Health Care and Managed Care: How Compelling a Fit?

Implications For Local Government Managers

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Health care reform and managed care are linked inextricably in current policy discussions and legislative proposals. If health reform is the goal, then managed care is a major part of the solution. Although these concepts legitimately are viewed in tandem, it is critical to understand that they are not synonymous. Failure to recognize parts of the policy problem not addressed by managed care, as well as the learning curve faced by managed care in meeting the health reform challenge, will set unrealistic expectations for managed health plans.

Managed care delivery systems can substantially ameliorate (but will not by themselves solve) today's health care dilemma. This article presents an overview of the health care reform agenda, a description of managed care techniques and how they relate to reform, an analysis of the opportunities and challenges that health care reform offers for managed care, and the impact that reform will have on the public manager.

The Health Care Reform Agenda

Amidst the hundreds of health care reform initiatives proposed at both the federal and state levels, a common agenda has emerged focusing primarily on increasing access and decreasing costs. Most of the legislative proposals would fulfill this agenda by emphasizing several basic themes, as outlined in this section.

Standard Benefit Packages to Create Uniformity in Coverage. Many federal and state proposals stipulate a stan-

standard benefit package of health care services that would be offered to all or select populations. Proposed benefit packages can include all or some of the following: inpatient services, outpatient services, preventive care, mental health and chemical dependency services, prescription drugs, and community-based chronic care. Some proposals actually specify benefits to be offered, while others only identify the decision-making body (for example, a state-appointed commission) that would be responsible for defining the benefit packages.

Insurance Reforms for Expanded Access. Provisions often are included to reform the insurance market. Common components include restriction or elimination of preexisting-condition exclusions; mandates that coverage be portable between jobs and among geographic relocations; guarantees that small employer groups will be able to purchase and renew insurance coverage; and mandatory disclosure of rating practices, benefit design, and premium structure.

Purchasing Pools to Increase Buying Power. Another health care reform strategy involves the formation of purchasing pools, which would allow or encourage employers to group together when purchasing insurance. The goal of this strategy is to allow employers, particularly those with fewer than 100 employees, to increase their ability to buy more efficiently and to have more choices. The rationale is that a group of small employers collectively would represent a larger number of members to an insurer and thus motivate the insurer to offer cheaper rates.

Networks for Providers and Payors. Many proposals also include incentives or mandates for providers and payors to form networks to provide care. These usually are termed "organized delivery systems," "health plans," or "HMOs." Such a delivery system would compete for enrollees against other systems in its region or geographic area.

Cost Controls to Limit Overall Spending. Cost control is a major component of most reform proposals and one of the drivers steering health care reform. Proposals include various strategies aimed at containing costs: health plans would receive a fixed rate for each member they cover to encourage provisions of cost-effective care; administrative simplicity would be achieved by providing one, standardized claim form and by moving the health care industry toward electronic submission of all claims; the rate of federal and state spending for Medicare and Medicaid would be reduced; the fee schedule used for Medicare providers would be expanded to Medicaid and the uninsured; and a competitive market would be created wherein health plans would disclose price information to facilitate competition, thus lowering overall costs.

Expansion of Coverage to the Uninsured. A goal of many proposals is to increase the ability of all or portions of the uninsured population to obtain coverage. Various techniques are proposed: subsidies would be offered to help the poor uninsured purchase coverage; insurance reforms would be implemented to help those who had been excluded previously from coverage because of a medical condition; and/or states would be allowed to expand their federal Medicaid allocations to incorporate the uninsured.

Data Initiatives to Facilitate Cost Containment and Informed Purchasing. Many proposals would mandate that delivery systems publish information on their performance in such areas as quality of care, consumer satisfaction, administrative efficiency, and cost. Consumers would then use this information in making prudent decisions when choosing health care coverage. Also, it is assumed that publication of performance information would motivate delivery systems to keep costs down while demonstrating high levels of quality and satisfaction in order to compete.

At this point, it is unclear which, if any, of these components will end up in reform legislation. The mere discussion of reform issues, however, has opened the door for wider interest and focus on managed care, as the two matters are inextricably linked.

Managed Care Approaches That Complement Reform

Rapid Expansion. The prepaid health plans we now call "managed health care" originated on a small scale in the early part of this century. Kaiser Permanente in northern California, for example, was founded in 1938. More rapid growth of this type of health care delivery began in the 1970s and has continued steadily. From 1986 to 1994, for example, managed care plans have had annual growth rates of about 5 to 15 percent. Fastest growth has been in the type of managed health plan that looks most like traditional medical care delivery—broad freedom of provider choice, relying on community-based physician networks, not HMO clinics. Despite this steady growth, however, less than 20 percent of the U.S. insured population belongs to a managed health plan today.

Any health reform legislation will accelerate the trend toward managed care. Even today, there are few delivery systems that admit to being "unmanaged"; as managed care becomes more prevalent, purchasers and consumers will need to become better versed in specific attributes of managed care, which may vary from plan to plan.

Experience with Employed, Metropolitan-Area Populations. The early prepaid plans were developed to serve working people, and a large proportion of those served by managed care plans remain employees and their families. In addition, managed care today still is a regional phenomenon, with high percentages of the population enrolled in some states and next to none in others. Massachusetts, California, and Minnesota have approximately 35 percent of the population enrolled in managed care, and residents have multiple health plans from which to choose. Most rural residents still do not have managed health plans available to them, which explains the low enrollment in such less populated states as Wyoming, Alaska, and West Virginia.

Other segments of the population historically not served by managed care include elderly, disabled, and low-income individuals. This picture is beginning to change as states become more receptive to managed care for vulnerable populations and as managed care organizations develop more customized approaches to serve special needs. Several states have passed or proposed legislation, for example, that would have all Medicaid recipients obtain care from managed care plans. Also, programs have been developed to manage the care of the institutionalized elderly to help avoid unnecessary hospitalizations.

New Approaches to Monitoring Quality, Cost, Access, and Satisfaction. Managed care plans should be able to generate for purchasers meaningful information on health care costs, quality, and access within a delivery system. Managed health plans individually enroll all persons eligible for services using unique member identification numbers; consequently, it is possible to track health system performance on such recognized measures of quality as the percentage of children under 2 receiving all appropriate immunizations, or the percentage of insulin-dependent diabetics obtaining the recommended annual eye exams.

Linking cost, quality, and access measures has been a focus of recent efforts. Most health plans routinely track member satisfaction and perceived access to care. These survey results can be linked to actual use of the health system to determine how well a plan is meeting the needs of such subpopulations as asthmatics, diabetics, or cancer patients, and at what level of resource use it is meeting those needs. In addition to guiding internal management, such information also is sought by purchasers (public and private employers) and individual consumers. Most health reform proposals call for health plan "report cards" that could be compiled by purchasing alliances or other third parties, using data supplied by managed care plans in a standard format.

Managed care plans have long been recognized for superior cost management. Managed care organizations selectively contract with physicians and hospitals that have demonstrated cost-effective care delivery or that are willing to follow the practices required by managed care organizations. In addition, many managed care organizations already have implemented systems to process claims electronically and for years have been focused on claims simplification, particularly for individual consumers. These practices are well in line with the goals of reform, which call for cost containment and administrative simplification.

Diversity of Approaches. Managed care is not monolithic, and many variations exist. The basic types of managed care plans are: (1) those that contract with community physicians who participate in multiple health delivery systems, and (2) those that hire staff or contract with physicians to provide care only to the members of their particular managed care plan. Either of these types may allow members to use non-health plan physicians at a higher cost.

Moreover, managed care approaches have been developed for such areas as pharmacy benefit management and mental health/substance abuse, which are available to purchasers regardless of the basic health care program they have adopted. New trends continue to emerge; recently, there has been great activity on the part of hospitals and their medical staffs in proactively creating their own managed care plans (versus waiting to be asked to participate in a health plan's provider network).

The common thread in all true managed care services is a commitment to managing costs within a fixed budget, choosing providers on the basis of cost and quality of performance, and generating information to assist providers and health managers in continuously monitoring and improving health quality and outcomes.

Opportunities and Challenges of Health Care Reform

If managed care and health care reform are linked intrinsically, then managed care organizations will have a responsibility to meet the demands of a new system. These demands will include expanding service delivery to new populations, improving information for consumers, and improving methods for managing resources.

Service for New Populations. Health care reform will provide increased opportunities for managed care to serve new populations, particularly rural residents and the physically and mentally challenged. Managed care's involvement with rural areas should improve health care access

and quality for patients by better managing health care resources. Tested care management strategies can improve rural patients' access to medical advice, relieve the burden of isolation to providers, improve the integration of services, and provide rural areas with greater purchasing power. Examples of specific strategies currently in limited use in rural areas include: a primary care nurse telephone service to improve the access of rural residents to medical advice; a case management service to assist providers and improve the integration of care; and a pharmacy service to improve the purchasing of rural pharmacists and expand their health care delivery services.

Caring for rural populations will pose challenges as well. Managed care organizations have limited experience in rural areas. Transportation to primary care physicians, as well as to specialists and hospitals, will have to be addressed, as will the problem of attracting physicians to remote places. Managed care organizations will have to adapt their selective contracting practices to accommodate areas with few physicians from whom to choose.

The physically and mentally challenged also should benefit from managed care. These populations typically need substantial and ongoing care, and they need to access the health care system in such multiple areas as specialists, physical therapists, and mental health providers. Therefore, these populations will benefit from a primary care provider who can coordinate care for them, help them decide what care they need, and inform them where they can get it.

Providing care for the physically and mentally challenged will not be easy. These populations will require increased and intensive case management to coordinate multiple and long-term care needs. These populations also will require the provider to blend social and health care services to adequately meet their chronic and acute care needs.

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Improved Information for Consumers. The data initiatives included in many reform proposals will allow consumers more information on their health plans. Most of the data initiatives would have health plans report on their performance in terms of quality, access, administrative efficiency, and cost. This reporting system would give consumers information that goes beyond cost when they are comparing health plans and deciding which one to join. This should help consumers make better, more appropriate choices that meet their needs.

Even performance reporting that uses relatively simple data indicators, however, requires a purchaser to have a fairly sophisticated understanding of the health care delivery system. When examining health plan data, for instance, a consumer must have some understanding of what high-quality health care would look like and what administrative efficiency means. Performance reporting poses a significant double challenge: consumers must learn the language of health care, and health plans must figure out how to explain health care efficiently.

Performance reporting also should help policymakers and regulators gain a clearer understanding of the health care system. No longer will they be forced to rely predominantly on price and use when monitoring health plans. Instead, data covering multiple indicators should help them understand the individual performance of health plans along with the equally important dimensions of quality, outcomes, and enrollee satisfaction.

Policymakers and regulators face many challenges if they are to receive comparable data from multiple health plans. Standardized reporting is crucial for successful performance measurement and comparison, but this will be a difficult task, as the health care industry currently contains dozens of different models for reporting similar data.

Improved Information for Managing Resources. Anticipated health reform, combined with competitive pressure in the current marketplace, has accelerated managed care's drive for improved information technology and analytic capabilities. Such information capabilities span the development of electronic highways for the transfer of eligibility, billing, and eventually clinical information; the use of artificial intelligence to detect inappropriate or fraudulent billing;

automated claims screening for compliance with recommended practice guidelines; profiling of specific providers' performance on quality and cost; and various cost and use tracking systems.

Collectively, the health care industry has embraced an information strategy, on the premise that better information will result in improved quality of care and contained costs by informing the decisions and actions of health care managers, providers, and eventually patients. The development of better information is a necessary first step toward the desired end. Today, the state of the art has advanced so that the most data- and systems-savvy managed care organizations have easy workstation access to a variety of presummarized cost indicators, as well as decision support access to the entire database of health care claims experience. A wide variety of vendors has emerged to satisfy the new health information demands of managed care.

Also critical, and arguably harder to achieve, is the appropriate organizational response to the messages transmitted by improved data and information systems. The challenge for managed care in this new era is to cull the essential messages from the reams of data and to change behaviors and policies accordingly. As health plans are beginning to discover, it is easier to pinpoint the rate of mammography in women over age 50 (a common quality indicator) than it is to improve that performance. A sustained increase in the use of mammography has proven challenging to achieve.

Even if mammography rates increase, however, there are multiple steps that intervene before a reduction in breast cancer mortality due to early detection can be achieved. Mammography readings must be of sufficient quality to minimize false negatives; positive test results must be promptly communicated; and appropriately staged treatment must be undertaken. As this example illustrates, many of the underlying causes of poor performance in health care delivery are complex and difficult to change. Thus, true improvement may be frustratingly slow.

Implications for Public Managers

As states and possibly the federal government begin to pass and implement reforms, cities and counties most likely will bear some of the burden of full implementation. For instance, as mentioned earlier in this article, several states have legislated that all Medicaid recipients receive care through managed care plans and/or that more of the uninsured be covered by Medicaid. In these situations, affected counties and cities probably will play major roles in the implementation process. Localities will have to examine how to redirect their current practices of caring for these populations to accommodate new rules. For this process to run as smoothly as possible, managers should involve themselves in the legislative process early, so that their individual concerns are met through legislation and so that they understand the role they will play in implementation.

Public managers also will play a changing role as purchasers. Legislation that includes the creation of purchasing cooperatives or the expansion of managed care often proposes to pilot these initiatives with public employees. This situation calls for the public employer to understand clearly, for example, the implications of purchasing cooperatives (in which employees would be responsible for choosing their own health plan, rather than employers). Also, employers must help their employees understand new roles. Under the new scenario, financial impact for employers will be determined by the sum total of individual employee decisions in choosing among the competing health plans offered by a purchasing cooperative, not by decisions made by benefit managers.

The local government as employer will have to reassess the mechanism and the impact of funding benefits (e.g., employee cost sharing). To the extent that these arrangements are subject to collective bargaining, issues for negotiation may arise, making it desirable to educate bargaining units as partners. Will the city or county, for example, fund benefits up to the cost of the lowest-priced or the average plan offered in its region to create incentives for employees to choose lower-cost plans? Will employees agree through collective bargaining to share in these costs in order to make this mechanism effective? Is there a baseline quality/satisfaction level measured by standardized performance indicators below which the public employer will not recommend employee enrollment in a plan, regardless of cost? How involved will the public employer be in helping its employees make individual purchase decisions?

Answers to such questions will become clearer as health reform takes shape. In any case, public managers will face significant new issues with respect to health care. It is not too early to become familiar with managed care models and nomenclature, "report cards" and other performance indicators, and any local or national resources available to support education of employers, employees, and unions on their changing roles and responsibilities in a health care reform(ed) environment. PM

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