

MANAGED CARE, REGULATORY OVERSIGHT, AND HEALTH PLANNING: CHALLENGES FOR A NEW AGE

*by John Steen, PhD (written November 1995)
Consultant in Health Planning, Morristown, New Jersey*

(The following article is a synopsis of Mr. Steen's presentation as a panelist at the President's Session during the American Public Health Association's Annual Meeting in San Diego on October 30, 1995.)

The headlong rush into a competitive business model of healthcare delivery is exemplified by the explosive growth of managed care, representing the ascendancy of insurance interests over those of consumers and caregivers alike. With the dislocation of the old patterns of power and of accountability come new challenges to those funding and regulating healthcare to meet the need for oversight traditionally addressed through state licensure.

Pilot programs of oversight by industry groups, employers, states, and Federal agencies are being developed in the wake of the collapse of Federal healthcare reform legislation last year. President Clinton had proposed report cards for all health plans, and that provision survived in the final reform proposal considered by Congress. The Clinton plan proposed the measurement of service quality in terms of four "critical indicators": Access (availability of care); Appropriateness (of the care for the condition); Outcomes (whether results were favorable); Consumer Satisfaction.

With the failure of a national approach to managed care, it is left to the states to create mechanisms to bring the practice of managed care into conformity with their conceptions of public interest. In this regard, quality assurance systems are especially important in an effort to overcome the financial incentives to underserve inherent in managed care. For most states, administration of their Medicaid programs will be their first experience with regulating managed care.

One of the first challenges faced by states in regulating Medicaid managed care is that of developing new information systems and data collection efforts to track beneficiaries' experiences, since these are very different from those for a fee-for-service program. A further challenge is that of assuring health plans' solvency through adequate financial review, and monitoring the allocation of program revenues to healthcare delivery.

California's experience with Medi-Cal, its \$15 billion Medicaid program, is raising serious questions about service quality. The Medicaid HMOs in which Medi-Cal beneficiaries have been enrolled report overhead of 16% while the state's overhead for the balance of the Medi-Cal program is 2%. In the East, the Philadelphia Inquirer conducted an investigation this year in which it revealed that managed care plans under contract to HMOs to serve Medicaid clients in Southeastern Pennsylvania were experiencing "loss ratios" (the percentage of the state's premium actually spent on healthcare) of less than 70%, even though the premium was below the state's cost per client. In consultation with the HMO industry, the Pennsylvania Department of

Insurance estimated that reasonable loss ratios would range between 83% and 90%, leaving plans with profit margins of 2-5% of revenues.

This experience reflects the performance of business practice models in healthcare, models which operationalize perverse incentives to avoid risk and to underserve. Being inherent in managed care, they raise vitally important national issues about medical care and professional practice. Medical practice has historically been accorded a unique degree of prestige and autonomy amounting to a sacred trust. Medicine has been understood to be a social contract based on trust between patient and caregiver, a trust which presupposes the ethical commitment of the caregiver and the humanist commitment of the overall provider community. Insofar as medicine is judged by concepts of value to be achieved in the marketplace, its nature as a fiduciary trust may be eroded and with it the striving for excellence which has always been felt as a moral imperative by its finest practitioners.

For state regulation, the challenge is in the form of a conflict of interest. On one hand, they wish to promote the growth of Medicaid managed care in an effort to save money and cover more people. On the other hand, states have responsibility for assuring the quality of plans and adequate basic health care for uncovered populations as well as the overall public health. This conflict is illustrated by Florida's experience. In order to attract HMOs into serving Medicaid patients, Florida exempted Medicaid HMOs from the more rigorous standards it applied to commercial HMOs serving privately insured patients. The lack of regulation has come back to haunt Florida with a growing set of inequities and abuses including fraudulent marketing practices and lapses in care.

But the biggest issue facing each state is the interplay between its managed care networks and its statewide problems of access. A state may adopt a global community leveling approach requiring that all plans extend coverage to all populations, urban inner city and rural, Medicaid, Medicare, and uninsured. What is at stake is the resultant burden on the public health system of any deficits of access created by the inevitable selectivity in coverage by plans. Within this global issue is the need to ensure the survival of the public health system and of access to it by the most underserved populations, and the continuity of the core public health functions such as surveillance of communicable and chronic diseases and public education. The challenge for states adopting a regulatory approach to this issue is to risk adjust managed care plans to encourage their enrollment of higher risk populations.

The incentive to underserve in turn demands answers as to the quality of care delivered by plans. Major managed care organizations - United Healthcare Corporation in Minneapolis, Kaiser Permanente Northern California Region, U. S. Healthcare - issued the first "report cards" in 1993, but these were self-reports of performance based on process measures, not outcomes, and did not permit comparisons among plans. This has led employers seeking to determine value to form their own regional coalitions and carry out consumer satisfaction surveys of their employees, thereby producing regional report cards.

The report card approach raises many complex issues which need to be resolved before consensus can be developed around any one approach. These issues are inherent in any attempt to define what is "best" in healthcare or healthcare plans. There are experts who adhere to

process of care measures and experts who advocate outcomes of care. The challenges presented in designing an operational quality monitoring system are truly daunting. Behind these tensions is the realization that the practice of medicine is both a science and an art.

There is a debate about the use of report cards too. Should they be designed primarily to empower consumers or providers? In one approach, consumers (or employers representing consumers) are to be given information encouraging them to find the "best" care or the best value in healthcare plans. In the other approach, healthcare professionals who are responsible for providing care are given report cards on their own performance and how it compares with other performances, thereby encouraging them to study their clinical processes and outcomes and continuously improve their performance.

There are a host of issues relating to report cards and healthcare costs. The tension among equity of access, quality, and cost is far from resolution. Each of these parameters will be understood differently depending upon the scope of a report card's service population. There will be no true equity among plans and populations until the entire community, and ultimately the entire country, is included in one report card. Short of that, differences of access and cost shifting will continue among plans and between those included in plans and the uninsured who are left out.

Even where conceptual agreement can be secured for the approach to be used in measuring the quality of healthcare, there are many technical problems which need to be solved. Among these are the lack of uniform national data gathering, disagreement on what constitute adequate measures of quality, methodologies for comparison of performance with proven validity, a shortage of clinical (as compared to administrative) data, and the inability to adequately adjust statistical data for severity of illness.

There are national initiatives now underway to help states meet these challenges. Through its Information for State Health Policy Program (InfoSHP), the Robert Wood Johnson Foundation in 1992 assisted states to develop their health data systems. In Phase II (1994), seven states (Arkansas, California, Mississippi, New York, North Carolina, South Carolina, Wisconsin) were awarded implementation grants enabling them to organize and present data in formats accessible to policymakers and consumers.

year into a two-year project using a systems perspective incorporating public health. It is attempting to identify indicators to assess population health status, risk factors, and other public health concerns. Its report will be aimed primarily at strengthening data systems and improving core functions of public health agencies, but it should lay the foundation for a national health information network and recommend indicators of health plan performance.

State regulation may employ a range of strategies from reliance on competition to encouragement of collaboration, establishment of standards and regulations for reporting plan performance, and promotion of quality improvement and consumer education through accountable public processes.

Whatever form state oversight takes, it is already clear that the restructuring of the healthcare delivery system and its performance are monumental issues of public concern, too important to

be left to business interests and competition alone. States are being forced to ensure that health plans are accountable for their performance, and to do so they must convene the state's stakeholders to begin to build consensus through a strategic planning process.

Does this sound familiar?