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The backlash against managed care continues to gain force. Current legislative agendas at both the state and federal levels suggest that policy makers are willing to contemplate stronger measures to regulate managed care and take more risks of increasing costs than was the case a year ago (Stauffer 1998). Private decisions on the part of employers that provide managed care coverage and by employees who have a choice of plan suggest an increasing demand for managed care products that involve fewer restrictions in accessing care.

In this short essay we present some evidence from the Community Tracking Study (HSC 1999; Kemper et al. 1996) that the backlash against managed care appears to be quite uniform, despite significant variation in local health care markets. We also argue that backlash has evoked responses from both private and public sector decision makers' responses that are likely to reshape managed care. While these changes have produced more responsiveness to consumer concerns, they also have a potential downside in the form of higher health care costs and a loss of opportunity to improve quality.

Sources of Backlash

Understanding consumers' concerns about managed care is not always straightforward because underlying concerns are often confused with the means to achieve them. This is most apparent over choice of physician. Consumers (and policy makers who listen to their concerns) have placed

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a high priority on having broad choice of physicians. But some observers perceive that broad choice is really a means to an end of maintaining control over one's health care. Having broad choice is a protection against physicians who are perceived to be more responsive to health plan interests than to the interests of the patient.

The backlash appears to emanate more from perceptions about others' experiences with managed care than from one's own personal experiences. Recent polling suggests that most of the negative perceptions about managed care are not due to the experience of the respondent or the respondent's family but the experience of others—often conveyed through the media (Blendon et al. 1998). On the one hand, this is a rational approach, since few have had the experience of being seriously ill while enrolled in a managed care plan and we should not have to wait to learn from personal experience. But given the penchant of the media for reporting rare events, consumers run the risk of factoring in a higher risk of "horror stories" than is actually the case. This appears to explain at least partially, why despite personal satisfaction with managed care, public opinion polls suggest broad-based consumer support for increased health plan regulation (ibid.).

Recent site visits to twelve communities across the country echo this disconnect. Although individual communities' health systems are markedly different from one another in terms of market structure and experience with managed care, we find striking uniformity in the presence and tenor of consumer backlash. Questions about consumer satisfaction with care, consumer perception of quality, and physician perception of quality on household and physician surveys elicit responses that vary across sites, yet strong anti–managed care sentiment was noted consistently by site visit respondents across communities (Lake and St. Peter 1997; Reed and St. Peter 1997; St. Peter 1997). This was true in a market with high managed care penetration such as Boston, where well-established local health plans have received among the highest consumer satisfaction ratings in the nation, as well as markets, such as northern New Jersey, with low penetration by HMOs and more limited experience with managed care.

The vigorous anti–managed care legislative agenda seen across the country is an indication of the growing force of backlash. Although community respondents note little impetus from local consumer organizations, nearly every site has witnessed increased state legislative activity to regulate managed care. These policy debates have been remarkably similar, focusing on issues such as health plan grievance procedures,

provider access, mandated benefits, and minimum lengths of stay for certain services. Several states also have instituted new reporting requirements to provide consumers information about plan performance. Some of the most aggressive legislative initiatives have been in markets, such as Boston, where consumers report high satisfaction with care. Even markets such as Orange County, California, which has a dramatically different structure for the delivery of care and extensive experience with managed care, have seen these similar legislative initiatives take hold.

The uniformity of recent state legislative efforts and anti–managed care sentiment across the sites suggests that national forces are at play. Indeed, respondents in many sites note the role of the national media driving anti–managed care sentiment locally. Other researchers have noted the growth of national media coverage of managed care and the increased focus on backlash over the past several years. As national television news coverage, in particular, intensified, there was a noticeable increase in the use of "high drama" stories that highlight life and death decisions and stories that cast managed care as the villain (Brodie, Brady, and Altman 1998). Respondents in the twelve communities that the Center for Studying Health System Change (HSC) tracks contend that national media influence consumers across markets, while locally, the media take stories that have been successful nationally and seek out local examples to engage their local audience.

Others note that the similarity of legislative initiatives suggests knowledge of the legislative activities of other states and of activities at the federal level, as well as of the political currency that these issues have had with voters. Positions taken by national trade associations also likely influence state legislative debates, if only indirectly. The success that these issues have had, both with voters and as stories in the media, appears to be feeding on itself and fueling increased backlash against managed care.

While these forces have helped backlash to spread, its roots may lie in another national trend: the rapidity of employers' shift to managed care. The proportion of employees enrolled in managed care plans increased from 29 percent in 1988 to 86 percent in 1998 (KPMG Peat Marwick 1998). Although some of this shift reflects choices by employees, some reflects the termination of conventional plan offerings. In 1998, only 38 percent of employees could choose a traditional plan, compared to 63 percent in 1995. Moreover, in that year 21 percent were offered only a point of service or HMO plan (Gabel 1999). Those enrolled in managed care as the only option are likely to feel differently about it than those who chose it over a conventional plan.

At the same time, many employees with managed care coverage found that they had fewer plans to choose among. In 1998, almost half (49 percent) of employers offering an HMO offered only one plan (KPMG Peat Marwick 1998). Among employers offering POS plans, 73 percent offer only one POS option. Particularly problematic has been the "total replacement" strategy pursued by some employers, where there is a choice among products but all of the options are provided by the same insurer.

Indeed, this reaction may have been magnified further by the human resources policies of media companies. One of us recalls that when the backlash issue first arose, he would often ask reporters at the end of an interview (usually on another subject) what type of health plan they had. A large portion reported having a managed care plan for the first time because their employer had dropped the conventional plan offered. Presumably these reporters' editors were having the same experience. Their frustrations with this change may have spurred special interest in this story, helping to bring national attention to the issue and to shape the tenor of the debate over managed care.

Public and Private Responses to Backlash

Consumer backlash against managed care has produced visible responses from the market and policy makers alike. Since 1995, when the HSC began tracking local health systems across the country, we have observed a rapid and far-reaching change in the structure and management of managed care plans. Most striking has been the movement to broader networks. Employers have asked health plans to offer products with broader networks and plans have complied rapidly. Data from the twelve communities that HSC tracks intensively show that by 1996, health plan networks had already become so broad and overlapping that there was often little differentiation in plans' provider networks within a local market (Grossman in press). Recent site visits indicate that this remains the case today. A portion of this is likely due to employers making managed care plans the exclusive offering, but part is likely due to employees' backlash against managed care.

At the same time, pure HMOs have become less popular as the opportunity to go outside of the provider network has become a more important consideration. Reversing a longstanding trend, the HMO market share of employment-based insurance declined from 33 percent in 1997 to 30 percent in 1998 (KPMG Peat Marwick 1998). In its place, enrollment in preferred provider organization (PPO) and POS products has

grown and health plans have scurried to increase such offerings. Market observers across our twelve study sites note that while many once envisioned PPO and POS as transitional products to lead consumers into pure HMOs, they now clearly have established themselves as viable alternatives that are expected to have longevity in the market.

Most recently, direct access to specialists has become a sought-after feature in health plans. This has resulted in the emergence of new "open access" products across markets and has led plans to adopt more lenient referral policies. United Healthcare has perhaps the most well-known open access product; noted in several markets, this product consists of a closed panel of providers and no gatekeeper. Other health plans indicate a movement away from the gatekeeper model as well. In Seattle, for example, PacifiCare is moving to implement an "express referral" policy with some of its provider subnetworks, allowing consumers direct access to any provider in that subnetwork. Similarly, in Orange County, California—arguably one of the most advanced managed care markets in the country—nearly all of the health plans recently established, or soon plan to introduce new products or policies that allow patients direct access to specialists.

Furthermore, recent site visit interviews indicate that some health plans also appear to be making behind-the-scenes changes in the ways they authorize coverage as a response to mounting consumer demand for greater flexibility. For example, in Orange County, consumers have reportedly become savvy about how to exploit plans' grievance procedure policies in order to win retroactive approval for out-of-network care. Through this backdoor mechanism, health plans have been expanding their coverage policies and eroding their ability to manage utilization. Across markets, many health plan respondents note a similar backing off from stringent preauthorization policies in response to consumer interests.

Concurrently, many states have recently enacted legislation aimed at protecting consumer rights in managed care plans. Some of these laws have built on market responses, taking innovations in product offerings and policies regarding provider access and requiring them uniformly throughout the market. For example, one common feature in recent managed care legislation is a requirement that health plans offer a point-of-service option to ensure that consumers have access to managed care products that provide out-of-network coverage. Similarly, many states have enacted legislation that requires health plans to give enrollees timely access to and adequate choice among qualified providers; some

explicitly require plans to ensure timely access to out-of-network providers. These policies promise to accelerate some of the trends already observed in the market.

Other consumer protection legislation has focused on establishing greater oversight of managed care plans' operations. For example, several states have established standards for consumer grievance procedures and require external review of appeals to provide an objective check on health plans' decisions denial of benefits. Many states also have established health plan reporting requirements in order to provide consumers comparative information about plan performance. These policies address consumer concerns that the market would not pursue independently, by establishing a floor for certain operating procedures and exposing plan operations and performance to outside review. Data from recent site visits suggest that these policies—or simply the expectation that such policies will be enacted—in turn, are prompting the market to respond to consumer interests in different ways. For example, these policy debates appear to have contributed to health plans' attention to grievance procedures and public information efforts, even in markets where these policies have not been enacted.

Implications of Managed Care Backlash

Both private and public responses to backlash have begun to have profound effects on how care delivery is organized and regulated and have raised troubling implications for consumers because they challenge the health system's continued pursuit of cost control and quality improvement.

Managed care appears to have had substantial success in slowing the rate of increase in health care costs. National health expenditures as a proportion of gross domestic product has been roughly level between 1994 and 1997 (Levit et al. 1998), and many attribute this trend to the growth of managed care. Yet, the growing backlash against managed care threatens the ability of managed care to continue on this path. Both private actions and public policy responses to backlash appear to be eroding ways health plans currently manage costs and appear to be blocking the development of the additional care management activity that will be necessary to further control health care spending. Moreover, these responses may increase the difficulty of making managed care plans or provider organizations accountable for quality.

The movement toward more loosely managed products raises all of these issues. The broadening of provider networks, for example, has

interrupted strategies some plans had for working more closely with a limited network of physicians and hospitals in order to control costs and improve the quality of care. Plans have less reason to invest in providing physicians with information on how to practice more effectively and physicians have less reason to follow information from any one plan. Monitoring physician quality by plans is also more difficult when networks are broad because of insufficient numbers of patients in a practice from any one plan. Holding plans responsible for quality of care is less viable under these circumstances.

Broader networks have also weakened plans' bargaining power with providers. The implications of a group of physicians' or a hospital's refusing to contract with a plan are more serious when networks must be broad. As a result, health plans' ability to secure discounts from providers has been constrained and the incentive for providers to hold down costs is dissipated.

Similarly, the proliferation of out-of-network utilization threatens to weaken cost control and quality improvement efforts. This phenomenon disrupts the financial and organizational structures established by health plans and provider organizations to manage care. For example, in Orange County, demand for out-of-network utilization appears to be contributing to the unraveling of tight provider subnetworks, producing fissures in the organizations that form the core of this delivery system and limiting the progress of care management efforts.

These developments raise serious issues for consumers across the country. Both policy makers and private sector decision makers have looked to managed care as the most viable cost containment strategy in the United States. The Canadian/Western European model, containing costs by limiting resources, has not succeeded in this country and appears less viable today than when it was half-heartedly applied in the 1970s. Heavy patient cost sharing has never been popular but may very well arise by default if other efforts to contain costs do not succeed. Those Medicare beneficiaries without coverage for pharmaceuticals may be the first visible example of unintentional use of the cost-sharing strategy in response to high costs.

At the same time as policy makers and industry leaders look to managed care to foster quality improvement in the U.S. health system, their responses to consumer backlash appear to be eroding this opportunity. While advances in science and medical technology promise continued improvement in diagnostic and treatment options, under the traditional delivery system, individual providers have neither the means nor the

impetus to drive changes in the way care is delivered across the continuum of care. Under managed care, however, the organizations necessitated by this model—whether a health plan or a provider organization—provide a mechanism for promoting quality improvement activity and greater accountability.

Consequently, the decision makers responsible for the purchasing and regulating of managed care—employee benefits managers and legislators on the state and federal level—have a challenging task. They need to identify those shortcomings in managed care that should be corrected through activities of purchasers and through regulation, but at the same time identify those structures in managed care that have the greatest long-term potential to control health care costs and improve the quality of care.

References

Blendon, R. J., M. Brodie, J. M. Benson, D. E. Altman, L. Levitt, T. Hoff, and L. Hugick. 1998. Understanding the Managed Care Backlash. *Health Affairs* 17(4):80–94.

Brodie, M., L. A. Brady, and D. E. Altman. 1998. Media Coverage of Managed Care: Is There a Negative Bias? *Health Affairs* 17(1):9–25.

Center for Studying Health System Change (HSC). 1999. *An Update on the Community Tracking Study: A Focus on the Changing Health System*. Issue brief no. 18. Washington, DC: HSC.

Gabel, J. R. 1999. Personal communication.

Grossman, J. M. In press. Health Plan Competition in Local Markets. *Health Services Research* (forthcoming).

Kemper, P., D. Blumenthal, J. M. Corrigan, P. J. Cunningham, S. M. Felt, J. M. Grossman, L. T. Kohn, C. E. Metcalf, R. F. St. Peter, R. C. Strouse, and P. B. Ginsburg. 1996. The Design of the Community Tracking Study: A Longitudinal Study of Health System Changes and Its Effects on People. *Inquiry* 33:195–206.

KPMG Peat Marwick. 1998. Health Benefits in 1998. Washington, DC: KPMG Peat Marwick.

Lake, T. K., and R. F. St. Peter. 1997. Payment Arrangements and Financial Incentives for Physicians. *Results from the Community Tracking Study*. Data bulletin no. 8. Washington, DC: Center for Studying Health System Change.

Levit, K., C. Cowan, B. Braden, J. Stiller, A. Sensenig, and H. Lazenby. 1998. National Health Expenditures in 1997: More Slow Growth. *Health Affairs* 17(6):99–110.

Reed, M. C., and R. F. St. Peter. 1997. Satisfaction and Quality: Patient and Physician Perspectives. *Results from the Community Tracking Study*. Data bulletin no. 3. Washington, DC: HSC.

Stauffer, M. 1998. Comprehensive Consumer Rights Bills. *Health Policy Tracking Service Issue Brief*. Washington, DC: National Conference of State Legislatures.

St. Peter, R. F. 1997. Access to Specialists: Perspectives of Patients and Primary Care Physicians. *Results from the Community Tracking Study*. Data bulletin no. 2. Washington, DC: HSC.