Strengthening State Government through Managed Care Oversight

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The distress that managed care has provoked among consumers and health care providers is also the source of significant changes in state health policy. State officials are increasingly aggressive managers of the health plans and providers with whom they contract for acute, long-term, and behavioral health care. In more than a dozen states, government purchasers collaborate with their business counterparts to regulate these contractors by requiring them to disclose information.

Outdated ideologies obscure the emerging influence of the states as both purchasers of care and coregulators with private corporations of a competitive market in health services. States are the largest purchaser of health care in every regional market. They purchase health care for their employees and retirees, as well as for poor children and adults, frail elders, persons with mental illness and developmental disabilities, and prisoners. In 1997, state spending for health care, not counting federal aid, was $208.5 billion (NASBO and RSG 1999).

Leaders of state government were early enthusiasts of managed care; a few in the 1980s (notably in Arizona and Wisconsin), most of the rest in the early 1990s. Like their counterparts among private sector purchasers, these officials found compelling the logic of making health care markets more competitive.

Managed care promised to contain the rate at which costs increased and to improve the quality of care. The new strategy could contain costs by reducing the oversupply of hospital and specialty services and preventing overutilization of care. It could improve quality, especially for

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persons with chronic disease, by holding providers accountable to standards drawn from the findings of clinical epidemiology, usually called "evidence-based research." Managed care, in sum, seemed sufficiently promising for legislators and governors to risk retribution from the hospital and physicians' organizations whose members' incomes and professional autonomy it threatened.

This new approach to policy substituted competition for state regulation of capital investment and prices. Legislators and executive branch officials in most states learned in the 1970s and 1980s that regulating capital spending by requiring certificates of need did not reduce the growing oversupply of acute hospital and specialty services. Officials in several states decided that regulating reimbursement to hospitals and nursing homes did not contain cost increases sufficiently to justify unceasing political pressure to raise rates from both providers and advocates for the poor and the frail. By 1990 state rate regulation had only a handful of prominent supporters, mainly in Maryland, Massachusetts, and New York. Moreover, spending for Medicaid increased no matter what states did to control costs. The burden of Medicaid became intolerable when the recession of the early 1990s reduced states' tax yields (Fox and Ludden 1998).

The promise of managed care enabled leaders in a few states to propose increased access to health insurance without new federal subsidies. The architects of health reform in Oregon and Minnesota in the early 1990s, for example, relied on managed care to control per capita costs over time by reducing unnecessary utilization of acute care and increasing access to preventive services (Fox and Iglehart 1994).

The capacity of state government to manage complicated programs had improved since the 1950s, when persons across the political spectrum joined academics in dismissing states as incompetent, unrepresentative, corrupt, and, as a result, obsolete. Court decisions in the 1960s forced legislative reapportionment on behalf of voters in cities and the growing suburbs. The enormous increase in federal grants to the states for health care, education, social services, and criminal justice in the 1960s and 1970s brought new requirements for accountability. These requirements gave the states incentives to improve the pay and qualifications of their employees and purchase modern information systems. Many states, moreover, had effective policies for economic development and higher education (Fox 1997).

This history encouraged leaders in most states to embrace managed health care as an extension of what they were already doing to spend

state appropriations and federal grants. Each state had considerable experience monitoring the behavior of vendors of health services and reimbursing them for negotiated costs. State contracts frequently placed vendors at risk, especially under prospective payment systems. Risk-based contracting with managed care organizations was a logical next step that required new policy for setting prices and monitoring compliance.

The backlash against managed care among consumers, physicians, and hospital executives was in many ways a new version of a familiar problem for state officials. It resembled the outrage they addressed when voters, advocates, providers, and the media complained, as they did routinely, about policy and spending for transportation, education, and criminal justice.

But the new backlash against managed care was unique in two ways. The focus of the backlash was managed care organizations, not state government. State officials had potential allies among private employers and labor unions in making policy to address the outrage of consumers and providers.

More important, the backlash created popular demand for improved oversight and more regulation by the states. The backlash was a political opportunity for politicians of the center, both Democrats and Republicans, following two decades of rising antigovernment sentiment that had recently included the adoption of term limits in twenty-one states.

As a result of this new political situation, officials in many states behaved in ways similar to their counterparts among health care purchasers in the private sectors. They criticized special pleading by providers, more rigorously monitored contracts with managed care organizations, and expanded consumers' choices among providers in exchange for higher premium costs.

State officials are more vulnerable than many of their private sector counterparts to complaints and advocacy that are based on irritation or greed rather than on evidence that harm has been done. Notable examples of this vulnerability included passage of laws in more than twenty states that mandated hospital stays after childbirth and bills introduced in every state, and passed in many, that required managed care organizations to contract with any willing provider.

By 1996, officials in an increasing number of states recognized that both the promise of managed care and the backlash against it created an unprecedented opportunity for profound change in health care policy. State officials who purchased care for large and diverse populations sought allies among private sector purchasers in order to strengthen both

sectors in negotiations with managed care organizations. An increasing number of business leaders decided that they shared interests as purchasers with state government. However, many of them were wary of the aspirations of state officials to regulate employee benefits and the companies with which self-insured employers contract to administer their health plans.

Over the next several years, many public and private sector purchasers began to coordinate their purchasing power to influence the actions of managed care organizations. By 1999, for example, leaders of business and government in a substantial number of states were collaborating on policy to regulate managed care through the disclosure of information. Formal public-private collaboration on information policy has been documented in ten states (RSG 1999). In others, there is evidence that collaboration between state officials leaders of coalitions of private sector purchasers occurs informally.

In a growing number of states, public and private purchasers have similar information policies that specify what data managed care organizations will submit, how it will be audited, and how it will be used. As a result of these policies, data are now available to the public in several states about what services health plans do and do not routinely offer to patients with particular conditions, as well as about consumer satisfaction. In some states, plan sponsors in both sectors share data about cost and outcomes, under strict rules governing privacy and confidentiality. In still others, private and public sector purchasers have begun only recently to collaborate on information policy.

Moreover, some states are choosing to manage considerable health care themselves as an alternative to contracting management to health plans. This change from risk-contracting to supervising providers is occurring initially in long-term care and treatment for persons with severe and persistent mental illness, services for which states are the largest purchasers. In both long-term and behavioral health care, states are responding to backlash from consumers and providers and consolidation in the managed care industry by using their market power to be more assertive managers. State officials, like some private sector employers, in Minnesota for example, are experimenting with direct contracting to providers.

The shared self-interest of public and private sector purchasers also generates business support for state regulatory initiatives in other areas of health policy. For example, private sector purchasers in twenty states have generally supported bills to regulate the acquisition of nonprofit

hospitals by investor-owned corporations, the conversion or sale of Blue Cross and other nonprofit health plans to for-profit corporations, and mergers among nonprofit hospitals. Private sector purchasers are as eager as their colleagues in state government to prevent provider monopolies and to avoid increased taxes to replace community benefits that nonprofit providers and plans had exchanged for tax exemption (Fox and Isenberg 1996). Another example is the shared interest of state and private purchasers in encouraging such alternatives to nursing homes as housing with supportive services.

Three issues, however, threaten the political alliance of state and private sector purchasers. One is the volatility of antitax and antigovernment sentiment among voters. A second is uncertainty about how many states can maintain and improve their managerial capacity. Senior state officials remain underpaid and often underappreciated in comparison with their peers in business, the professions, and the nonprofit sector. If antigovernment advocacy groups are not marginalized for at least several years, states are unlikely to be able to offer salaries and career paths that compete with those in other sectors. Third, uncertainties about federalism continue to impede the efforts of state officials to be effective public managers (RSG 1998). The federal Health Care Financing Administration, for instance, has transposed its suspicion of state flexibility under Medicaid to its implementation of the State Children's Health Insurance Program.

The vacuum that results from the preemption of state regulation of employee benefit plans under the Employee Retirement and Income Security Act of 1974 (ERISA) remains the most difficult issue in contemporary federalism (Copeland 1998; Fox and Schaffer 1989). On the one hand, Congress has punctured the vacuum three times since 1997 and may do so again if it legislates to protect consumers enrolled in managed care (Atchinson and Fox 1997). Moreover, the U.S. Department of Labor has recently been more willing than ever before to fill the vacuum with regulation and enforcement. On the other hand, there is still considerable support in Congress and among effective lobbyists for measures to extend ERISA preemption to health insurance markets for small business that are now regulated by the states.

These uncertainties should not, however, obscure an important change in the context in which federalism is debated. As a result of managed care and the backlash against it, a growing number of people have firsthand evidence of the capacity of state government to intervene effectively in health care markets. Managed care, it is conventional to say, is

a necessary if painful transition from fee-for-service medicine and cost-based reimbursement to unknown but perhaps more cost-effective forms of organization. Managed care may also turn out to have assisted state government in acquiring new allies and supporters and hence new responsibilities in management and regulation.

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