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Ten years ago, when Alain Enthoven and I proposed "A Consumer Choice Health Plan for the 1990s," we imagined a world in which all Americans had health insurance and health plan competition for consumer loyalty was actively "managed" by sponsors (large employers and government agencies) (Enthoven and Kronick 1989).

The sponsors, we proposed, would use a variety of strategies to assure that health plans succeeded by doing the hard job of organizing the delivery system for quality and efficiency, rather than figuring out how to select favorable risks. Sponsor strategies would (1) make consumers cost conscious (require them to pay more for a plan with a higher premium and less for a plan with a lower premium and reward plans that provide care efficiently), (2) standardize the benefit package (to prevent plans from tailoring the benefit package to select good risks, and to simplify what is inevitably a difficult consumer choice problem), (3) provide information on quality and satisfaction, (4) avoid contracts with "copy-cat" individual practice association (IPA) health plans, (5) risk-adjust sponsor contributions to encourage plans to serve sick people, and (6) assure that plans (and sponsors) had well-functioning grievance procedures. Sponsors would be nimble managers; rather than blindly pursue a fixed menu of strategies, they would continually study trends in the marketplace and determine what actions they needed to take in order to create a market

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that rewards high-quality, efficient health plans. In this hypothetical marketplace, we imagined that successful health plans would be those that aligned (more or less) the incentives of physicians, patients, and health plans; successful plans would enlist physicians as partners, not adversaries.

If only it were so. With 43 million Americans uninsured, we have moved away from universal coverage. (I am painfully reminded of this when I occasionally use my daughter's America On-Line account, which she established in 1993. Her password is "37mill.") Our unwillingness to arrange the rules of health care financing to assure that all persons are covered by health insurance is a political failure which the managed competition proposal was unable, at least in 1993–1994, to overcome.

While the absence of universal coverage is clear, returns on the "managed marketplace" are a bit muddier. Many large employers have standardized benefit packages among competing plans, and have made their employees cost conscious by contributing at the price of the low-price HMO. These trends have sharpened price competition among health plans, and have been accompanied by low rates of growth in health plan premiums from 1993 to 1998.

Price competition has increased, but we do not, for the most part, have active and intelligent sponsors flexibly managing the market to assure that the health plans that succeed are those that deliver high-quality care. Large employers perform some sponsor activities, but eschew many others. Medicare and Medicaid agencies are far from flexible, and their attempts to manage the market are often thwarted by political and bureaucratic obstacles. The many Americans working for small- or medium-sized employers have no effective sponsor other than the limited activities of a state's division of insurance or department of health.

Even consumers with the benefit of sponsors may not be comforted that the sponsors have the consumer's best interest at heart. The benefits managers for large employers may be perceived as being more interested in saving money than in assuring the availability of high-quality care for employees. Similarly, bureaucrats at Medicare and Medicaid may be perceived as more interested in saving their jobs, protecting the taxpayer, or improving their future employment opportunities than in protecting beneficiaries and creating a market that works.

In this environment of partially managed competition, powerful institutional interests are fueling the managed care backlash. Many physicians are unhappy. We do not have a marketplace in which most physicians see their success as tied to the success of their health plan. Some

physicians see health plans as the enemy—organizations that have reduced physician autonomy, lowered the rate of growth of income, created a speed-up in the office, needlessly complicated the referral process, and imposed additional paperwork and hassles. And there is little counterweight in the physician community to this sentiment; outside of organized systems such as Kaiser, not many physicians feel that they can take better care of their patients as a result of managed care. Organized medicine is a strong supporter of many proposals for managed care regulation. Just as important, physician unhappiness has undoubtedly created patient concern. If my doctor is disgruntled with her health plan or dissatisfied with her practice environment, I am likely to be concerned as well. In addition to physicians, trial lawyers, nurses, and other health care workers provide important sources of support for the managed care backlash, lobbying politicians directly and providing financial support to a panoply of "consumer" lobbying groups as well.

Organized support for the managed care backlash is a necessary but not sufficient condition to get politicians excited about patient (and provider) protection legislation. Patient protection legislation also is responsive to voter concerns about managed care. It makes sense for health care consumers to have at least three kinds of worries:

1. We may worry that when we get sick our physician will want to provide us with health care services that would help us get better, but our managed care company will not authorize these services. We fear that a health plan's failure to authorize services could lead to unnecessary pain, disability, or even death.
2. We may worry that our physician is no longer on our side: faced with the financial pressures of capitation, our physician will not recommend treatment that is beneficial.
3. We may worry that even if health plans do not deny needed services, and even if physicians are still on our side, the financial pressures caused by managed care and the disruption it has created will simply cause the health care system to function less well, and that we will suffer as a result. A myriad of specific worries are possible: physicians forced to see patients more quickly, and as a result provide less-thorough diagnosis and treatment; hassles from being required to see a primary care physician in order to get a referral to a specialist, and sometimes not getting a referral we think we need; HMO formularies that keep patients from getting the drugs that would most effectively treat their conditions; money wasted

on bureaucrats and highly compensated health plan executives; inability of hospitals to purchase new technology that would lead to improvements in treatment.

The first concern—about denial of services—is understandable. However, outright denials of coverage for services are relatively rare. When health plans have set up independent review processes for patient appeals, they are infrequently used. While this may be partially due to people not knowing about the appeals processes or how to use them, it is much more likely a result of there simply not being that much to appeal.

Even if denials are rare, the fear that we will be denied needed care strikes a responsive chord in voters and consumers. There is an appropriate and sensible policy response to this fear. State government can and should establish an external, unbiased review procedure and should require that all patients be allowed to appeal coverage denials and obtain a speedy response. Proposals for external review plans are supported widely and have been endorsed by the California Association of Health Plans. Knowledge that a speedy and unbiased external review is available may begin to restore some trust in the health care system, although the existence of this process is unlikely to have much effect on the quality of health care patients receive.

It is, unfortunately, not so easy for politicians to fashion an appropriate response to the two other consumer worries. Politicians cannot pass legislation which will make health plans improve the quality of care that is provided. The U.S. Health Care Financing Administration (HCFA) regulates physician payment arrangements, limiting the percentage of physician compensation that can be "at risk," but there are too many varieties of payment arrangements for the government to effectively assure that physicians cannot have a financial incentive to withhold treatment. Even more difficult is to figure out what legislation could be passed that would encourage medical groups and health plans to develop the environment that patients and doctors desire: telephone systems that work, information technology that gives physicians and other personnel the information they need to function efficiently, good communication between primary care and specialists, well-trained physicians with enough time and support staff to do their job well, front office staff that are welcoming and courteous, and health planning processes that do a good job of assessing the health care needs of an enrolled population and assuring that resources are available to meet those needs.

The well-managed marketplace is supposed to accomplish these goals.

The theory suggests that medical groups that figure out how to deliver high quality, economical care will prosper, and those that do not will be forced to change. Does the market work as intended? For the most part, not yet, although there are some bits of progress. Many health plans have designed systems to increase the provision of preventive services, and these systems appear to be working. Some plans and provider groups have implemented disease-management programs that provide meaningful support for patients with chronic illnesses and the physicians who care for them. Some physician groups and hospitals are systematically studying health outcomes and trying to figure out how to improve them. Many hospitals and medical groups are adopting the customer service mantra of the service industry. But disruption, rather than constructive systems change, has been the predominant response to date from the financial pressures created by managed care.

It is frustrating to policy analysts, politicians, and the public that there are no silver bullets that will magically cause the health care system to function more responsively. In both state capitols and in Washington there are strenuous fights over extending tort liability to HMOs. These fights are largely a digression; making HMOs liable for treatment decisions is not likely to significantly improve quality or outcomes for patients, nor is it likely to seriously impair the ability of health plans to provide cost-effective care. The most likely effect of extending tort liability is that HMOs will be forced to more closely scrutinize the utilization management (UM) decisions made by the medical groups to whom the HMOs have delegated the UM function; this is a mixed blessing, at best. Similarly, many other pieces of managed care reform legislation will have very little effect on improving quality or responsiveness. Some proposals, such as legislation requiring plans to accept "any willing provider" into their network would have pernicious effects; other proposals would be benign, but ineffective.

In environments such as California, where HMOs have largely passed financial risk on to medical groups and have delegated utilization management decisions to them, it is even more difficult to craft legislative remedies that effectively respond to patients' worries. Improvements in quality must come from medical groups, while most patient protection proposals target HMOs. The contracting arrangements between HMOs and medical groups make it difficult for purchasers to hold HMOs accountable—employers, public sponsors, or the legislature can demand better performance or better data from health plans, and the plans can

conveniently respond that they would like to comply, but the medical groups with which they contract are recalcitrant.

What, if anything, can politicians do to either respond to voter worries or to actually improve the functioning of the market? In addition to establishing an independent review process of coverage denials, I suggest three other policy changes that would lead to improved health care quality. One is to provide the administrative resources and political freedom for public-sector purchasers to do a better job of managing competition. Another is to collect and publicize information on health plan and medical group performance; the third is to create an *ombuds* function to help patients navigate their health plan and put direct pressure on medical groups for improvement. I briefly discuss each of these three proposals below.

The Medicare program is the single largest purchaser of managed care in the United States, and in many states the Medicaid program is the largest managed care purchaser. Intelligent and hardworking officials in these programs attempt to hold HMOs accountable for performance and to create a market in which high-quality plans and medical groups flourish. However, they often do not have the administrative resources needed to be successful. Further, the ability of government managers to respond flexibly to changing market conditions is often limited. If the response reduces the revenue or hurts the market position of health plans or provider groups, health plans have ready access to the legislature and the courts. The ability of Medicare and Medicaid program officials to encourage the development of high-quality health care would be increased if they had more administrative resources and greater flexibility, with fewer of their decisions subject to legislative micromanagement.

A second important area for public-sector activity is the collection and publication of information on health plan and medical group performance. Private purchasers (large employers and employer coalitions) do a little bit of this now, and Medicare and some Medicaid programs are working in this area as well. The state of the art in producing and disseminating reliable information that consumers can use when making health plan or medical group choices is not far advanced. Nevertheless, greater public-sector investment in advancing the state of the art and in requiring plans and providers to produce information is warranted: the rewards to health plans and medical groups from improving quality and responsiveness will be much stronger if good information is available on performance than if consumers must rely on word-of-mouth, plan-generated advertising, or anecdotal reports.

Neither of these two proposals—more resources and political flexibility for public-sector bureaucrats, nor additional investment in generating consumer information on performance—is likely to be wildly politically popular. It is not easy for politicians to reassure anxious voters (much less satisfy the demands of physicians, trial lawyers, or health care workers) with such measures. The third proposal—to establish a statewide ombuds program—might both reassure the worried as well as lead to improvement in health care delivery. An ombudsperson—perhaps a nongovernmental organization under contract to the government—would listen to consumer concerns and determine appropriate responses. Sometimes the response would be simply to explain health plan rules, or provide suggestions on methods of resolving problems. Sometimes the response might involve contacting the medical group or plan to make sure they are aware of the problem and engaged in seeking a solution. The ombudsperson would not have regulatory authority but would be a patient advocate, working on behalf of the public.

Summary

Managed care has done a better job at reducing expenditure growth than it has in improving quality. Although reduced expenditure growth is not appreciated by many, it has real benefits. For the majority of Americans who are privately insured, it results in greater disposable income for goods and services other than health care (although the illusion of employer-paid health insurance obscures this reality for many). For Medicaid programs, slower growth of expenditures facilitates efforts at expanding coverage. For low-income workers, slower expenditure growth results in larger numbers of people retaining insurance coverage than would have been the case if premiums rose more quickly.

While there are some victories to which managed care organizations can point, we cannot credibly argue that overall levels of quality and health outcomes are improving as the health care system is massively disrupted by changes in health care finance and delivery. The disruptions create real hardships for some physicians and other health care workers, and worries for many consumers. These worries fuel the managed care backlash. The danger is that politicians will respond to these worries with policies that inhibit the development of high-quality delivery systems. The opportunity is for relatively modest public policy changes—external review organizations, better public-sector purchasing capabilities, public investment in producing and publicizing information on

health plan and medical group performance, and establishment of a public ombudsperson—to respond to consumer worries and lead to improvements in health care quality and outcomes.

Finally, I would be remiss without a reminder that the single most effective action politicians could take to improve health care quality and outcomes would be to change the rules of health care financing to assure that all Americans are covered by managed care. Even with all of its inadequacies, managed care is much superior to the patchwork care available to the 43 million Americans who are uninsured. The managed care backlash is concerned with protecting patients who are insured (and their providers). Far more valuable would be to protect those without insurance. Sadly, no politician has yet figured out how to do this. Still waiting.

Reference

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