The View from the Health Plan Trenches

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The current debate over managed care offers both an opportunity to improve managed care and a danger that some of the gains managed care has made in controlling health care costs and improving health care quality may be undermined.

No doubt, as the industry argues over and over again, much of the current pressure for reform comes from misperceptions about managed care and the reluctance of consumers to accept the message that cost does count. Managed care today is, in a very real sense, between the proverbial rock and a hard place. The rock is the patient/consumer who wants all the choice, access, new drugs, and new technology he or she can get and—here is the critical point—doesn't pay for most of it. The hard place is the employer and government purchasers that don't generally want to pay anymore than they have to. Managed care thus tries to serve two masters—patients and purchasers—who want very different things. Satisfying both may be next to impossible, especially when, as the economist always reminds us, consumers don't perceive themselves as paying their health care premiums. Managed care's key dilemma in this regard is that its greatest contribution—the ability to control health care costs—is grossly undervalued by the American consumer. To the extent that most consumers believe that managed care has lowered costs, they view the benefit as going to employers in lower costs or insurers in increased profits, but not to them.

Indeed, until the consuming public sees the full costs, or at least most of the full costs of health care, it may be difficult for managed care to work

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its way out of the pressure cooker. Given this reality, one is tempted to suggest—tongue in cheek, perhaps—that the best thing for the industry today might be a reverse HMO Act which mandates that all employers offer their employees a traditional insurance plan with easy access to specialists, unlimited choice of physician, an open formulary, and so on. Then, at least, the consumer might see more value, about $1,000 per family, in their much-maligned HMO.

But whatever the squeeze or economics of managed care, and whatever the unwillingness of many to face hard realities, many public concerns are real and need to be addressed. Attacking managed care may be great politics today, but its executives should take little comfort in such a reality. Attacking managed care is good politics for a reason; people are concerned about it. Managed care does impose incentives to do less, and it has not yet convinced the public that those incentives can produce better quality as well as a lower price. Naturally enough, consumers fear the opposite. The industry should not be surprised that charges that patients may not get the care they need strike a responsive chord with the public which, it is important to note, is also the electorate.

Above all, then, the industry must take steps to assure all enrollees that they will get the care they need when they need it—and that needs to be more than a slogan.

In an effort to address this critical issue, the California Association of Health Plans supports a wide array of reform proposals. Most importantly, we support a system of external, independent review of medical necessity decisions. If a plan rejects an enrollee's request for treatment, the enrollee ought to be able to have the case reviewed by an expert or panel of experts and the findings of the expert should be binding on the plan. We also support a new, stronger regulator for managed care, a strengthened ombudsman's office, a shortened grievance process, some rights to a second opinion, reforms aimed at the utilization review process, additional disclosure provisions, and a number of other consumer protection proposals.

The industry also needs to work at simplifying the managed care process and rendering it more consumer friendly. The vast majority of calls that come to HMO or regulator offices are not about denials of care or access to specialists; they are about what is covered, why a certain process exists, whether or not a deductible applies to a certain service, and so on. And as the industry attempts to respond to public demands for choice, the numbers of products and options increase, as does the confu-

sion. In California, the problem is further complicated by the predominance of the "delegated" model, in which many functions are delegated by the HMO to the medical group. The model has many advantages; but simplicity may not be one of them. Many consumers appear confused, for example, as to what their network is—Blue Cross or the medical group. Many are not really aware of what the medical group componet is or its critical role in the system. Add complexity to uncertainty and confusion and concern are likely to result.

The legitimacy of concerns being acknowledged, policy makers still need to assert great care and restraint in addressing them. Unfortunately, there is all too little evidence that they are prepared to do so. Sitting in a legislative hearing these days is likely to lead one to the conclusion that adding new services as well as a host of restrictions on the means by which HMO's control costs will actually lower health care premiums. One thinks, with some humor hopefully, of the many idioms America uses to describe the same phenomenon: you can't have your cake and eat it too; you must face the music and pay the piper; there's no free lunch; you can't have both guns and butter; you can't pass the buck, and so on. Then one wonders, perhaps, about why America has so many expressions to describe and warn against the same behavior pattern. Indeed, maybe there is a reason why we are the only civilization which tends to believe death is an option.

Of course, many reform proposals, as suggested above, are reasonable and appropriate. But many are seriously flawed. In some cases, the flaw may be one extreme element in an otherwise reasonable proposal. For example, some guarantee of a second opinion is in order: but that shouldn't necessarily mean that any enrollee should be able to visit any academic medical center at almost any time and at no cost. Other reform proposals, such as significant limitations on capitation strategies, may be based more on fear than reality. The extent to which individual physicians are actually at risk is a good deal less than the public or reform proponents may imagine. And unless truly justified, such regulation may unnecessarily restrict managed care's capacity to control costs or to innovate in the organization of health care delivery systems. Still other proposals, such as mandates to provide mental health parity, may have obvious value, but must be balanced against the ability and willingness of employers and employees to pay for them. Finally, some proposals, while having obvious political merit, are clearly unwise or unworkable. Highest on this list might be proposals to limit administration and profit to a

fixed percentage of total premiums. Among other things, this proposal suffers from the total impossibility of attempting to determine what are administrative costs: A new computer system to track outcomes of care? A beefed-up effort to recruit only the best physicians?

What's needed? Perhaps three things. First, a recognition on the part of health plans that many consumer concerns are truly legitimate and need to be addressed. Second, a greater public understanding of managed care and, most specifically, of the value of lower health care costs and managed care's role in that regard. Third, an evidence-based debate on managed care. This is where those who read journals like this come in. Today's managed care debate needs knowledgeable intermediaries, those who can explain the values, successes, limitations, and weaknesses of managed care, and who can estimate the impacts, benefits, and costs of various reforms.

Knowledgeable intermediaries won't, of course, all agree. But, as a group, they will inform the debate and move it toward a focus on the most critical problems and the most reasonable approaches to solving them.