Backlash as Prelude to Managing Managed Care

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Backlash: As Prelude to Managing Managed Care

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The cynical view of the managed care backlash runs something like this. First, the media misled the public about how managed care works with sensational, inaccurate, and unrepresentative news *stories,* mostly anecdotes (Ignani 1997, 1998; Hyman 1998a, 1998b). Providers then masqueraded as consumer representatives to protect their own turf (Roth 1997; Kilborn 1998; Hyman 1999). Finally, legislatures practiced medicine without a license and enacted "legislation by body part" (Kassirer 1997a). Such legislation micromanaged clinical decision making by requiring unnecessary hospital use which prevented cost-saving innovations and locked in the status quo.[1] Other legislation, such as bans on "gag rules" that prevent physicians from communicating with patients, addressed problems that had no basis in fact (Ignani 1998). Summed up, the backlash was interest group politics at its worst and produced bad policy.

Managed care organizations (MCOs) and the private sector, so the story goes, are not perfect, but the alternative—having legislatures manage health resources and bureaucracies make health care decisions—is

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1. Consumer-oriented proposals have costs, but they are less than critics claim. For data and analysis on why drive-through deliveries produce only small cost savings, see Tai-Seale, Rodwin, and Wedig 1999. For analysis of cost-protection trade-offs, see Rodwin 1996a: 1374–1379.

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even worse. Experts in the private sector should manage health care.[2] Managers should listen to the public's fears, better explain the rationale for what they do, and be more politic. Over the long run, however, the market will ensure that MCOs deliver high quality health care. Consumers will leave poorly performing MCOs for ones that respond to their concerns (Enthoven 1993).

This account makes some points that are reasonable as individual statements but the story it tells distorts what backlash is about. Recall that managed care is a response to providers abusing their discretion, overusing medical services, often mixing up their own financial well-being with patient welfare. Managed care was the antidote. MCOs have incentives to limit spending, tools to limit the use of services, and can oversee medical practice. These features were supposed to enable MCOs to address problems of a health care system characterized by fee-for-service, indemnity insurance, and sole or small group practices that did not coordinate medical care (Millenson 1997).

In part, they did, but MCOs overreacted. Their solutions created new problems, which MCOs ignored even in the face of public dissatisfaction. The backlash that followed is an attempt to address problems, which the market has not solved. Managed care has also changed. No longer an *alternative*, it is the main option. Because managed care claims to oversee medical providers, the public wants MCOs held to a high standard.

As the public learned about problems with managed care, patients wanted assurances that MCOs would not interfere with doctors giving neutral medical advice and that attempts to reduce spending through financial incentives and rules would not distort clinical decisions. They sought the right to appeal to neutral external parties when MCOs denied medical care. Patients also wanted coverage for visits to emergency rooms when they thought there was an emergency, fewer restrictions on access to specialists, and traditional hospital respite care after a mother gave birth (Rodwin 1996a; Annas 1997; Bodenheimer 1996).

These options were not available at any price on the MCO market. Consumer surveys did not ask the right questions, ignored the answers, or assumed that consumers would make do with the choices offered. But the public had an alternative. They voiced complaints through the political process and used government to obtain their goals. Consumers and providers pushed for legislative standards that helped them both (H.R.

2. For a discussion of how experts in health care have missed important perspectives of patients and consumers, see Rodwin 1994.

358, the Patients' Bill of Rights Act 106th Congress). Backlash against managed care demonstrates consumer voice in action (Rodwin 1997).

Further important consumer protections are unlikely to come without backlash. Recall the story of the boy who is having trouble getting a donkey to behave. His father tells him that he must reason with the donkey, then whacks the donkey with a stick. The surprised son asks, "Didn't you just tell me to reason with the donkey?" "Yes," says the father, "but you need to get its attention first." Surely a crude management tool, backlash has focused the industry's attention on long-standing problems, a prelude to reason.

Consumer Complaints, the Press, and Legislation

The managed care industry set itself up for criticism by fostering expectations not easily met. MCOs claimed that they would *manage* care better than traditional insurers and fee-for-service practice. Through advertising, they projected warm images of doctors and patients. They did not publicize their risk-sharing incentives for physicians or criteria for denying care. This did not prepare the public for the tough procedures used to control health spending and assure quality. MCOs limited available clinical choices and utilization review created administrative obstacles to treatment, which patients resented. Then MCOs argued that they should not be liable for medical malpractice because physicians, not they, make the medical choices. The public was frustrated, and rightly so. When problems arose, MCOs got blamed, not clinicians.

Typical in reporting, press coverage of managed care used individual stories to catch readers' attention and illustrate key points. It focused on failures, not successes. Some newspapers printed sensational stories or, as the *Washington Post* has shown, used anecdotes without checking the facts (Kurtz 1998). Despite errors, the press reported reasonably fairly. Press coverage was neutral 64 percent of the time, critical 25 percent, and positive 11 percent (Kaiser Family Foundation 1998). The press accurately reported public dissatisfaction (Blendon et al. 1998), but as is typical, skimped on policy and investigative reporting.

Critics of press coverage often do what they complain about: to bolster their argument, they pick unrepresentative examples of error. They discount the sophisticated reporting in major national newspapers, National Public Radio, and some television programs. They ignore first-rate investigative journalism by regional newspapers, such as the Ft. Lauderdale

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Sun-Sentinel's five-year series highlighting a general failure of regulatory oversight, as well as fraud and mismanagement, by several managed care firms, and problems in marketing to Medicaid recipients (Schulte and Bergal 1990, 1993, 1994, 1995).

MCOs, supposedly responsive to consumers, and equipped with sophisticated information systems, were clueless about significant problems. They were also slow to change once consumer complaints, the press, and lawsuits lay problems on their plate. Consider a case that reveals a systemic problem.

Since 1971, Kaiser Permanente required its members to forego the use of courts and to arbitrate malpractice and other legal complaints. This practice was challenged in 1991 when Wilfredo Engalla's estate sued Kaiser Permanente for medical malpractice. Engalla claimed that Kaiser breached its fiduciary duties to members by administering the arbitration system to its advantage and that Kaiser intentionally delayed the appointment of arbitrators (for periods longer than would be required for a trial) in an effort to obtain more favorable settlements. Kaiser argued that it had no fiduciary duty to administer its arbitration system impartially and could "act in its own business interests" (*Engalla v. The Permanente Medical Group*, 43 Cal. Rptr 2d 621,626). The court found that in 99 percent of cases, neutral arbitrators were not appointed in the sixty days that Kaiser set as a time limit in its rules and that it took, on average, 863 days from filing a claim to have a hearing. Engalla waited 144 days, then died the day after the arbitrator was appointed.

Rather than resolve the problem quickly, Kaiser let the case drag on. It set the groundwork for long-running news stories that tarnished its image and inspired legislation to address the problem. In 1993, rather than enforce the mandatory arbitration agreement, the trial court found sufficient evidence of fraud to allow the case to be heard in court. In response to the case, California enacted legislation in 1996 that mandated an alternative process to choose arbitrators if one was not appointed in less than thirty days (California Health and Safety Code, Sec. 1373.20). The case was appealed in 1995 to the California Court of Appeals. In 1997, the California Supreme Court reviewed the case. It said, "There is evidence that Kaiser established a self-administered arbitration system in which delay for its own benefit and convenience was an inherent part, despite . . . contractual representations to the contrary" (*Engalla v. The Permanente Medical Group*, 1997: 951). Also in 1997, and again in 1999, bills were introduced before the California legislature that would ban health care or consumer contracts that *require* arbitration of disputes (A.B.

1557, Cal. 1997; A.B. 858, Cal. 1999). In January 1998, a blue ribbon panel appointed by Kaiser recommended that its arbitration system be administered by neutral outside parties (Blue Ribbon Advisory Panel 1998). Kaiser's reformed system started resolving claims in April 1999.

Backlash would have been defused years ago if Kaiser had adopted a neutral system or let members choose whether to arbitrate or go to court. But like many other industries subject to public scrutiny, MCOs denied significant problems exist, opposed standards and governmental oversight, and raised spending on public relations (Jeffrey 1998).

The Perverse Logic of Incremental Legislative Change

What is most significant about recent legislation is not its detailed provisions, but its political dynamic. It pressures the managed care industry to respond to public sentiment or risk further regulation (Annas 1995). The legislative response to managed care problems makes more sense than critics admit when one considers the constraints. There are few opportunities for consumers to exercise voice in MCO governance, or in organizations that exert influence over MCOs, such as purchasing cooperatives and accrediting organizations (Rodwin 1998). So legislation is the main voice option. Health care consumers have diffuse interests and, aside from a few chronic disease groups, are not effectively organized (Rodwin 1996b). They therefore rely on coalitions, and providers are natural allies even though the two groups' interests coincide on some issues but not on others. Not surprisingly, providers have used this opportunity to protect their interests as well. Yet most standards do serve the interest of consumers.

Some managed care legislation sets too detailed standards (e.g., maternity care) (Kassirer 1997a) or is unenforceable (prohibitions on gag rules). Yet most legislative standards (e.g., external review, access to specialists, network accessibility, coverage of emergency care) (Tapay, Feder, and Dallek 1998) are workable and reasonable. True, a federal agency to oversee health care could allow for continued flexible oversight of MCO problems, an advantage over legislation. However, detailed, piecemeal legislation makes good sense given political constraints. Americans are wary of broad regulatory authority and more apt to support legislation that addresses concrete problems. The Republican majority in Congress also opposes a strong federal role, but makes exceptions for targeted regulation when subject to political pressure.

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The managed care industry also fostered this approach, although it opposed the legislation produced. The American Association of Health Plans (AAHP) argues that MCOs are already subject to costly, complex, overlapping, and fragmented regulations which micromanage decisions better left to the discretion of private firms (AAHP 1998). But if there is to be regulation, the industry argues, it should be only so much as necessary to deal with clear problems, rather than a broad grant of authority. When reform seems inevitable, MCOs push for standards that go halfway and protect their key interests. (Senate passed Patients' Bill of Rights, 15 July, 1999.) Industry, more than consumers, responds to symptoms, and in a piecemeal fashion, even when problems are systemic.

External Review of Denial of Services: A Halfway Reform

Like physicians who oppose managed care, MCOs seek to preserve their autonomy. The AAHP opposed legislation which enacts a patients' bill of rights, guarantees payment for emergency room services when laypeople have reason to believe they have an emergency, requires minimum hospital coverage for birthing (Marshall 1995), and bans gag rules (Pear 1997a). It recommends instead unenforceable industry standards and voluntary codes of conduct (Ignani 1999; Kassirer 1997b). Kaiser Permanente, Group Health Cooperative of Puget Sound, and HIP Health Insurance Plans, however, have called for federal consumer protection legislation, though not very strong measures; they are exceptions (Pear 1997b). The industry's general stance toward regulation is to defeat, or at least weaken it. Their approach to external review of denials of treatment illustrates their approach.

Health care consumer advocates have been clamoring for the right to appeal denial of treatment to neutral outside parties ever since the 1993 Clinton health care reform proposal (CCQHCR 1993). President Clinton's Commission on consumer protection and quality in health care recommended such external review in 1997 (Advisory Commission 1997). Opponents took out advertisements portraying the legislation as a "Frankenstein" (see Figure 1). They said it would significantly raise health premiums and lead to increased numbers of uninsured (Health Benefits Coalition 1998),[3] despite good studies suggesting the contrary

3. Over thirty firms including the American Association of Health Plans and the Health Insurance Association of America signed the advertisement, which specifically opposed the Patient Access to Responsible Care Act.

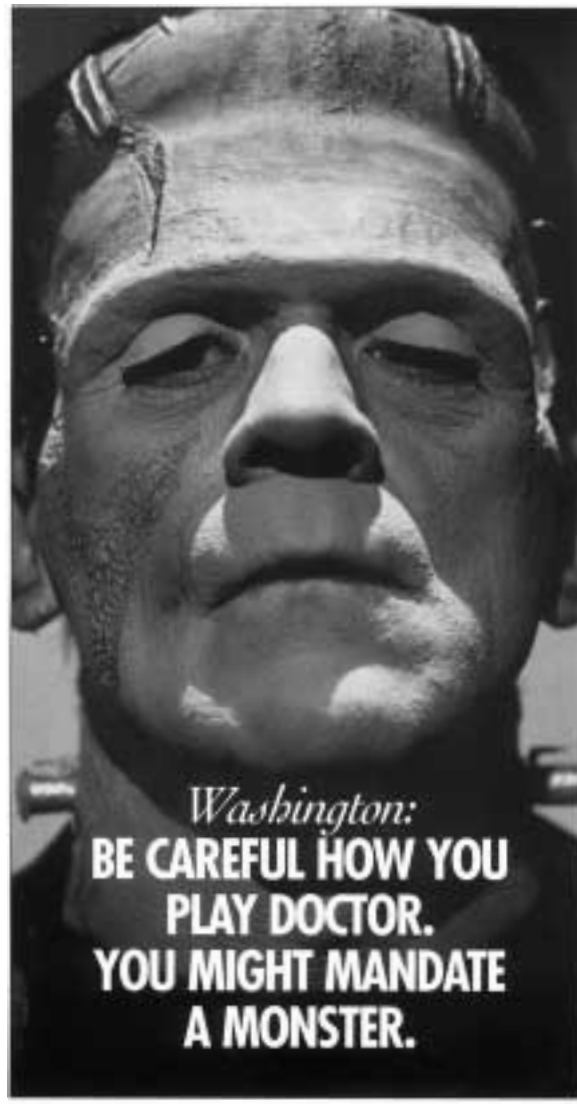

Figure 1 Health Care Frankenstein. *Source:* Courtesy of the Health Benefits Coalition

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(Dobson et al. 1997; Hunt et al. 1998).[4] One California MCO administrator's response was typical. He told me in 1997 that his MCO used external review for denials of experimental treatment or organ transplants, but that it was not economically or administratively feasible to allow independent review of all denials of treatment. Moments later he walked me down the hall to speak to colleagues who administered benefits for Medicare, a program that automatically reviews *all* denials of care and other grievances as well. They found complying quite feasible: just a cost of doing business.

In December 1998, the California Association of Health Plans (CAHP) did an about-face and supported voluntary external review by its members and also legislation that would set rules for external review (CAHP 1998; A.B. 55, Cal. 1998; A.B. 189, Cal. 1999; A.B. 254, Cal. 1999). Why the change? "If you can't beat them, join them." Regulation made MCOs use external appeals for Medicare patients. Large damage awards convinced MCOs to allow (and then sponsor legislation requiring) independent review when MCOs denied experimental treatment and organ transplants (*Fox v. HealthNet*, No. 219692 1993 WL 794305 [T.D. Cal. Jury, 23 December 1993]; A.B. 1663, Cal. 1996). Then eighteen states enacted legislation creating a right to external review for all patients and similar legislation was introduced in Congress (Pollitz, Dallek, and Tapay 1998).

Was it simply an idea whose time had come? Not quite. By supporting legislation, CAHP (and AAHP at the federal level) were able to garner good public relations while securing changes in the bill that limited its effects. They also hoped to substitute external review for what it feared most: legislation that would make MCOs liable for their own malpractice and that of affiliated doctors (Ignani 1999: 13). The bill CAHP supports only requires independent review for disputes over medical necessity, not disputes over what benefits are covered under contracts. MCOs are likely to interpret ambiguous contract terms to their advantage and deny payment or services. In contrast, courts (and possibly independent reviewers) interpret contracts against the drafter, and in favor of consumers. In fact, of cases where care is denied in Medicare, 65 percent are due to disputes over coverage (personally communicated to me by David A. Richardson of the Center for Health Care Dispute Resolution on 4 March 1999). Given that under the proposed legislation MCOs won't have all claims automatically reviewed, the error rate is unlikely to be less and

4. Dobson et al.'s (1997) cost estimates ranged from as low as .003 cents per person per month to as high as seven cents per person per month. Hunt's best estimate is ten cents per person per month.

probably will be higher. The CAHP supported bill probably excludes over half the appeals over service denials.

Public Policy and Managed Care

The AAHP points to the successes of MCOs—they reduced unnecessary services and innovated ways to promote quality—then claims that all is well. Should we conclude that MCOs ought to manage health care as they wish? Well, no.

Over the past two decades, and especially since the defeat of the Clinton health reform proposal in 1993, the federal government has effectively delegated authority to MCOs to ration medical care, decide what rights consumers should have, and to make other important health policy decisions. Yet, government should not shirk policy choices or public management once the public raises its voice. The monitoring that we apply to physicians and hospitals also makes sense for MCOs. Most private actors—including MCOs—need oversight. Firms that manage medical care and subject doctors to oversight should be subject to standards that withstand professional and public scrutiny.

The odds are, however, that our patchwork system of regulation, mostly at the state level, will muddle along for at least a while. However, states can't do an adequate job. The Employee Retirement Income Security Act preempts from state insurance regulation firms that self-insure, so most employees are not subject to state oversight. Also, state insurance laws don't usually create medical quality standards. There are also limits to what can be achieved through piecemeal federal legislation. Malpractice and other tort litigation also have limited ability to hold MCOs accountable (Jacobson 1999; Weiler et al. 1993; Brennan et al. 1991; Leape et al. 1991; Localio et al. 1991). We need new approaches.

A national regulatory authority could be more efficient and systematic, but is unlikely to be tried before alternatives are exhausted. It took the Great Depression to start the comprehensive regulation of the securities market and an environmental movement to pass major environmental legislation. Despite initial howls from the industries regulated, they function better than before, even allowing for occasional senseless regulations and regulatory failure.

Greater regulatory oversight for MCOs will not mean a return to physician autonomy. There is no going back to fee-for-service and indemnity insurance any more than we will swap cars—because of their dangers—for horses and buggies. Yet the cars of today are better and

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safer than in the past because of federal regulation and consumer advocates who promoted seat belts, air bags, and other safety features, as well as tort awards against manufacturers who chose to increase risk in order to cut costs. Managed care is not yet as good as it gets. It will improve as it is subject to consumer pressure. Backlash is unlikely to disappear until the industry matures and thoughtful regulatory authority protects the public, and the industry from itself.

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