bad faith be read into the contract of care between the consumer and

41. See *id.* at § 609.24.

42. See December Proposed Rules, Ins 9.07(1) & (2), *supra* note 16.

43. See Rhea K. Ramsey, *Proposed Guidelines and Recommendations of Ins 9.07(1) and (2); Copies of Provider Agreements 1* (Feb. 9, 1999) (unpublished legal memorandum, materials on file with author).

44. See *id.* at 3.

45. See John E. Noyes, *Implied Rights of Action and the Use and Misuse of Precedent*, 56 U. CIN. L. REV. 145 (1987).

46. See generally Orna S. Paglin, *Criteria for Recognition of Third Party Beneficiaries' Rights*, 24 NEW ENG. L. REV. 63 (1989); see also Kevin A. Coyle, Comment, *Standing of Third Parties to Challenge Administrative Agency Actions*, 76 CAL. L. REV. 1061 (1998).

MCO.⁴⁷ The potential to use these private enforcement remedies depends in part on how provisions regulating contracts are treated in administrative rules. The development of these new remedies depends not only on access to contracts but also on whether the pertinent administrative rules outline in detail the scope of prohibited contract provisions. Consumer advocates prefer to rely on court challenges, rather than extensive administrative rules, to develop private enforcement.

The language in physician-MCO contracts also may be an instrument for increasing trust among health care professionals, MCOs, and patients.⁴⁸ The passage of gag clause prohibitions was an effort to guarantee that contract language did not harm patients. Contracts, if well-negotiated and drafted, can lay the groundwork for respectful and successful relationships between providers, MCOs, and patients.⁴⁹ Careful contracting processes can lead to informal relationships that work, with less subsequent litigation.

*System Responses: Internalization, Advocacy,
and Collaborations*

These new mechanisms are redefining the way consumers, health care professionals, MCOs, and regulators conduct their business and participate in the regulatory process. The traditional model of regulatory relationships is shifting: internalizing public rules and norms into MCOs, energizing consumer and physician advocacy roles, and creating unexpected collaborations.

MCOs use management techniques to control costs and monitor quality. Their large size and business characteristics are often criticized as leading to impersonal, cost-driven care. These characteristics, however, also enable them to efficiently create and use data in reviewing quality. MCO management is able to use information about disputes to monitor performance of

47. See Charles A. Lattanzi, Note, *Nursing Home Contracts: Is it Time for Bad Faith to Come Out of Retirement?*, 6 J.L. & HEALTH 61, 64 (1991/1992).

48. For an interesting discussion of the topic of ethics and managed care contracts, see Howard Brody & Vence L. Bonham, Jr., *Gag Rules and Trade Secrets in Managed Care Contracts: Ethical and Legal Concerns*, 157 ARCHIVES OF INTERNAL MED. 2037 (1997).

49. This point was raised by an attorney who represents providers and HMOs in contract negotiations. See Lecture of Terry Hottenroth (Feb. 22, 1999) (materials on file with author). For a more general discussion, see Stewart Macaulay, *Non-Contractual Relations in Business: A Preliminary Study*, 28 AM. SOC. REV. 55 (1963).

health care professionals and detect poor quality. The information also can be used to adapt policy provisions to prevent consumer dissatisfaction. MCO management may use decisions of independent external reviewers to modify MCO practice protocols, possibly incorporating national norms.

Regulators recognize that MCOs can be encouraged to use their size and managerial techniques to comply with legislative enactments. They are mandating that MCOs maintain compliance systems in order "to verify compliance" with administrative rules.⁵⁰ The effect on regulators is to shift their role from direct collection of data to oversight of data collection by the MCOs. However, regulators, consumers, and health care professionals must be aware of the need for public access to information contained within internal systems. Reporting requirements for data such as the composition and disposition of disputes is crucial. A "watch dog" stance among regulators, consumers, and health care professionals is still crucial for a credible system.⁵¹

Encouraging claims systems and mandating contract provisions are likely to increase the importance of advocacy. This is sometimes referred to as "bureaucratization" of the health care system, leading to a decline in "trust" between patients and health care professionals.⁵² Creating claims may be positive, however, serving as a way to rebuild consumer confidence in the health care system. An accessible disputing system, starting with grievances followed by external review, provides an informal method for resolving disputes. The potential for these positive results is more likely if there is substantial assistance available for consumers and patients in using the dispute system. Health care professionals also can serve as advocates; for example, physicians can represent their patients in disputes with the MCO.⁵³ Consumers can become more active; with the availability of useful information, many can "do it themselves."⁵⁴ Regulation will shift toward increasing reliance on private

50. See December Proposed Rules, Ins 9.41, *supra* note 16.

51. See Schlosberg, *supra* note 26.

52. See Richard E. Miller & Austin Sarat, *Grievances, Claims, and Disputes: Assessing the Adversary Culture*, 15 L. & Soc'y REV. 525 (1980-81).

53. See Field, *supra* note 37, at 481-82. There is a more skeptical view of the ability of physicians to advocate credibly for patients because of the conflict posed by their financial incentives and organizational loyalty. See Kinney, *supra* note 36.

54. See Center for Public Representation, *Health Care Protection/Health Care Action Guides*, (visited Mar. 2, 1999) <www.law.wisc.edu/pal>. However, some consumers may require assistance.

enforcement, especially in the physician-MCO contract area. The role of the regulator may change to information dissemination and assistance, perhaps creating an ombudsman's office within regulators' offices.⁵⁵

Shifting collaborations among the various actors in the health care system is an inevitable result of the new regulatory regime. The regulatory arena is now lively and multifarious. In Wisconsin patient protection lobbying, there is a new collaboration that includes a medical society, an elderly advocacy group, and a consumer advocacy law firm.⁵⁶ The members of the collaboration are united in their effort to enact more patient protections, but there is not always complete agreement. For example, independent external review is a priority of all the groups, but commitment to provider contract access has proven more controversial. Regulators face a more complex regulatory picture as a result of the increased activity; participation is greater and locating support is tricky. A positive result is that regulators are able to develop new enforcement mechanisms and share responsibility with other actors.

CONCLUSION

The dramatic redesign of the health care delivery system is intimidating. Small steps, however, may establish confidence and trust in the system. Patient protection legislation is a small step to "right the balance" between cost containment measures and access and quality ideals; its success depends on the effectiveness of new enforcement mechanisms. Effort and energy, including vigorous debate, are required to ensure that these initial steps are successful. If the mechanisms flourish, they will provide impetus for expanded system responses.

55. There was surprise in Wisconsin when the Governor recently proposed the creation of an ombudsman position within OCI. See Simms, *supra* note 14.

56. See Sneider *supra* note 34.