

# Managed Care: *Devils, Angels, and the Truth in Between*

BY EMILY FRIEDMAN



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I was on an airplane, seated next to a man who was a high-ranking executive of a major hotel chain. I was making notes for a piece I was writing about managed care. He asked what I was doing, and I told him that I was trying to analyze the backlash against managed care that had led many people to believe that all health plans were a form of the Devil Incarnate. He sniffed and said, "Well, aren't they?"

I replied by asking him how he would respond if I turned to him and snarled, "Those @!!\$\*&#! hotels! They're all dirty and overpriced. The room service never arrives, the fax machines don't work, and the staff are hostile and incompetent." He paled and said, "But *our* hotels aren't like that! They're very good. We have much higher standards than that!"

*Touché.*

That exchange is a good metaphor for what is happening in the wonderful world of managed care these days. On one side, we have a wildly pluralistic bunch of health plans that run the gamut from fast-buck profiteers to community-conscious, long-established not-for-profit entities. Many of these plans have about as much in common as I do with Sen. Jesse Helms. Yet they are all defined—and condemned—as "managed care."

These plans are also represented by very effective lobbyists and advocates. Their public relations and policy campaigns often focus on opposing any effort at regulation, no matter how mild, constantly warning that any attempt to legislate, regulate, or otherwise curb inappropriate managed care behaviors will lead to skyrocketing premiums and millions more uninsured Americans.

On the other side, we have a large and growing collection of plan members, patients, families, consumer advocates, politicians, physicians, hospital executives, other providers, policy wonks, attorneys, and journalists who paint managed care as a hideous and homogeneous monolith, an Evil Empire bent on killing patients, destroying caregivers, and wrecking the American way of life.

## A Collision of Beliefs

So far, the result of this collision of beliefs has been a tidal wave of negative news stories, countered by letters or editorials defending managed care; legislative initiatives in virtually every state to protect patients, providers, or both, including bills in a couple of states where there was no managed care activity at the time; a bitter debate in Congress over competing "patients' bills of rights," none of which has become law; litigation and more litigation; and growing support for federal legislation that would allow plan members or families to sue health plans for malpractice in state court, an option that most courts have ruled is barred by current federal law.

The public is confused and nervous; politicians are using managed care as a campaign issue; the plans are pleading innocent; the attorneys and consumer advocates are crying "foul"—and some 99 million people are now members, voluntarily or involuntarily, of managed care plans, according to SMG Marketing of Chicago. Among that group are about 15 percent of Medicare beneficiaries, most low-income Medicaid beneficiaries, and even hundreds of thousands of prison inmates, whose care is increasingly being turned over to investor-owned prison managed care companies. Talk about a captive population!

Meanwhile, more and more providers—especially physicians—are joining the fray, howling to anyone who will listen that health plans are ruining healthcare by forcing physicians to skimp on services, stealing doctors' income, "deselecting" physicians from plan contracts for no reason, hurting or killing patients, and profiteering like mad. One young physician of my acquaintance recently described capitation as "obscene"; another complained to me that "you can't do a decent physical on a patient in 15 minutes!"

There are more issues involved in all this than can be covered here. What I do hope to argue for is a more rational approach to the debate. There has been enough hysteria. There has been enough exploitation and opportunism. There has

been more than enough lying and deception. There must be a better way to address these questions than standing around screaming at each other while trying to woo policymakers to one side or the other. We must begin to unbraid the rope of managed care that is currently being used to threaten or lynch the opposition, and try to tease out real issues from false. It might not make the debate any more pleasant, but it would certainly enhance its quality and precision.

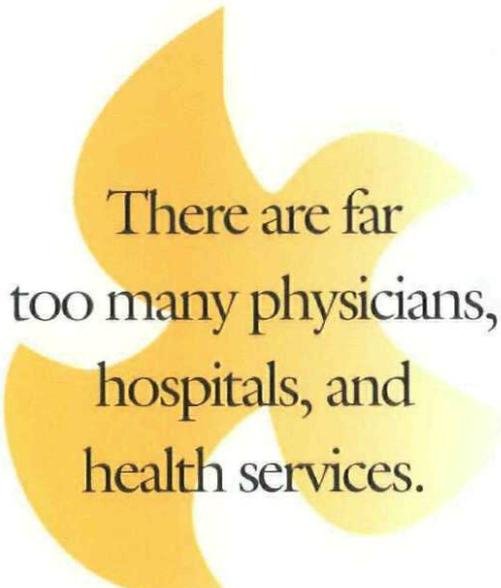
## Unbraiding the Rope

I would first like to dispense with several inaccurate beliefs. One is that managed care is inherently evil and riddled with perverse incentives. Well, all payment policies are riddled with potentially perverse incentives, in and out of healthcare. Managed care is just a way of organizing healthcare payment and sometimes health services, and it is no more evil in concept than any other way of organizing things. Judgment must be based on how health plans behave.

The second myth is that managed care will go away if we just kick it hard enough. It won't—and if it does, it's quite certain that we will not return to fee-for-service arrangements, whose costs were even worse than managed care's, and which were almost impossible to regulate or even monitor. So if managed care doesn't work, we will likely head in the direction of a public utility or single-payer model. But that will be a long time from now; for the moment, managed care is the predominant long-term trend in healthcare.

The third myth is that angelic providers are being forced to do terrible things to patients—lie, deny, cheat, steal—by the devilish health plans. The fact is that much of this provider angst is rooted in three less innocent truths.

First, providers—physicians in particular—are seeing their net incomes decline, and they are blaming it on managed care. They are right, in part; managed care plans and entrepreneurs, seeing providers throwing money around like there was no tomorrow, realized they could move into the market and make at least one-time huge profits by extracting discounts, so they did. But the root cause of provider and physician income decline—and managed care success—is that there are far too



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many physicians, hospitals, and just about every other service in healthcare, and sooner or later this oversupply was going to force incomes down. All that was necessary for this to happen was for providers to lose control of the healthcare system—and they lost that to payers and employers some time ago.

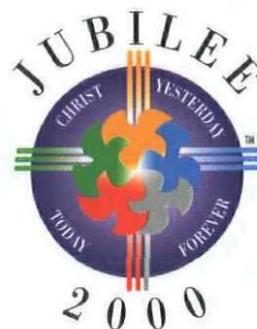
Second, healthcare providers are a stodgy bunch—conservative as all get-out and change

resistant to a fault (and it is a fault). Confronted with payment arrangements, incentives, rules, procedures, and policies that in many cases are wildly different from or even the opposite of what they learned in school, they rebel. We all do when faced with profound changes in how we usually do things. But that doesn't mean the changes are wrong or inappropriate; it just means they are changes.

The third underlying reason for provider—as well as patient—unhappiness is that managed care (if you can make any global characterizations about it at all) encourages more conservative healthcare practice. It also limits choice of provider, in one form or another. This leaner approach flies in the face of the “more is better” culture that pervades American society generally and medical education in particular.

This is the land of 32-ounce steaks and 17 brands of canned chili, and we like it that way. Anyone who even purports to claim that less is better and that limited choice is perfectly acceptable will face rough sledding. It doesn't matter that endless choice of provider isn't available to anyone these days except in the Medicare program, or that hundreds of thousands of patients have been seriously injured or maimed or killed by unnecessary treatments and procedures. The culture of managed care is different from the culture of the society around it, and it makes people nervous.

The final myth is that all managed care is the same. Nope. Some plans are capitated fully; some use selective capitation; most still use discounted fee for service. Most, but not all, plans are investor owned. Some are highly sensitive to their communities; others couldn't care less. Some have employed or exclusively contracted physicians; most do not. Some are regional, some national. Some spend the vast majority of their revenues on patient care; others spend far less. Some are in it for the long haul; others are here today, gone



## Justice Is the Theme

Ms. Friedman's article, the third in a series, explores an issue of major importance for Catholic healthcare in the new millennium.

tomorrow. When you've seen one HMO, as the joke goes, you've seen one HMO.

## The Real Issues

It seems to me that those who actually provide services to patients, as well as plan advocates, regulators, policymakers, and wonks, would be well served by jumping off their respective bandwagons of either unswerving adoration of all managed care, or mindless hatred of all managed care, and start making some distinctions. These are the issues and questions on which I think these distinctions should be based.

**Plan Ownership** Two-thirds of all health plans are investor-owned, and two-thirds of all enrollment is in investor-owned plans. This sets up what is, to my mind, an irresolvable conflict between duty to investors and duty to members and patients. This is not to say—believe me!—that not-for-profit plans are all wonderful and are always honest with patients and never interfere in clinical decision making. Nor does it automatically imply that every for-profit plan is grasping every dollar it can find to send to Wall Street, regardless of the consequences. It does suggest to me that when patients and families are competing with investors for money, patients and families will lose.

The fact is, however, that most managed care is for-profit, and that is not likely to change any time soon.

There are actions providers can take in the face of this. One is to make rational decisions about which plans to contract with. If the plan has a horrible reputation, or looks and smells like a short-term "investment opportunity," don't contract with it. Furthermore, providers can share their concerns with employers, business coalitions, and other purchasers, seeking to encourage them to contract with responsible plans. It also goes without saying that ethical providers do not accept equity positions, stock, or partnerships in organizations with which they contract—that really is a perverse incentive.

Most important, if providers really think that most of the plans in their markets are more Wall Street than Main Street, they can start their own. Some provider organizations already have. The Balanced Budget Act of 1997 gave providers the chance to form provider-sponsored organizations (PSOs) that can contract directly with Medicare to



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provide managed care services to beneficiaries. So far, PSOs have been a non-event, with one PSO (sponsored by a Catholic organization) licensed as of the beginning of 1999. The general reason given for lack of interest in PSOs by providers is that they "don't want to take the risk." Well, fine; but then don't complain when sleazy for-profit health plans put you in compromising positions.

And by the way: What kind of health plans do providers offer their own employees? Often they contract with the very plans whose behavior they condemn in public. What kind of message does that send, especially to the employees?

**Plan Structure and Risk Arrangements** As everyone knows, health plans these days come in 57 varieties—staff, group, network, IPA/broker, PPO, point of service, mixed, and on and on. They all have their advocates. My personal preference is plans that integrate the provision of health services with the *insurance* of health services, such as the old standby Kaiser Permanente. I also strongly favor the salaried practice of medicine because I think it is unfair to patient and provider alike to have a physician's income dependent on how much or how little care he or she provides to patients.

However, this model represents a tiny minority of health plans these days. The reasons are simple enough. Owning your own hospitals, clinics, and other bricks and mortar means huge overhead and great difficulty in adjusting to increases or decreases in member enrollment; you're laying people off one year and restaffing the next. Furthermore, virtually every study on the subject has found that salaried physicians' productivity is much lower than that of self-employed or other nonsalaried practitioners.

But the main problem is risk, in the insurance sense. It is much safer for a plan to contract with an employer or payer for a population of "covered lives," and then essentially sell them and their medical records to the lowest bidder while pocketing a hunk of the premium. All the risk—for cost overruns, a bad flu season, sicker-than-average patients—is shoved onto providers.

It is this issue of risk that has led to many unacceptable practices, most of them geared to making patients and providers, rather than plans, vulnerable to great financial loss. Other strategies are focused on avoiding the sick and disabled—heaven forbid that sick people should actually have coverage!



Providers should be willing and able to shoulder some, but not all, of the risk if they are contracting with an outside health plan. They should also challenge the plan about enrollment and recruitment practices, to ensure that people who are ill, or disabled, or poor, or minority are not ignored or discouraged from joining the plan. Think about it: When was the last time you saw an HMO ad on television that featured someone who was blind, diabetic, or in a wheelchair? No, it's always the "Centrum couple"—beautiful, looking like they're maybe 40, and skipping stones while on a backpacking trip. Obviously, the typical 75-year-old American.

The long-term solution, of course, is to see to it that the health status of enrollees does not result in financial penalties, by outlawing any insurance discrimination based on how sick or healthy an enrollee is. All premiums in a given area should be the same, adjusted only between regions for cost-of-living considerations. Specific plan populations should be risk-adjusted, with higher payments to plans with sicker members; Medicare is supposed to initiate this practice in 2000. And any plan found to be discriminating against people because of their health status should lose its license and eligibility to participate in Medicare and Medicaid.

**Plan Priorities** What does the plan value? Where does it put most of its energy? Is it involved in subsidy of medical education, nursing education, and clinical and health services research? Does it really focus on prevention, or does it just talk the talk? Is it involved in any way in care or subsidy of the uninsured? Does it contract with "safety net" providers? Does it market its wares in all parts of the town, or only the affluent suburbs? Does it have a mission statement, and, if so, do its actions reflect that statement?

It is amazing how many managed care executives are perfectly honest (at least in private meetings) about their health plans being temporary investment opportunities. It is amazing how many are founded by people who simply pile up the requisite number of "covered lives" (often by pricing products unreasonably low), get that stock price up to the right level, and then either exercise stock options or sell out to a larger plan. There are literally billions of dollars to be made by this method. But the people could just as easily be buying and selling electronics as human beings' healthcare.

It must also be said that providers can be every bit as cynical in their motivations, with the added attraction that they are often hypocritical about it as well. At least investor types are honest about what they are doing.

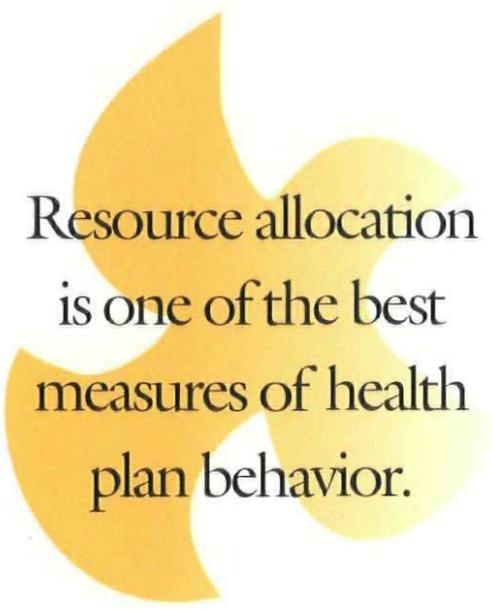
Providers and patients would be well served by demanding a code of conduct—one that has teeth—for all health plans. That code should serve as the basis for granting or denying state licenses

and participation in Medicare and Medicaid. There should be periodic monitoring and surprise visits. Financial records should be available for independent audit. And plans should be required to make public the priorities they claim to espouse. I think it would result in better behavior all around.

**Relations with Providers** It is sadly true that many physicians and some hospitals would be perfectly willing to put up with health plan misbehavior if they could simply get a larger piece of the pie. In other words, their worries about managed care are all financial. On the other hand, physicians, nurses, and others have made legitimate complaints about health plan policies that play fast and loose with provider ethics. These include "gag clauses" (which were never in common use, but nobody knows that), alluring incentives laden with conflicts of interest, penurious capitation, simple disrespect, and ditching physicians whose practices happen to attract diabetics or schizophrenics or persons with AIDS as patients.

In judging plans and deciding which ones to do business with, providers should ask around, especially among their medical staff members, about how the plan treats them and their patients. Don't just settle for gripes about money; but take very seriously indications that plans, intentionally or not, are crippling clinicians' ability to do their jobs. **Communication with Patients** Several studies have found that the public is hopelessly confused about managed care. And small wonder; many health plan ads are deceptive, patient information materials are often a joke, and some customer service phone lines have an average time on hold of three days. In fact, I have come to the reluctant conclusion that many plans *want* to keep people in the dark. If that's the aim, they're succeeding; one recent survey by the Employee Benefit Research Institute found that 56 percent of people in health plans swear they've never been in managed care, and 6 percent of people in indemnity coverage think they're in managed care. In a recent AARP (American Association of Retired Persons) survey, 55 percent of Medicare beneficiaries reported that HMO ads were a major source of information for them about managed care.

Health plans worthy of our respect and participation tell patients the truth: that some providers are off-limits, that some procedures are not covered, that there may be a wait for appointments, that referrals to certain specialists are mandatory, and so on. This information should be in writing, at no more than an eighth grade reading level (for Medicaid patients, fifth grade level, according to a recent study). The customer service line should be staffed by people who can and will answer questions and solve problems. If emergency department use is discouraged, there must be a way for members to get information and assess-



## Resource allocation is one of the best measures of health plan behavior.

ments after hours. And there must be an objective process for patient appeals and grievances to be heard in a timely manner. Many of these protections are already being enacted into law; providers should be supporting, indeed demanding, such initiatives.

I would add a small pet peeve: Any plan that preaches prevention should have a policy of contacting members once a year (or whatever the recommended time interval is) to remind them that it's time for a mammogram, Pap smear, prostate or rectal exam, immunization, or other preventive service. Dentists do this; a multizillion dollar health plan ought to be able to do the same.

**Resource Allocation** This is one of the best-documented measures of health plan behavior; yet few providers take advantage of it. The question is simple: How much of a plan's revenue is spent on patient care? The current range, nationally, is from 59 percent to 95 percent. I am not one who believes that money is necessarily a surrogate for quality, but it's hard to believe that the plans at the extremes of those figures provide the same access, quality, and service. Some state insurance commissioners have proposed that a minimum percentage of revenue—85 percent or so—be spent on patient care in order for a plan to operate in a state. What a great idea!

Beyond that, how does the plan allocate its money? How much of its administrative funds go to investors, executive stock options, or fancy golf outings in Fiji with legislators? Does it subsidize memberships for the uninsured poor? Does it participate in the new children's health insurance programs? Does it cover—and actually make available—hospice, rehabilitation services, long-term care, and mental health services?

Data on much of this is collected by states; in California, the state medical society makes this information available every year. Providers should be doing the same everywhere—helping the public and policymakers understand where managed care premium monies are going. But I must add an important caveat: Providers should be able and willing to answer the question of where their revenues are going as well.

**Long-Term Stability** As I read the business press and note that Health Plan X is for sale, and that Health Plan Y has just gobbled up Health Plan Z, I

wonder what that means for members of those plans. I know that when it happened to a plan I used to belong to, the customer service deteriorated, the number of physicians available shrank, and more restrictions appeared. For many plan members, it can mean losing a cherished physician.

Meanwhile, as the stock price zooms up and then plummets, investor-owned plans must take appropriate

action to "restore Wall Street confidence." The result is a roller coaster of greater benefits, fewer benefits, better access, less access, higher provider payment, lower provider payment. In any enterprise, some volatility is inevitable; but for the investor-owned plans, the ride seems wilder than most.

For patients, families, providers, and communities, this is just unacceptable. No one can plan. No one knows which physicians or hospitals will be available. No one knows where the money is going. And as the mergers and acquisitions progress, fewer and fewer health plans are headquartered anywhere near most of their members. Try calling the Cayman Islands when you are denied a service your physician thinks you need!

The age of a plan, how long it has had its headquarters in a given place, where it operates, how many times it has merged or been acquired, and its long-term commitment to its communities are singularly important indicators of its accountability. This will become even more crucial as plans' profit margins decline, which is inevitable after artificially high one-time-only savings are achieved. Providers and patients need partners who will still be around when the big bills start coming due.

I have no illusions that these modest suggestions will bring total rationality to the war over managed care, or that acting on them will end all the problems and challenges that health plans represent. But, as former U.S. Surgeon General Joycelyn Elders, MD, once observed in another context, perhaps we can at least tone down the rhetoric. Then we can begin thinking in terms of distinctions, rather than blanket condemnations, and can clarify where we should be focusing our attention. For as managed care becomes the dominant form of healthcare reimbursement and structure, at least in our urban areas, our responsibility is to see to it that this means humane progress in healthcare. The only way to do that is to know what we are talking about.

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