

# Methods to Identify and Address the Ethical Issues Associated with Managed Care

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## Abstract

There are many benefits of managed care, such as its focus on disease prevention and health promotion, its integration of healthcare services to minimize inefficiencies, and its ability to restrict healthcare costs; however, there are also some ethical concerns that arise from managing care. In the context of managed care, ethics is a method for examining conflicts of values and obligations where there are competing interests, each of which presents a reasonably justified position. The principles of procedural, commutative, and general justice are particularly applicable to the ethical issues associated with managed care. Through a review of relevant literature, this paper will examine different methods and principles of justice to consider in establishing an ethical managed care organization and it will offer some examples of plans that have established policies to meet their ethical goals. By setting common goals, plans and enrollees can minimize ethical conflicts and collaborate to ensure that plans consistently use just procedures to ensure that quality care is available.

## The Shift to Managed Care

In response to employer and government demands for cost containment, enhanced access, and improved quality, the managed care system of healthcare has grown tremendously in the United States. With the previously open-ended reimbursement policies of the post-World War II period that gave doctors incentives to provide unnecessary care, the costs of health care inflated at a rapid pace. Under the payment system of indemnity insurance, spending more healthcare dollars did not appear to be improving America's health, (Bodenheimer, 1993, p. 376) and public concern with healthcare quality increased. Pressure from politicians and interest groups to reform the nation's healthcare system ultimately fueled managed care's rapid growth in the late 1980s and early 1990s. However, even with the healthcare dollars saved by managing care, the ethical implications associated with managing care still exist.

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Managed care refers to various healthcare coverage products and services that attempt to reduce costs by encouraging more efficient healthcare delivery. The purpose of managing care is to "eliminate choices that are wasteful, harmful, or too expensive" (Mariner, 1995, p. 237). Thus, in the managed care system, a limited number of contracted physicians provide healthcare at reduced rates of reimbursement. Managed care works to shift some of the financial risk from payers (e.g. insurance companies) to healthcare providers, through financial rewards and penalties, in attempts to influence providers' clinical decisions. Managed care plans direct members to these contracted providers and, in theory, patients save money (e.g. lower insurance premiums) by receiving care that is more efficient. There are many benefits of managed care, such as its focus on disease prevention and health promotion, its integration of healthcare services to minimize inefficiencies, and its ability to restrict healthcare costs; (Mariner, 1995, p. 239) however, there are also some ethical concerns that arise from managing care.

## Justice and Managed Care

In the context of managed care, ethics is a method for examining conflicts of values and obligations where there are competing interests, each of which presents a reasonably justified position (Randel, et al., 2001, p. 46). "The principle of justice, which governs resource allocation, is especially relevant to managed care organizations because the very nature of managed care requires allocating resources for the benefit of all members of a group" (Mariner, 1995, p. 240). Three types of justice are particularly applicable to the ethical issues associated with managed care. They are procedural justice, commutative justice, and general justice.

### *Procedural Justice*

Dr. Marjorie Chan, professor of management at the College of Business Administration, California State University at Stanislaus, describes procedural justice as "the fairness of process with which outcomes are delivered" (Chan, 2002, p. 316). A managed care organization (MCO) concerned with upholding procedural justice principles will create clear policies that are consistent, unbiased, and accurate. Members should have full access to all plan policies and procedures that may affect their ability to receive quality care. This also means that members should have the ability to uncomplicatedly challenge coverage denials. In addition, internally, a plan maintaining procedural justice will have

standardized mechanisms in place to resolve any financial and/or ethical issues.

### *Commutative Justice*

Commutative justice pertains to medical relationships and that which is owed to patients that enter into professional relationships with providers (Bondeson, 2002, p. 3). In a managed care setting, determining the proper ethical actions that providers should undertake suggests a need to balance obligations to patients (of providing the best care) against responsibilities due to a health plan and its members (of managing limited financial and medical resources). Concerns may be greater in some forms of managed care than others; yet, changes in the physician-patient relationship, changes in standards of appropriate care, and changes in the locus of decision-making will always raise commutative justice issues.

### *General Justice*

Relating closely to managed care's responsibility of rationing resources, general justice pertains to that which individuals owe to the common good in their uses of healthcare resources (Bondeson, 2002, p. 8). In managed care, general justice concerns not only the particular patient, but also the other plan members. Without general justice guidelines, plan members would suffer from what Garret Hardin, biologist from the University of California, Santa Barbara, termed "the tragedy of the commons," in which overuse depletes all resources (Hardin, 1968, generally). Embracing the principles of general justice in managed care means proper usage of scarce medical resources; thus, maintaining general justice requires that healthy plan members do not demand wasteful care and that sick members comply with prescribed therapeutic measures. Ethical issues arise when a plan denies access to certain services that members (or their healthcare provider) deem necessary or when a plans will not pay for members to receive care from the members' choice provider.

A quality managed care system could avoid many justice conflicts with close attention to the ethical concerns inherent to the managed care industry. While creating and maintaining an ethical MCO would require vigilant monitoring and continuous consideration of new ethical issues, there are examples of managed care organizations that have taken on the challenges of managing care ethically. This paper will examine different methods to consider in establishing an ethical managed care organization and it will offer some examples of plans that have implemented policies to meet their ethical goals.

### **Tax-Exempt Status and Commutative Justice**

Along with shifting financial risk to physicians, MCOs in effect have the authority to make some medical decisions that previously had been reserved for healthcare providers (Bodenheimer, 1993, p. 374). "MCOs perform

both medical and business functions, taking actions to provide or withhold care that touch the traditional sphere of medical ethics, and, at the same time, acting like ordinary business enterprises with no moral obligations or, at least, obligations that have little to do with traditional medical ethics" (Mariner, 1995, p. 240). As businesses, corporate values (such as efficiency, cost-reduction, competition, and profit) influence MCOs, which may differ from the traditional ethics and values of practicing medicine.

To reduce the conflicts between providing care and running a business, MCOs should minimize disagreements by focusing on providing quality care to their members. For this to happen, truly ethical managed care organizations should be nonprofit. Investor-owned MCOs have dual, often conflicting, obligations: they have a financial duty to increase profits and shareholder dividends, while also maintaining a contractual responsibility of providing members needed medial services. Nonprofit MCOs, on the other hand, have the analogous duties of providing members healthcare while only using its income to support its charitable operations and stated purposes. Thus, nonprofit plans allocate any profit to benefit their members (or perhaps provide subsidized coverage for new, low-income members).

Holy Cross Health System (HCHS) represents a healthcare plan that successfully uses its mission to justly serve all members at the forefront of major medical decisions. HCHS has a strong faith-based mission that emphasizes fidelity, excellence, stewardship, and empowerment. It established a process called "mission discernment," whereby potentially conflicting business and clinical decisions are evaluated for both their financial and strategic implications but also for their ethical implications. HCHS uses a systematic list of questions that plan clinicians and administrators discuss to determine the impact of all major decisions on achieving the ethical norms essential to the organization's stated purpose.<sup>1</sup> While the mission discernment process is not intended to yield a yes or no decision, it is a process through which the organization can openly work to better ensure that policies or decisions are restructured to realize the plan's mission.

Traditionally, healthcare delivery remained in the nonprofit realm, with providers offering more charity care with lower administrative costs than for-profit organizations (Bodenheimer, 1993, p. 376). Because nonprofit organizations are required to have mission statements that stress the organizations' charitable purposes, nonprofit managed care organizations' business structures,

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<sup>1</sup> Randel, 52. The questions covered in the mission discernment process are as follows: What considerations make this decision important in the mission and values of HCHS? How will the quality of services be determined and maintained? How will care for the poor be addressed with this development? What is the community benefit from this development?

policies, and practices allow for the provision of better quality care than profit-seeking MCOs.<sup>2</sup> In fact, some studies have indicated that for-profit status is associated with lower quality and satisfaction performance levels. In a recent study using survey responses from Medicare beneficiaries, Landon et al reported that “for-profit and nationally affiliated health plans scored lower for almost all of the outcomes they examined” (Landon, et al., 2001, p. 282). Thus, nonprofit MCOs are able to uphold their medical responsibilities and business values with fewer ethical conflicts in providing healthcare and higher customer satisfaction.

### Patient Choice and Procedural Justice

Limits on choice of physician and access to specialists are inherent to the managed care system; however, choice is a component of the central ideal of self-determination that Americans value dearly. Consequently, there is often a conflict between plans’ structures, which only authorize use of contracted physicians, and enrollees’ wishes to receive care from out-of-network providers. It is important that patients feel comfortable with their primary care physician. Patients are more likely to adopt healthy habits (such as quitting smoking) or bear painful but efficacious therapies if recommended by a trusted physician (Emanuel, 2000, p. 324). To facilitate patients’ willingness to use physicians under contract with their MCO, plans must explain carefully the terms of contracts and the basis of the types of limitations they will impose.

Patients need to understand that plan membership may allow for lower out of pocket costs but only in return for accepting some limitations on choice and the type and amounts of care provided. However, “full disclosure is necessary, but insufficient to foster a fair contractual relationship” (Mariner, 1995, p. 242). Ezekiel Emanuel, MD, PhD suggests two conditions for fairness in imposing restraints on enrollees’ choice of providers: the first is that the policies for limiting access to treatments and physicians should be accessible to the public and plan members. Secondly, doctors and enrollees should be able to challenge plan decisions and argue for revisions through set, accessible mechanisms (Emanuel, 2000, 324). Dr. Ronald Duska, a business ethics professor at American College, conducted research of the 10 largest national plans.<sup>3</sup> His research revealed that member grievances concerning limited access to health services often were attributed falsely to plans

denying claims, whereas the limited access to care was more accurately the result of a lack of knowledge of the methods to gain access to care (Duska, 2000, p. 70). To avoid these misconceptions, plans should provide complete information to their members and healthcare providers that articulate the plan’s policies and how access conflicts can be resolved.

In 1999, BlueCross BlueShield of Tennessee (BCBST) attempted to actively inform its members by making its medical policies available to clinicians, members, and the public. BCBST made all relevant information available through a link on the company’s website that is updated on a monthly basis. The site explains the process that BCBST generally uses to determine “medical necessity” and it offers the rationale for its policies (Randel, et al., 2001, p. 52). This includes a list of in-network doctors and covered procedures, as well as medical literature supporting the plan’s decisions not to reimburse for certain procedures. “By presenting its reasoning as well as its conclusions, BCBST encourages trust and creates the possibility of constructive debate with its key stakeholders” (Randel, et al., 2001, p. 53). Although members and physicians may disagree with the plan’s decision-making process, BCBST provides them with the appropriate information and clear guiding principles to appeal or protest a coverage decision in a focused manner.

### Medical Decision-Making and General Justice

In general, the law recognizes that anytime a person receives advice or counseling from a professional, they enter into a contractual relationship where the professional is morally (and often legally) obligated to put the client’s wellbeing ahead of any other motivating factors. “Bioethics and law both have long regarded physicians as having a fiduciary relationship with their patients. Thus, the physician is supposed to put the patient’s interest first, ahead of any others” (Rosoff, 2001, p. 3). However, as physicians also have contractual obligations with managed care organizations, there is a potential ethical conflict because physicians have incentives to compromise patient advocacy in order to limit healthcare costs. MCOs require physicians to make decisions based on utilization and economic goals determined by the health plan and these goals could compromise a doctor’s duty to patients.

Physicians that have to make medical decisions that are not in accordance with MCO reimbursement structures often have to show that the treatment prescribed has been proven to be cost-effective. Managed care is structured around a variety of incentives to encourage the practice of efficient medicine and to minimize variation in clinical practice patterns. This means providing a healthcare product while minimizing unnecessary resources to treat each patient. Often, increasing productivity and fixing costs maximizes efficiency. Hence, managed care may

<sup>2</sup> Monroe, 181. An example of a nonprofit MCO’s mission statement is that of California HealthCare Foundation, whose mission is “to expand access to affordable quality healthcare for underserved individuals and communities and to promote fundamental improvements in the health status of the people of California.”

<sup>3</sup> The ten largest plans in the study covered the lives of over half the U.S. population.

create pressure to do more with less: less time per patient, less costly medicines, and fewer costly diagnostic tests and treatments.

One of the most powerful managed care driven initiatives to reduce waste is its focus on evidence-based decision making. Evidence-based medicine applies scientific research findings to the practice of medicine. It is the process of using relevant scientific and statistical data to formulate medical decisions. Although evidence-based medicine has helped to verify and refute the effectiveness of certain medical practices, it has also created many ethical and legal issues within managed care. As evidence-based medicine, uses aggregate data to make medical decisions for individual patients, managed care organizations and plan practitioners cannot easily manage individual variation. "When working with numbers there may be tendencies to focus on the aggregate, with insufficient regard for the people those numbers represent" (Robbins, 1998, p. 33). These variations are inevitable; however, an MCO's duty is to provide care even to those outlier patients that require unique treatment. The true ethical issue arises in determining whether a prescribed treatment is futile or appropriately deviates from standard plan guidelines.

Supporting principled standards and sponsoring an ethics program can help to foster commutatively just procedures to resolve the issue of needed versus wasteful treatment. While an ethics committee should not explicitly make coverage decisions, it could serve as a consulting body that provides suggestions based soundly on bioethical principles. In 1991, Community Health Plan (CHP) established an exemplary MCO ethics committee that addressed sub-acute and outpatient oriented issues. The 18-member multidisciplinary group was comprised of representatives from the medical, legal, nursing, and behavioral health communities, as well as clergymen and plan administrators. The committee, which had direct access to the plan's Board members, had a stated mission to (1) identify significant ethical issues affecting CHP, (2) serve as a consulting body on bioethical issues which affect a patient's individualized care or a specific component of CHP's program, and (3) actively educate CHP staff, healthcare providers, and members (Felder, 1997, p. 358).

There are many noteworthy elements of CHP's ethics committee. The goals and purposes of the ethics committee are clearly stated, which aid in determining appropriate ethical issues for the group to evaluate. By functioning as a forum for discussion of ethical issues, the committee establishes itself as a deliberative group and consulting resource that can influence but not explicitly make coverage decisions. In undertaking the mission of educating the plan staff and members, the ethics committee works towards creating a coordinated system under which all the plan takes all participants' concerns into consideration.

CHP's committee is just one example of how ethics

committees can serve as a medium for reconciling ethical conflicts, assuring honesty, maintaining minimum standards of quality, and preventing the wasteful or inadequate use of health care funds.

## Conclusion

Managed care offers the United States' healthcare system real and potential benefits and challenges. As long as healthcare expenditures continue to rise, providing efficient services that lower consumer costs will play a pivotal role in making care more economical and accessible. Market-driven principles in managed care control costs and encourage the supply of high quality healthcare that meets or exceeds consumer demands. Nonetheless, MCOs' financial motivations in providing care could potentially damage the traditional physician-patient relationship and undermine plans' obligations to members.

MCOs, by definition, work to integrate the inherently opposing principles of business and medicine. To effectively address significant issues associated with managing care and to protect patients, a health plan should minimize competing corporate and medical obligations by creating ethical guidelines that mediate these conflicting interests. A managed care organization that focuses on its responsibility to provide the best care possible can refocus plan policies, ensuring members' best interests are at the forefront of all major business decisions.

In order to successfully manage and allocate limited medical resources, managed care organizations and members must understand and be committed to the justice principles as ethical guidelines. It is essential that all plan participants (enrollees, contracted physicians, staff, and administration) actively and collectively engage in the formulation and evaluation of its mission and policies. A health plan and its members can minimize conflicts by setting common goals and establishing just procedures that ensure quality care is available to all enrollees. Ultimately, with conscientious examinations of their structure, processes, and policies, plans can manage healthcare ethically. 🍌

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*This author has been recognized for Excellence in Bioethics Writing with a first place cash award presented on April 11th, 2006. More information on eligibility for future award is available online at [www.bioethicsjournal.com](http://www.bioethicsjournal.com)*