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The California HealthCare Foundation
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A GUIDE TO THIS REPORT

This report is composed of three Volumes and each volume has its own Table of Contents for easy refer-
encing.

Volume 1—Executive Summary
Volume 1 contains the following:
• The Chairman’s Letter
• Acknowledgments
• the Task Force Adopted Executive Summary.

Volume 2: Main Report [This Volume]
Volume 2 contains the following:
• The Chairman’s Letter [the same letter in Volume 1]
• All Task Force Adopted Findings and Recommendations
• the paper, entitled, “Public Perceptions and Experiences with Managed Health Care” which was
written based, in part, on results obtained from the Task Force’s commissioned public survey
• Letters written by Task Force members on issues addressed in the Report

Volume 3: Appendices
Volume 3 contains the following:
• All Background Papers
• An Appendix to the paper, entitled, “Public Perceptions and Experiences with Managed Health Care”
• All Task Force Meeting Minutes, Study Session Notes and Public Hearing Notes [a collection of
verbal testimony given at the public hearings]

All adopted Findings and Recommendations have accompanying amplifying Background Papers [con-
tained on Volume 3]. In accordance with Task Force Bylaws and Rules, all Findings and Recommendations
required individual adoptions by the Task Force before they were included in this report. In addition,
members were required to adopt the Executive Summary. Adoption of any Task Force document required
an affirmative vote of a simple majority of the total authorized number of appointed members to the Task
Force [16]. Members did not vote on any background paper, including the paper entitled, “Public Percep-
tions and Experiences with Managed Health Care”.

The vote for each adopted Findings Section and , where appropriate, each recommendation, is listed at the
end of each Findings and Recommendation Section in Volume 2 of this report. The vote for the Executive
Summary is provided at the end of Volume 1.

The Task Force adopted all business meeting minutes, with the exception of four sets [November 22,
December 12, December 13 and January 5] that were not available to the Task Force before its final
meeting. The Task Force did not vote on Study Session Notes or Public Hearing Notes. These documents
are contained in Volume 3.

Pursuant to the Task Force Standing Rules, Task Force members were allowed to submit letters for inclusion in the 
Main Report [Volume 2] conveying their personal viewpoints on issues discussed [or not discussed] by the Task Force in this report.
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January 5, 1998

Governor Pete Wilson
Honorable Bill Lockyer, Senate President pro Tempore
Honorable Cruz Bustamante, Speaker of the State Assembly
Honorable Members of the California Legislature
Sacramento, CA 95814

Dear Governor, President pro Tempore, Speaker, and Members:

The Task Force was made up of 30 people chosen to represent very divergent views about managed health care. Members were made up of, in equal numbers, health care service plans including at least one local initiative under contract with the State Department of Health Services as part of the two-plan model for Medi-Cal managed care and at least one disability insurer, employers who purchase health care, health care service plan enrollees, providers of health care (e.g., physicians and hospitals), and representatives from consumer groups. In many cases, members entered the process with very strong expertise in their specialties, but without a common broad base of knowledge of the managed care industry as a whole. We needed to spend some time building a common base of knowledge about managed health care, its functioning, and its regulation.

We had to work on a very tight time schedule for such a complex problem. We built staffs in Sacramento and at Stanford, the latter with financial assistance from the California HealthCare Foundation.

The Task Force devoted substantial time to public testimony and benefited greatly from the diverse views presented to it. We appreciated hearing directly from consumers and from a wide array of health professionals. From both groups we heard compelling testimony about how the changing health care system is affecting those who receive and deliver care, both positively and negatively. The Task Force also conducted a substantial public survey on the problems Californians are experiencing to inform its deliberations and recommendations.

Because of the strict interpretation of the Open Meetings Act, we were obliged to limit our work in important ways. While public involvement was important, as I have just said, the fact that no more than two members could meet together to discuss Task Force business prevented me from convening small group gatherings for members (often adversaries) to

(Continued on page 10)
get acquainted with each other as people with common interests and concerns, to search out informally common ground and relative priorities, and to try to build trust and understanding of opposing viewpoints. Meeting only in open public meetings made it unnecessarily difficult for many members to depart from the script provided by their organizations and suggest compromises. In addition, the requirement to notify the public of meetings ten days in advance frustrated my desire to convene meetings in more sufficient numbers. In my view, the restrictions placed upon us by the Open Meetings Act are inappropriate for a purely advisory body that does not make official decisions.

All these restrictions put limitations on what we could produce.

We polled our members early in the process, and we discussed member priorities. We modified our work plan as we went along in response to member requests. We chose not to cover some topics because we considered them outside the scope of our charter (e.g. the problems posed by the large number of uninsured in this state). We agreed that we were not asked to, and therefore would not, comment on individual bills moving through the legislative process during the 1996 legislative session. We did not cover other important topics (e.g. managed mental health services) because we did not have enough time given our requirement to report back to the Governor and Legislature by January 1998. The fact that the Task Force did not address a topic does not mean that members did not consider it to be important.

In particular, the Task Force did not think that it was within its mandate to engage in significant deliberations regarding the problems posed by the large and growing numbers of uninsured in California. The Task Force, however, strongly believes that the number of Californians without insurance needs to be addressed and that managed care has implications for the current systems that care for the uninsured. The Governor, Legislature, and private sector groups are strongly encouraged to continue to seek to address the issue of the large number of uninsured Californians.

As state, federal, and private purchasers increasingly contract with managed care plans, the financial stability of the safety net that traditionally serves the uninsured has become further eroded. Managed care's cost control mechanisms reduce the ability of safety net providers to shift costs from uninsured to insured patients. Trauma systems, emergency service networks, and the system of public health centers are most at risk in cities and counties throughout the state.

Moreover, we did not have either the time or the resources to estimate the costs of our recommendations, either in isolation or taken together. The Task Force recommends that much more information about health care than is now available be gathered, analyzed and made available to the public. Provision of valid, audited information can be very costly, especially in the absence of electronic medical information sharing capabilities. The long-term costs and benefits of our recommendations should be evaluated and weighed before being implemented. Much of the information would help markets function

(Continued on page 11)
better, including helping consumers and managed care organizations to identify better providers, and this would tend to have an overall cost-reducing effect in the long run.

The Task Force members were sensitive to the importance of making health care affordable and avoiding making cost-increasing recommendations, as premium increases would be likely to increase the ranks of the uninsured. Roughly half of the health care bill is a drain on public sector budgets, so increasing health care costs reduces the number of people who can be assisted in health care by government. Moreover, increased premiums relative to income reduce the number of people who can or choose to afford coverage, thereby adding to the numbers of uninsured.

Another consequence of our tight schedule is that the Task Force did not have time to prioritize its recommendations. Some are clearly more important than others, and some were more thoroughly researched than others. But views would differ among members as to which were more important, and it would have taken more time to achieve agreement on priorities.

Implementing the Task Force’s recommendations will require a combination of private sector and governmental actions. Some recommendations require legislation in order to be implemented. Others can be implemented through regulatory action, pursuant to existing statutory authority. Still others require private sector entities – sometimes alone and sometimes in combination with each other or with a government agency or agencies – to follow the Task Force’s recommendations. The public interest will be best served by a positive public-private collaboration.

Finally, drafting recommendations by such a committee under pressure of time has inevitably led to some inelegantly worded recommendations. The experience has given me a new and more sympathetic understanding of the problem faced by legislators.

These recommendations go too far for some, not far enough for others. However, I believe that taken together, they represent a very significant and valuable reform package. I hope you will study them carefully and work together cooperatively to adopt such a package.

Yours truly,

Alain C. Enthoven, Ph.D.

Chairman, Managed Health Care Improvement Task Force
Public Perceptions and Experiences with Managed Care

Findings

I. Introduction
The Managed Health Care Improvement Task Force was charged with researching and reporting on the state of managed care in California today and formulating recommendations for the future. To successfully meet this mandate, the Task Force recognized that it must not only solicit the views of health policy experts, but also those of all California consumers. The testimony we received through our public hearings provided invaluable first-hand information for us to consider, but it was not based on a random or representative sample. In addition to what we were able to learn in our hearings and from reading the literature about the state of managed care, we wanted to explore these issues from the perspective of the overall California population. Therefore, we commissioned a statistically valid survey of insured, adult Californians, building on prior studies and the testimony we heard, to enable us to gain a more comprehensive view of the experience of the full spectrum of the public.

II. Survey Goals and Objectives
The Task Force commissioned this survey to provide Task Force members with data to help inform their deliberations and recommendations regarding California’s managed health care system. Among other objectives, the survey is intended to document the extent and nature of difficulties Californians report having with their health insurance plan in the last year, to assess the differences in the types of problems Californians experience with different types of managed care models, and to assess Californians’ views on key policy issues. To gain a more thorough understanding of problems in the current health care system and the concerns of those consumers who are most in need of health care services, we oversampled two populations: 1) Californians who reported having a problem with their health insurance plan in the previous 12 months and 2) Californians who had been hospitalized in the previous 12 months and/or who have a serious or chronic illness.

For an overview of results from other surveys on similar topics, please refer to Appendix A: Literature Review.

III. Survey Design and Methodology
A. Design Advisors and Funding
Chairman Enthoven, Vice-Chairman Kerr, and an advisory group of Task Force members worked closely with staff and outside experts in the design and question development of the survey instrument. Helen Schaufller, Ph.D., Associate Professor at the University of California, Berkeley, School of Public Health, served as the project’s Principal Investigator. Dr. Schaufller coordinated the technical design of the survey instrument and conducted the analysis of the data with assistance from Task Force staff. A distinguished group of outside experts lent varying levels of technical assistance (and in many cases, the use of components of surveys they had already completed):

Linda Bergthold, The Lewin Group;
Robert Blendon, Harvard University;
Susan Edgeman-Levitan, Picker Institute;
David Hopkins, Pacific Business Group on Health;
Lee Kemper, California Center for Health Improvement;
Hal Luft, University of California, San Francisco, Medical School;
Arnie Milstein, William M. Mercer, Inc. and The Pacific Business Group on Health; and
Mark Schlesinger, Yale University.
The survey was funded by generous grants from the California Healthcare Foundation, the Institute for Health Care Advancement, California’s Department of Corporations (DOC), and the Office of Statewide Health Planning and Development (OSHPD) with funding from the Robert Wood Johnson Foundation.

B. Survey Instrument
To the extent possible, the survey built on instruments that were already tested and available to create a comprehensive survey instrument tailored for the specific needs of the Managed Health Care Improvement Task Force. We relied on instruments developed by Robert Blendon; the 1995 “Health Care in California” L.A. Times poll; the Pacific Business Group on Health (PBGH) Health Plan Value Check; the Center for Health Care Rights poll developed by the Lewin Group; the Consumer Assessment of Health Plans Survey (CAHPS), developed primarily for the Agency For Health Care Policy and Research by RAND, Harvard University, the Research Triangle Institute, and the Picker Institute; and the suggestions of the advisory group.

C. Methodology
Field Research Corporation, under the direction of Mark DiCamillo, conducted the survey interviews using random digit dialing and a Computer Assisted Telephone Interview (CATI) system. Each interview was approximately 25 minutes in length. Interviews were conducted in both English and Spanish.

The survey instrument included screening questions to obtain interviews from three distinct samples:

1. General Insured Sample. This randomly drawn sample included 1,201 insured, adult Californians who have resided in the state 12 months or longer. To be included in the sample, the respondents had to be insured through at least one of the following sources: their own or their spouse’s employer, labor union, or trade association; individually-purchased coverage; Medicare; or Medi-Cal. Individuals whose primary source of health coverage was a military program (such as the CHAMPUS or VA programs), the Indian Health Service, or other source, were excluded. Respondents also had to be at least 18 years of age and had to have lived in California for at least one year. These interviews were conducted between September 2 and September 24, 1997.

This sample represents approximately 16 million insured, adult Californians who have lived in the state 12 months or longer.

2. Sample of Dissatisfaction/Problems. This randomly drawn sample included 1,373 insured adult Californians (as defined in Sample 1, above) who stated that they were “dissatisfied” or “very dissatisfied” with their current health insurance plan and/or who had one or more problems with their health insurance plan in the prior 12 months. Approximately 500 respondents included in this sample are also included in the general insured sample. An additional oversample was drawn to reach the total of 1,373. These interviews were conducted between September 25 and October 19, 1997.

This sample represents approximately 6.72 million insured, adult Californians who have lived in the state 12 months or longer.

3. Sample of Persons with Serious/Chronic Illness. This randomly drawn sample included 1,227 insured, adult Californians (as defined in Sample 1, above) who had been hospitalized in the prior 12 months and/or who had at least one of the following chronic or serious conditions: hypertension, heart disease, diabetes, cancer, asthma, emphysema, chronic bronchitis, migraine, HIV/AIDS, severe arthritis, treatment for depression in the prior 12 months, or suffered a heart attack in the prior 12 months. Approximately 140 respondents included in this sample are also included in the general insured sample. An additional oversample was drawn to reach the total of 1,227. These interviews were conducted between October 20 and December 3, 1997. Due to time constraints, limited information from the third sample is included in this report.
Improving Managed Health Care In California Volume Two

Note: Though Californians with traditional, unmanaged indemnity insurance were included in the survey samples, results for that type of health insurance are not reported separately because the numbers are too small to make accurate estimates. In the general insured sample, a weighted total of 160 individuals (13%) were covered by unmanaged indemnity insurance. Of those, 56 (5% of total insured) were covered by traditional Medicare and 39 (3%) by traditional Medi-Cal. Only 65 (5%) were covered by private unmanaged indemnity insurance: 50 (4%) in employer-based unmanaged indemnity and 15 (1%) in individually-purchased unmanaged indemnity. Therefore, this report presents no findings comparing managed care and unmanaged indemnity care.

IV. Findings
A. Californians' Views of Their Health Insurance Plans and California's Health Care System

The majority of Californians are both satisfied with their current health plan (76%)1 and with California's health care system as it affects their families (62%)2. While their personal experiences have been generally satisfying, the majority of Californians are concerned about the health care system overall3: they believe that California's health care system either needs to be fundamentally changed (43%) or completely rebuilt (11%) to make it work better. A total of 84% of insured Californians believe that at least minor changes are needed to make California's health care system work better. Those Californians who stated a stronger desire for system change were more likely to report having had a problem with their health insurance plan in the previous 12 months.

Overall, Californians in IPA/Network model HMOs are significantly less likely to be very satisfied and significantly more likely to be very dissatisfied compared to those in Group/Staff model HMOs. Californians in IPA/Network model HMOs are also significantly more likely to be very dissatisfied compared to those in PPOs.4

B. Problems Californians Report with Their Health Insurance Plan

Overall, 42% of Californians (approximately 6.72 million people) report having had one or more problems with their health insurance plan in the previous 12 months. The severity of those problems varies considerably. Approximately one in four Californians who are “very satisfied” with their current health insurance plan report having had a problem with their plan, therefore having a problem should not necessarily be interpreted as having a serious grievance. Among other characteristics, Californians who report having had a problem with their plan in the last year are more likely to be dissatisfied with their plan’s concern for their health, dissatisfied with the choice of physicians in their plan, dissatisfied with the process of getting a referral to a specialist, dissatisfied with the preventive care provided by their plan, to have postponed or not gotten needed medical care because of cost, to have been a member of their plan from 2 to 5 years, and to be in good, fair, or poor health (i.e., not in excellent or very good health).

The probability of reporting having had a problem with one’s health plan in the last year does not vary by any of the following characteristics: education, income, employment status, size of the firm providing coverage for its employees, household size, geographic area of the state (urban/suburban/rural), having been hospitalized, or smoking status.

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1 The question read, “Overall, how satisfied are you with your current health insurance plan?”
2 The question read, “How satisfied are you with the overall health care system in California as it affects you and your family?”
3 The question read, “Which of the following statements best describes your overall view of the health care system in California?”
4 Though Californians with traditional, unmanaged indemnity insurance were included in the survey samples, results for that type of health insurance are not reported separately because the numbers are too small to make accurate estimates. In the general insured sample, a weighted total of 160 individuals (13%) were covered by unmanaged indemnity insurance. Of those, 56 (5% of total insured) were covered by traditional Medicare and 39 (3%) by traditional Medi-Cal. Only 65 (5%) were covered by private unmanaged indemnity insurance: 50 (4%) in employer-based unmanaged indemnity and 15 (1%) in individually-purchased unmanaged indemnity. Therefore, this report presents no findings comparing managed care and unmanaged indemnity care.
Those Californians who reported having had more than one problem with their health insurance plan in the last year were asked to identify which one was the “biggest problem”. Overall, these primary problems fell into five categories: problems with care or services (32% of insured Californians who reported a problem identified a problem from this category as their biggest problem); benefits or coverage (21%); choice (16%); claims or payment (14%); and accessibility (7%).

C. Problems by Type of Managed Care Plan

1. Comparison of Problems Reported across Health Insurance Plan Model Types. The types and prevalence of specific problems Californians report having with their health insurance plan in the last year vary significantly by type of managed care plan model (IPA/Network model HMO, Staff/Group model HMO, and PPO). Overall, Californians in IPA/Network model HMOs are significantly more likely to report having had a problem with their plan in the last year than those in either PPOs or Staff/Group model HMOs. In addition, Californians in PPOs are significantly more likely to report having had a problem than those in Staff/Group model HMOs.

- **Care/Services**: Californians in IPA/Network model HMOs are significantly more likely to report difficulties with referrals to specialists, compared to those in Staff/Group model HMOs and PPOs. Californians in IPA/Network model HMOs are also significantly more likely to report a problem with not getting the most appropriate care or what was needed, compared to those in PPOs.

- **Benefits/Coverage**: Californians covered by IPA/Network model HMOs and PPOs, compared to those in Staff/Group model HMOs, are significantly more likely to report problems with services they needed not being covered or misunderstandings over benefits or coverage.

- **Choice**: Californians in IPA/Network model HMOs are significantly more likely to report having difficulty selecting a doctor or hospital, compared to those in Staff/Group Model HMOs and PPOs. Californians in IPA/Network model HMOs are also significantly more likely to be forced to change doctors, compared to those in PPOs.

- **Claims/Payment**: Californians in IPA/Network model HMOs and PPOs are significantly more likely to report a problem with billing or payment of claims or premiums with their health insurance plan in the last year, compared to those in Staff/Group model HMOs.

- **Accessibility**: Californians in IPA/Network and Staff/Group model HMOs are significantly more likely to report a transportation problem with their health insurance plan in the last year, compared to those in PPOs.

2. Comparison of Problem Reported across Health Insurance Plan Model Types. Survey respondents who reported having had at least one problem with their health plan in the prior 12 months were asked to identify the single biggest problem they experienced. These primary problems vary significantly by type of managed care plan model.

- **Care/Services**: Californians in Staff/Group model HMOs are significantly more likely to report as their primary problem insensitivity of health professionals and not receiving the most appropriate medical care, compared to those in IPA/Network model HMOs and PPOs. They are also significantly more likely to report as their primary problem delays in getting needed care, compared to those in IPA/Network model HMOs and PPOs.

Though Californians with traditional, unmanaged indemnity insurance were included in the survey samples, results for that type of health insurance are not reported separately because the numbers are too small to make accurate estimates. In the general insured sample, a weighted total of 160 individuals (13%) were covered by unmanaged indemnity insurance. Of those, 56 (5% of total insured) were covered by traditional Medicare and 39 (3%) by traditional Medi-Cal. Only 65 (5%) were covered by private unmanaged indemnity insurance; 50 (4%) in employer-based unmanaged indemnity and 15 (1%) in individually-purchased unmanaged indemnity. Therefore, this report presents no findings comparing managed care and unmanaged indemnity care.
PPOs. Californians in IPA/Network model HMOs are significantly more likely to report as their primary problem difficulties with referrals to specialists, compared to those in Staff/Group model HMOs and PPOs. They are also significantly more likely to report as their primary problem delays in getting needed care, compared to those in PPOs.

- **Benefits/Coverage:** Californians in PPOs are significantly more likely to report as their primary problem their plan not covering important benefits and misunderstandings over benefits or coverage, compared to those in IPA/Network or Staff/Group model HMOs. Californians in IPA/Network model HMOs are also significantly more likely than those in Staff/Group model HMOs to report as their primary problem their plan not covering important benefits.

- **Choice:** Californians in both Staff/Group and IPA/Network model HMOs are significantly more likely to report as their primary problem being forced to change doctors, compared to those in PPOs.

- **Claims/Payment:** Californians in PPOs are significantly more likely to report as their primary problem difficulties with billing or payment of claims or premiums, compared to those in IPA/Network or Staff/Group model HMOs. Californians in IPA/Network model HMOs are also significantly more likely to report this as their primary problem, compared to those in Staff/Group model HMOs.

- **Accessibility:** There are no significant differences in primary problems across managed care plan types for this category.

**D. Resolution of Problems**

1. **Attempts to Resolve Problems.** Of those Californians who reported having a problem with their health insurance plan in the last year, 57% (approximately 3.8 million Californians) have tried to resolve their problem. Californians are most likely to seek resolution for problems involving difficulties with billing or payment or claims or premiums (81%) and misunderstandings over benefits or coverage (76%). In their attempts to resolve their problems, Californians are most likely to contact their physician, other health care provider, or health plan for information or assistance, or to refer to their health insurance plan documents for information. In addition, 4% of those who reported having had a problem with their health insurance plan in the last year (approximately 269,000 Californians) reported contacting a state or local agency and 3% (approximately 202,000 Californians) reported contacting an elected official about their problem.

2. **Resolution of Problems.** Of those Californians who reported having a problem with their health insurance plan in the last year, 52% reported that their problem had been resolved and 42% reported that their problem had not been resolved. The problems that are significantly more likely to be resolved are problems with being forced to change doctors (71% resolved), problems with billing or payment of claims or premiums (53% resolved), and problems with not getting the most appropriate care or what was needed (53% resolved). The problems that are significantly less likely to be resolved are problems with the health insurance plan denying care or treatment (40% resolved) and not covering important benefits needed (38% resolved).

3. **Satisfaction with the Resolution and Handling of Problems.** Of those Californians whose problems were resolved, 6% stated that the resolution exceeded their expectations and 43% stated that the problem was resolved satisfactorily. An additional 35% were not completely satisfied with the resolution and 13% were not at all satisfied with how it was resolved. Regarding how their health insurance plan handled their complaints, 29% of Californians who reported a problem with their health insurance plan in the last year were either dissatisfied (18%) or very dissatisfied (11%).
E. Impact of Problems
1. Financial Impacts. Of those Californians who reported having had a problem with their health insurance plan in the last year, 27% (approximately 1.8 million Californians) had an associated financial loss. Of those whose problem involved financial loss, 33% (approximately 599,000 Californians) lost in excess of $500. The problems that are significantly more likely to involve financial loss are problems with the plan not covering important benefits, misunderstandings over health care benefits or coverage, being denied care or treatment, or problems with billing or payment of claims or premiums.

2. Lost Time from Work. Of those Californians who reported having had a problem with their health insurance plan in the last year, 20% (approximately 1.3 million Californians) report that they lost time from work due to the problem. Of those, 27% (approximately 350,000 Californians) report that they lost more than five days of work. The problems that are more likely to be associated with lost time from work are problems with being denied care or treatment (38% report lost time from work), delays in getting needed care (35% report lost time from work), and not receiving the most appropriate medical care or what was needed (34% report lost time from work).

3. Health Impacts. Of those Californians who reported having had a problem with their health insurance plan in the last year, 32% (approximately 2 million Californians) reported that their problem caused them to experience pain and suffering that continued longer than it should have. In addition, 22% (approximately 1.4 million Californians) reported that the difficulty led to the worsening of their health condition and 6% (approximately 400,000 Californians) reported that it led to permanent disability and affected their daily living activities.6

Problems that are significantly more likely to lead to increased pain and suffering, other conditions not previously present, the worsening of the person's health condition, and permanent disability include problems with being denied care or treatment, not receiving the most appropriate medical care or what was needed, delays in getting needed care, and difficulties in getting a referral to a specialist.

F. Choice of Health Insurance Plan
Over 80% of Californians stated that having the choice of more than one plan was important (27%) or very important (54%) to them. However, 23% said that they had no choice of plans. Californians with the choice of at least three plans (49% of insured, adult Californians) were statistically significantly less likely to report having had a problem with their health insurance plan in the last year, compared to those with the choice of only one or two plans (48% versus 41%; the population mean was 42%).

70% of insured, adult Californians favor the idea of giving all employees a choice of health insurance plans, with at least one plan allowing employees to choose any doctor they want. Under this proposal as described in the interviews, employers would not be required to make any additional payments, but employees would pay some additional money for insurance that allows them to choose any doctor they want. The median additional amount respondents were willing to pay for this option (of the 68% who specified an amount above zero) was between $11 and $25 per month. Depending on the structure of such a plan (e.g., the size of the deductible and co-pay), this amount may be insufficient to cover the additional cost of the option.

G. Californians' Views on Key Policy Issues
1. Direct Access to Specialists. 44% of insured, adult Californians would be willing to pay an additional fee out of their own pocket each time they went to see a specialist, if they could go to the specialist without

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6The exact question read, “Please tell me whether any of the following did or did not apply to [your problem]: (a) There was the potential for injury, but no injury actually occurred. (b) I experienced pain and suffering that continued longer than it should have. (c) The difficulty led to other conditions not previously present. (d) The difficulty led to the worsening of my health condition. [Asked only of those who answered “yes” to (d)] the difficulty led to permanent disability and affected my daily living activities.” Respondents did not have the option to indicate that there was no potential for injury.
first having to get approval or a referral from their own personal doctor or health insurance plan. 37% of insured Californians would be willing to pay $10 or more and 15% would be willing to pay more than $20 each time they went to see a specialist without prior authorization.

2. Physician Incentives Not to Refer to Specialists. 53% of insured, adult Californians think that health insurance plans in California should not be allowed to lower their payment to doctors if the plan or the medical group believes the doctor makes too many referrals to specialists.

3. Who Consumers Trust to Provide Information. 64% of insured, adult Californians stated that they would trust a private, not-for-profit agency the most to provide consumers with neutral and complete information about specific health insurance plans, hospitals and doctors in California. 13% would trust a state government agency to provide such information.

H. Experiences of Californians Who Have a Chronic Condition and/or Have Been Hospitalized in the Last Year

1. Satisfaction with Their Health Insurance Plan. As with the general insured population, the majority of Californians who have a chronic condition and/or have been hospitalized in the last year are satisfied with their current health insurance plan (81%). This group and the population of insured Californians who have both a chronic condition and have been hospitalized in the last year are significantly more likely to report being very satisfied with their plan, compared to the general insured population. These two groups are also significantly less likely to be neutral about their plan. The level of dissatisfaction is approximately equal across all groups.

2. Problems Seriously/Chronically Ill Californians Report with Their Health Insurance Plan in the Last Year. Overall, the proportion of adult, insured Californians who have a chronic condition and/or have been hospitalized in the last year who reported having a problem with their health insurance plan in the last year (46%) is not statistically different from the general insured population (42%). However, two subgroups are significantly more likely to report having had a problem with their health insurance plan in the last year, compared to the general insured population: 1) those who have both a chronic condition and have been hospitalized in the last year (53%) and 2) those who have been hospitalized but have no chronic condition (55%).

The seriously/chronically ill population and all of its major subgroups are significantly more likely to report having had problems with being denied care or treatment in the last year. Otherwise, the likelihood of reporting specific problems varies across subgroups. Those who have a chronic condition, regardless of whether or not they have been hospitalized, are significantly more likely to report being forced to change medications and having transportation problems. Those who have both a chronic condition and have been hospitalized in the last year are significantly more likely to report problems with health professionals being insensitive or not helpful. Those who were hospitalized in the last year but have no chronic condition are significantly more likely to report problems with billing or payment of claims or premiums.

3. Primary Problems Reported by Seriously/Chronically Ill Californians. As with the general insured population, Californians with a serious/chronic illness who reported having had more than one problem with their health insurance plan in the last year were asked to identify a single biggest problem. There were statistically significant differences for those insured Californians who have both a chronic condition and have been hospitalized in the last year. Compared to the general insured population, those Californians are significantly more likely to report having transportation problems, insensitive or unhelpful health professionals, not receiving the most appropriate medical care, being forced to change medications, and being denied care or treatment. They were also significantly less likely to report their plan not covering important benefits and difficulties getting a referral to a specialist.
4. Problems Reported by Seriously/Chronically Ill Californians, by Type of Managed Care Plan. As with the general insured population, Californians who have a chronic condition and/or have been hospitalized in the last year who are in IPA/Network model HMOs are significantly more likely to report having had a problem with their health insurance plan in the last year (53%) than those in Staff/Group model HMOs (39%). There is no statistically significant difference for those in PPOs. The prevalence of specific problems varies by managed care model type.

- **Care/Services:** Seriously/chronically ill Californians in IPA/Network model HMOs are significantly more likely to report experiencing delays in getting needed care and difficulty with getting a referral to a specialist, compared to those in PPOs.

- **Benefits/Coverage:** Seriously/chronically ill Californians in PPOs are significantly more likely to report a problem with their plan not covering important benefits and misunderstandings over benefits or coverage, compared to those in Staff/Group model HMOs. Those in IPA/Network model HMOs are also significantly more likely than those in Staff/Group model HMOs to report having had misunderstandings over benefits or coverage.

- **Choice:** Seriously/chronically ill Californians in IPA/Network model HMOs are significantly more likely to report having had a problem with being forced to change doctors, compared to those in Staff/Group model HMOs and PPOs.

- **Claims/Payment:** Seriously/chronically ill Californians in PPOs and IPA/Network model HMOs are significantly more likely to report having had a problem with billing or payment of claims or premiums, compared to those in Staff/Group model HMOs.

- **Accessibility:** There are no significant differences in primary problems across managed care plan types for this category.

5. Experiences Related to Hospitalization. Of those insured Californians who were hospitalized in the past year, 67% reported that they were discharged at about the right time. However, 23% reported that they had been discharged either much sooner (9%) or a little sooner (14%) than they should have been. In addition, 21% of those hospitalized stated that they needed extra help at home, such as nursing care or help with their medications, after they left the hospital. Of that 21%, 27% reported that they did not get the help they needed.

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7 The question read, “In the past 12 months, have you been an (overnight) patient in a hospital for at least one day or longer? (If “Yes”) Thinking about your most recent hospital stay, would you say that you were discharged from the hospital much sooner than you should have been, a little sooner than you should have been, at about the right time, a little later than you should have been, or much later than you should have been?”

8 The question read, “After you left the hospital (on this last stay), did you need any extra help at home, which you could not get from family or friends, such as nursing care or help with your medications? (If “Yes”) Did you get the help you needed or not?”
Public Perceptions and Experiences with Managed Care

Background

I. Introduction
The Managed Health Care Improvement Task Force was charged with researching and reporting on the state of managed care in California today and formulating recommendations for the future. To successfully meet this mandate, the Task Force recognized that it must not only solicit the views of health policy experts, but also those of all California consumers. The testimony we received through our public hearings provided invaluable first-hand information for us to consider, but it was not based on a random or representative sample. In addition to what we were able to learn in our hearings and from reading the literature about the state of managed care, we wanted to explore these issues from the perspective of the overall California population. Therefore, we commissioned a statistically valid survey of insured, adult Californians, building on prior studies and the testimony we heard, to enable us to gain a more comprehensive view of the experience of the full spectrum of the public.

II. Survey Goals and Objectives
The Task Force commissioned this survey to provide Task Force members with data to help inform their deliberations and recommendations regarding California’s managed health care system.

Among the objectives that were considered in designing the survey were:

- To document the extent to which Californians are satisfied with and report having experienced problems with their health plan in the last year;
- To document the types of problems Californians have experienced with their health plans in the last year;
- To assess the differences in the types of problems Californians have experienced in the last year by managed care model type;
- To assess the severity of the problems Californians have experienced, measured in terms of their impact financially, on days lost from work, and on health status;
- To understand how Californians try to resolve their problems with their health plan, how successful they have been in getting them resolved, and their satisfaction with their plan’s grievance process;
- To assess the importance and availability of health plan choice for Californians; and
- To assess Californians’ views on key policy issues.

To gain a more thorough understanding of problems in the current health care system and the concerns of those consumers who are most in need of health care services, we oversampled two populations: 1) Californians who reported having a problem with their health insurance plan in the previous 12 months and 2) Californians who had been hospitalized in the previous 12 months and/or who have a serious or chronic illness.

III. Survey Design and Methodology
A. Design Advisors and Funding
Chairman Enthoven, Vice-Chairman Kerr, and an advisory group of Task Force members worked closely with staff and outside experts in the design and question development of the survey instrument. Helen Schaufller, Ph.D., Associate Professor at the University of California, Berkeley, School of Public Health, served as the project’s Principal Investigator. Dr. Schaufller coordinated the technical design of the survey instrument and conducted the analysis of the data with assistance from Task Force staff. A distinguished
group of outside experts lent varying levels of technical assistance (and in many cases, the use of components of surveys they had already completed):

Linda Bergthold, The Lewin Group;
Robert Blendon, Harvard University;
Susan Edgeman-Levitan, Picker Institute;
David Hopkins, Pacific Business Group on Health;
Lee Kemper, California Center for Health Improvement;
Hal Luft, University of California, San Francisco, Medical School;
Arnie Milstein, William M. Mercer, Inc. and The Pacific Business Group on Health; and
Mark Schlesinger, Yale University.

The survey was funded by generous grants from the California Healthcare Foundation, the Institute for Health Care Advancement, California’s Department of Corporations (DOC), and the Office of Statewide Health Planning and Development (OSHPD) with funding from the Robert Wood Johnson Foundation.

B. Survey Instrument
To the extent possible, the survey built on instruments that were already tested and available to create a comprehensive survey instrument tailored for the specific needs of the Managed Health Care Improvement Task Force. We relied on instruments developed by Robert Blendon; the 1995 “Health Care in California” L.A. Times poll; the Pacific Business Group on Health (PBGH) Health Plan Value Check; the Center for Health Care Rights poll developed by the Lewin Group; the Consumer Assessment of Health Plans Survey (CAHPS), developed primarily for the Agency For Health Care Policy and Research by RAND, Harvard University, the Research Triangle Institute, and the Picker Institute; and the suggestions of the advisory group.

The final survey instrument included questions from the following categories:

- Health Insurance Coverage/Plan Characteristics
- Personal Doctor/Health Plan Physicians
- Specialist Care
- Hospital Care
- Problems with Health Insurance/Health Plan (Type and Severity)
- Grievance Process and Problem Resolution
- Satisfaction with Health Insurance/Health Plan
- Public Opinions on Policy Options
- Respondent Health Status and Demographics

C. Methodology
Field Research Corporation, under the direction of Mark DiCamillo, conducted the survey interviews using random digit dialing and a Computer Assisted Telephone Interview (CATI) system. Each interview was approximately 25 minutes in length. Interviews were conducted in both English and Spanish.

The survey instrument included screening questions to obtain interviews from three distinct samples:

1. General Insured Sample. This randomly drawn sample included 1,201 insured, adult Californians who have resided in the state 12 months or longer. To be included in the sample, the respondents had to be insured through at least one of the following sources: their own or their spouse’s employer, labor union, or trade association; individually-purchased coverage; Medicare, or Medi-Cal. Individuals whose primary source of health coverage was a military program (such as the CHAMPUS or VA programs), the Indian Health Service, or other source, were excluded. Respondents also had to be at least 18 years of age and had to have lived in California for at least one year. These interviews were conducted between September 2 and September 24, 1997.
This sample represents approximately 16 million insured, adult Californians who have lived in the state 12 months or longer.

2. Sample of Dissatisfaction/Problems. This randomly drawn sample included 1,373 insured adult Californians (as defined in Sample 1, above) who stated that they were “dissatisfied” or “very dissatisfied” with their current health insurance plan and/or who had one or more problems with their health insurance plan in the prior 12 months. Approximately 500 respondents included in this sample are also included in the general insured sample. An additional oversample was drawn to reach the total of 1,373. These interviews were conducted between September 25 and October 19, 1997.

This sample represents approximately 6.72 million insured, adult Californians who have lived in the state 12 months or longer.

3. Sample of Persons with Serious/Chronic Illness. This randomly drawn sample included 1,227 insured, adult Californians (as defined in Sample 1, above) who had been hospitalized in the prior 12 months and/or who had at least one of the following chronic or serious conditions: hypertension, heart disease, diabetes, cancer, asthma, emphysema, chronic bronchitis, migraine, HIV/AIDS, severe arthritis, treatment for depression in the prior 12 months, or suffered a heart attack in the prior 12 months. Approximately 140 respondents included in this sample are also included in the general insured sample. An additional oversample was drawn to reach the total of 1,227. These interviews were conducted between October 20 and December 3, 1997. Due to time constraints, limited information from the third sample is included in this report.

Note: Though Californians with traditional, unmanaged indemnity insurance were included in the survey samples, results for that type of health insurance are not reported separately because the numbers are too small to make accurate estimates. In the general insured sample, a weighted total of 160 individuals (13%) were covered by unmanaged indemnity insurance. Of those, 56 (5% of total insured) were covered by traditional Medicare and 39 (3%) by traditional Medi-Cal. Only 65 (5%) were covered by private unmanaged indemnity insurance: 50 (4%) in employer-based unmanaged indemnity and 15 (1%) in individually-purchased unmanaged indemnity. Therefore, this report presents no findings comparing managed care and unmanaged indemnity care.

IV. Findings

A. Californians’ Views of Their Health Insurance Plans and California’s Health Care System

The majority of insured Californians are satisfied with their current health plan and with California’s health care system as it affects their families (Table 1). In general, Californians are more likely to be very

<table>
<thead>
<tr>
<th>Satisfaction with Health Plan</th>
<th>Satisfaction with Health System as It Affects Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>33%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>43%</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
<td>11%</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>7%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>3%</td>
</tr>
<tr>
<td>Not sure</td>
<td>3%</td>
</tr>
</tbody>
</table>

9 Due to rounding error, numbers may not add to 100%.
10 The question read, “Overall, how satisfied are you with your current health insurance plan?”
11 The question read, “How satisfied are you with the overall health care system in California as it affects you and your family?”
satisfied with their health plan (33%) than with California’s health care system as it affects their family (17%). In addition, Californians are less likely to be dissatisfied or very dissatisfied with their health plan (10%) than with the health care system as it affects their family (19%).

While their personal experiences have been generally satisfying, the majority of Californians are concerned about the health care system overall: they believe that California’s health care system either needs to be fundamentally changed (43%) or completely rebuilt (11%) to make it work better. A total of 84% of insured Californians believe that at least minor changes are needed to make California’s health care system work better. Those Californians who stated a stronger desire for system change were more likely to report having had a problem with their health insurance plan in the previous 12 months. (Table 2)

Table 2: Californians’ Characterization of Change Needed in California’s Health Care System.

<table>
<thead>
<tr>
<th>General Insured Population (n=1,201)</th>
<th>% Who Report Having Had a Problem with Their Health Plan in the Last Year (n based on column to left)</th>
</tr>
</thead>
<tbody>
<tr>
<td>It works well and no changes are needed.</td>
<td>9%</td>
</tr>
<tr>
<td>It works pretty well and only minor changes are needed to make it work better.</td>
<td>30%</td>
</tr>
<tr>
<td>There are some good things about it, but fundamental changes are needed to make it work better.</td>
<td>43%</td>
</tr>
<tr>
<td>It has so much wrong with it that we need to completely rebuild it.</td>
<td>11%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7%</td>
</tr>
</tbody>
</table>

Overall, Californians in IPA/Network model HMOs are significantly less likely to be very satisfied and significantly more likely to be very dissatisfied compared to those in Staff/Group model HMOs. Californians in IPA/Network model HMOs are also significantly more likely to be very dissatisfied compared to those in PPOs. (Table 3)

B. Problems Californians Report with Their Health Insurance Plan

Overall, 42% of Californians (approximately 6.72 million people) report having had one or more problems with their health insurance plan in the previous 12 months (Table 4). The severity of those problems varies considerably. Among the most frequently cited problems was that the plan did not cover important

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12 The question read, “Which of the following statements best describes your overall view of the health care system in California?”

13 Though Californians with traditional, unmanaged indemnity insurance were included in the survey samples, results for that type of health insurance are not reported separately because the numbers are too small to make accurate estimates. In the general insured sample, a weighted total of 160 individuals (13%) were covered by indemnity insurance. Of those, 56 (5% of total insured) were covered by traditional Medicare and 39 (3%) by traditional Medi-Cal. Only 65 (5%) were covered by private unmanaged indemnity insurance: 50 (4%) in employer-based unmanaged indemnity and 15 (1%) in individually-purchased unmanaged indemnity. Therefore, this report presents no findings comparing managed care and unmanaged indemnity care.

14 Due to rounding error, numbers may not add to 100%.

15 The exact questions read, “In the past 12 months, have you had any problems or difficulties with your health insurance plan for any of the following reasons: Do not include problems associated with routine vision care or dental care. M isunderstandings over health care benefits or coverage; your plan not covering some important benefits you needed; delays in getting needed care; difficulty with selecting a doctor or hospital; a language or communication problem; a problem with billing or payment of claims or premiums; being denied care or treatment; difficulty in getting a referral to a specialist; not receiving the most appropriate medical care or what you needed; transportation problems; doctors, nurses, administrators, or other staff were insensitive or not helpful; you were forced to change doctors; you were forced to change medications. Have you had any other problem with your health insurance plan in the past 12 months? (For those who reported more than one problem): Of these, which one was the biggest problem for you?”

16 Overall, 42% of Californians reported having one or more problems with their health plan in the last year.

24 Managed Health Care Improvement Task Force
### Table 3: Californians’ Satisfaction with Their Health Insurance Plan, by Type of Managed Care Plan.\(^{14}\)

<table>
<thead>
<tr>
<th>Overall Satisfaction with Health Plan</th>
<th>Staff/Group HMO (n=243)</th>
<th>IPA/Network HMO (n=605)</th>
<th>PPO (n=166)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Satisfied</td>
<td>44%**</td>
<td>(29%)</td>
<td>39%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>39%</td>
<td>46%</td>
<td>35%</td>
</tr>
<tr>
<td>Neither Satisfied nor dissatisfied</td>
<td>8%</td>
<td>13%</td>
<td>17%</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Very Dissatisfied (&lt;1%)</td>
<td>(4%)**</td>
<td>4%**</td>
<td>(1%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

** = statistically significantly higher; ( ) = statistically significantly lower

### Table 4: Problems Californians Report Having with Their Health Insurance Plan in the Last Year.\(^{15}\)

<table>
<thead>
<tr>
<th>Primary Problem</th>
<th>Prevalence in General Insured Population (more than one answer possible) (n=1,201)</th>
<th>(n=1,373)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>32% total</td>
<td>21% total</td>
</tr>
<tr>
<td>Care/Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not receiving the most appropriate medical care or what you needed</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Doctors/nurses/administrators/staff insensitive or not helpful</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Difficulty in getting a referral to a specialist</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Benefits/Coverage:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan not covering important benefits needed</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Misunderstandings over benefits or coverage</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Being denied care or treatment</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Choice:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty selecting a doctor or hospital</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Forced to change medications</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Claims/Payment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A problem with billing or payment of claims or premiums</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Accessibility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language or communication problem</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Did not report one primary problem</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
benefits the respondent needed. Benefits coverage is largely determined by purchasers (i.e., government and employers) and by state regulation rather than health insurance plans.

### Table 5: Prevalence of Problems among Californians Who Are Satisfied with Their Current Health Insurance Plan

<table>
<thead>
<tr>
<th>Satisfaction with Health Plan</th>
<th>% Who Report Having Had a Problem with Their Health Plan in the Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>33%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>43%</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
<td>11%</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>7%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>3%</td>
</tr>
<tr>
<td>Not sure</td>
<td>3%</td>
</tr>
</tbody>
</table>

Approximately one in four Californians who are “very satisfied” with their current health insurance plan report having had a problem with their plan (Table 5), therefore having a problem should not necessarily be interpreted as having a serious grievance. Among other characteristics, Californians who report having had a problem with their plan in the last year are more likely to be dissatisfied with their plan’s concern for their health, dissatisfied with the choice of physicians in their plan, dissatisfied with the process of getting a referral to a specialist, dissatisfied with the preventive care provided by their plan, to have postponed or not gotten needed medical care because of cost, to have been a member of their plan from 2 to 5 years, and to be in good, fair, or poor health (i.e., not in excellent or very good health). (Table 6)

The probability of reporting having had a problem with one’s health plan in the last year does not vary by any of the following characteristics: education, income, employment status, size of the firm providing coverage for its employees, household size, geographic area of the state (urban/suburban/rural), having been hospitalized, or smoking status.

Those Californians who reported having had more than one problem with their health insurance plan in the last year were asked to identify which one was the “biggest problem”. Overall, these primary problems fell into five categories: problems with care or services (32% of insured Californians who reported a problem identified a problem from this category as their biggest problem); benefits or coverage (21%); choice (16%); claims or payment (14%); and accessibility (7%). (Table 4)

### C. Problems by Type of Managed Care Plan

1. Comparison of Problems Reported across Health Insurance Plan Model Types. The types and prevalence of specific problems Californians report having with their health insurance plan in the last year vary significantly by type of managed care plan model (IPA/Network model HMO, Staff/Group model HMO, and PPO). Overall, Californians in IPA/Network model HMOs are significantly more likely to report having had a problem with their plan in the last year than those in either PPOs or Staff/Group model HMOs. In addition, Californians in PPOs are significantly more likely to report having had a problem than those in Staff/Group model HMOs. (Table 7)

---

17 Overall, 42% of Californians reported having one or more problems with their health plan in the last year.

18 Though Californians with traditional, unmanaged indemnity insurance were included in the survey samples, results for that type of health insurance are not reported separately because the numbers are too small to make accurate estimates. In the general insured sample, a weighted total of 160 individuals (13%) were covered by unmanaged indemnity insurance. Of those, 56 (5% of total insured) were covered by traditional Medicare and 39 (3%) by traditional Medi-Cal. Only 65 (5%) were covered by private unmanaged indemnity insurance: 50 (4%) in employer-based unmanaged indemnity and 15 (1%) in individually-purchased unmanaged indemnity. Therefore, this report presents no findings comparing managed care and unmanaged indemnity care.

19 Only those problems for which there were statistically significant differences across managed care plan types are reported. For the overall prevalence of problems, see Table 4.
Table 6: Characteristics of Californians Who Have Had a Problem with Their Health Insurance Plan in the Last Year.

<table>
<thead>
<tr>
<th>Demographics:</th>
<th>IPA/Network HMO (n=605)</th>
<th>Staff/Group HMO (n=243)</th>
<th>PPO (n=166)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In good/fair/poor health (not excellent or very good health)</td>
<td>50%</td>
<td>48%</td>
<td>46%</td>
</tr>
<tr>
<td>Under age 50</td>
<td>48%</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Female</td>
<td>47%</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>All races, other than White, Non-Hispanic</td>
<td>46%</td>
<td>46%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Health Plan Characteristics:
- Required by the plan to get a referral before seeing a specialist: 48%
- In an IPA/Network model HMO (compared to a Staff/Group model HMO or PPO): 46%
- Required by the plan to select a PCP as gatekeeper: 46%

Experiences with Health Plan:
- Dissatisfied with plan’s concern for their health: 92%
- Dissatisfied with process of getting a referral to a specialist: 80%
- Dissatisfied with preventive care provided by plan: 80%
- Postponed or did not get needed medical care because of cost: 79%
- Have been a member of their plan from 2-5 years: 50%
- Do not have a personal doctor: 46%

Choice:
- Dissatisfied with choice of physicians in their plan: 82%
- Have been offered the choice of only 1 or 2 health plans: 48%
- Consider having a choice of health plans very important: 48%

Table 7: Comparison of Problems Reported by Californians in Different Managed Care Plan Types (IPA/Network model HMOs, Staff/Group model HMOs, and PPOs).

<table>
<thead>
<tr>
<th></th>
<th>IPA/Network HMO (n=605)</th>
<th>Staff/Group HMO (n=243)</th>
<th>PPO (n=166)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Problem</td>
<td>47%**</td>
<td>(34%)</td>
<td>41%*</td>
</tr>
<tr>
<td>Care/Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty with referrals to specialists</td>
<td>14%*</td>
<td>(7%)</td>
<td>(4%)</td>
</tr>
<tr>
<td>Not receiving the most appropriate care or what was needed</td>
<td>14%*</td>
<td>10%</td>
<td>(5%)</td>
</tr>
<tr>
<td>Benefits/Coverage:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan not covering important benefits</td>
<td>16%*</td>
<td>(6%)</td>
<td>16%*</td>
</tr>
<tr>
<td>Misunderstandings over benefits or coverage</td>
<td>11%*</td>
<td>(5%)</td>
<td>15%*</td>
</tr>
<tr>
<td>Choice:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty selecting a doctor or hospital</td>
<td>9%*</td>
<td>(6%)</td>
<td>(4%)</td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>9%*</td>
<td>7%</td>
<td>(3%)</td>
</tr>
<tr>
<td>Claims/Payment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A problem with billing or payment of claims or premiums</td>
<td>15%*</td>
<td>(6%)</td>
<td>18%*</td>
</tr>
<tr>
<td>Accessibility:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation problem</td>
<td>4%*</td>
<td>4%*</td>
<td>(&lt;1%)</td>
</tr>
</tbody>
</table>

[* = statistically significantly higher than ( ); ( ) = statistically significantly lower than both * and **; ** = statistically significantly higher than both * and ( )]
- **Care/Services**: Californians in IPA/Network model HMOs are significantly more likely to report difficulties with referrals to specialists, compared to those in Staff/Group model HMOs and PPOs. Californians in IPA/Network model HMOs are also significantly more likely to report a problem with not getting the most appropriate care or what was needed, compared to those in PPOs.
- **Benefits/Coverage**: Californians covered by IPA/Network model HMOs and PPOs, compared to those in Staff/Group model HMOs, are significantly more likely to report problems with services they needed not being covered or misunderstandings over benefits or coverage.
- **Choice**: Californians in IPA/Network model HMOs are significantly more likely to report having difficulty selecting a doctor or hospital, compared to those in Staff/Group Model HMOs and PPOs. Californians in IPA/Network model HMOs are also significantly more likely to be forced to change doctors, compared to those in PPOs.
- **Claims/Payment**: Californians in IPA/Network model HMOs and PPOs are significantly more likely to report a problem with billing or payment of claims or premiums with their health insurance plan in the last year, compared to those in Staff/Group model HMOs.
- **Accessibility**: Californians in IPA/Network and Staff/Group model HMOs are significantly more likely to report a transportation problem with their health insurance plan in the last year, compared to those in PPOs.

**Table 8: Problems Reported by Californians in PPOs.**

<table>
<thead>
<tr>
<th>Significantly MORE likely to Report (compared to persons in Staff/Group model HMOs)</th>
<th>Significantly LESS Likely to Report (compared to persons in IPA/Network model HMOs)</th>
<th>Significantly LESS Likely to Report (compared to persons in Staff/Group model HMOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A problem with billing or payment of claims or premiums&lt;br&gt;• Plan not covering important benefits&lt;br&gt;• Misunderstandings over benefits or coverage</td>
<td>• Not getting the most appropriate care or what was needed&lt;br&gt; • Difficulty with referrals to specialists&lt;br&gt; • Difficulty selecting a doctor or hospital&lt;br&gt; • Forced to change doctors</td>
<td>• Transportation problem</td>
</tr>
</tbody>
</table>

**Table 9: Problems Reported by Californians in IPA/Network Model HMOs.**

<table>
<thead>
<tr>
<th>Significantly MORE likely to Report (compared to persons in Staff/Group model HMOs)</th>
<th>Significantly LESS Likely to Report (compared to persons in PPOs)</th>
<th>Significantly LESS Likely to Report (compared to persons in Staff/Group model HMOs and PPOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A problem with billing or payment of claims or premiums&lt;br&gt;• A problem with billing or payment of claims or premiums&lt;br&gt;• Difficulty with referrals to specialists&lt;br&gt; • Misunderstandings over benefits or coverage&lt;br&gt; • Difficulty selecting a doctor or hospital</td>
<td>• Difficulty with referrals to specialists&lt;br&gt; • Not getting the most appropriate care or what was needed&lt;br&gt; • Difficulty selecting a doctor or hospital&lt;br&gt; • Forced to change doctors&lt;br&gt; • Transportation problem</td>
<td>None</td>
</tr>
</tbody>
</table>
Table 10: Problems Reported by Californians in Staff/Group Model HMOs.

<table>
<thead>
<tr>
<th>Significantly MORE likely to Report (compared to persons in PPOs)</th>
<th>Significantly LESS Likely to Report (compared to persons in IPA/Network model HMOs)</th>
<th>Significantly LESS Likely to Report (compared to persons in PPOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transportation problem</td>
<td>• Difficulty with referrals to specialists</td>
<td>• Plan not covering important benefits</td>
</tr>
<tr>
<td></td>
<td>• Plan not covering important benefits</td>
<td>• A problem with billing or payment of claims or premiums</td>
</tr>
<tr>
<td></td>
<td>• A problem with billing or payment of claims or premiums</td>
<td>• Misunderstandings over benefits or coverage</td>
</tr>
<tr>
<td></td>
<td>• Difficulty selecting a doctor or hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Misunderstandings over benefits or coverage</td>
<td></td>
</tr>
</tbody>
</table>

Table 11: Problems Reported Equally across All Managed Care Plan Types (Staff/Group model HMOs, IPA/Network model HMOs, and PPOs).

For the following problems, there are **NO differences in the prevalence of the problems by type of managed care plan:**

<table>
<thead>
<tr>
<th>Problem</th>
<th>% Who Report Having Had this Problem with Their Health Plan in the Last Year (n=1,201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/nurses/administrators/staff insensitive or not helpful</td>
<td>11%</td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>10%</td>
</tr>
<tr>
<td>Language or communication problem</td>
<td>5%</td>
</tr>
<tr>
<td>Forced to change medications</td>
<td>4%</td>
</tr>
<tr>
<td>Denied treatment or care</td>
<td>3%</td>
</tr>
</tbody>
</table>

2. Summary of Problems Associated with Different Types of Managed Care Plans. The following tables summarize the types of problems that are statistically significantly more or less likely to be reported for each type of managed care plan (IPA/Network model HMO, Staff/Group model HMO, or PPO).

3. Comparison of Primary Problem Reported across Health Insurance Plan Model Types. Survey respondents who reported having had at least one problem with their health plan in the prior 12 months were asked to identify the single biggest problem they experienced. These primary problems vary significantly by type of managed care plan model. (Table 12)

- **Care/Services:** Californians in Staff/Group model HMOs are significantly more likely to report as their primary problem insensitivity of health professionals and not receiving the most appropriate medical care, compared to those in IPA/Network model HMOs and PPOs. They are also significantly more likely to report as their primary problem delays in getting needed care, compared to those in PPOs. Californians in IPA/Network model HMOs are significantly more likely to report as their primary problem difficulties with referrals to specialists, compared to those in Staff/Group model HMOs and PPOs. They are also significantly more likely to report as their primary problem delays in getting needed care, compared to those in PPOs.

- **Benefits/Coverage:** Californians in PPOs are significantly more likely to report as their primary problem their plan not covering important benefits and misunderstandings over benefits or coverage, compared to those in IPA/Network or Staff/Group model HMOs. Californians in IPA/Network model HMOs are also significantly more likely than those in Staff/Group model HMOs to report as their primary problem their plan not covering important benefits.
Table 12: Comparison of Primary Problems Reported by Californians in Different Managed Care Plan Types (IPA/Network model HMOs, Staff/Group model HMOs, and PPOs).20

<table>
<thead>
<tr>
<th>Care/Services:</th>
<th>IPA/Network HMO (n=605)</th>
<th>Staff/Group HMO (n=243)</th>
<th>PPO (n=166)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty with referrals to specialists</td>
<td>10%*</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Doctors/nurses/administrators/staff insensitive or not helpful</td>
<td>9%*</td>
<td>14%*</td>
<td>7%</td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>9%*</td>
<td>13%*</td>
<td>(1%)</td>
</tr>
<tr>
<td>Not receiving the most appropriate care or what was needed</td>
<td>6%*</td>
<td>11%*</td>
<td>(3%)</td>
</tr>
<tr>
<td>Benefits/Coverage:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan not covering important benefits</td>
<td>12%*</td>
<td>7%</td>
<td>23%**</td>
</tr>
<tr>
<td>Misunderstandings over benefits or coverage</td>
<td>6%*</td>
<td>3%</td>
<td>11%*</td>
</tr>
<tr>
<td>Choice:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>8%*</td>
<td>9%*</td>
<td>(1%)</td>
</tr>
<tr>
<td>Claims/Payment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A problem with billing or payment of claims or premiums</td>
<td>14%*</td>
<td>5%</td>
<td>26%**</td>
</tr>
</tbody>
</table>

*=statistically significantly higher than (); ( ) =statistically significantly lower than both * and **;
** = statistically significantly higher than both * and ()

- **Choice:** Californians in both Staff/Group and IPA/Network model HMOs are significantly more likely to report as their primary problem being forced to change doctors, compared to those in PPOs.

- **Claims/Payment:** Californians in PPOs are significantly more likely to report as their primary problem difficulties with billing or payment of claims or premiums, compared to those in IPA/Network or Staff/Group model HMOs. Californians in IPA/Network model HMOs are also significantly more likely to report this as their primary problem, compared to those in Staff/Group model HMOs.

- **Accessibility:** There are no significant differences in primary problems across managed care plan types for this category.

**D. Resolution of Problems**

1. **Attempts to Resolve Problems.** Of those Californians who reported having a problem with their health insurance plan in the last year, 57% (approximately 3.8 million people) have tried to resolve their problem. Californians are most likely to seek resolution for problems involving difficulties with billing or payment or claims or premiums (81%) and misunderstandings over benefits or coverage (76%). In their attempts to resolve their problems, Californians are most likely to contact their physician, other health care provider, or health plan for information or assistance, or to refer to their health insurance plan documents for information. In addition, 4% of those who reported having had a problem with their health insurance plan in the last year (approximately 269,000 Californians) reported contacting a state or local agency and 3% (approximately 202,000 Californians) reported contacting an elected official about their problem. (Table 13)

20 Only those primary problems for which there were statistically significant differences across managed care plan types are reported. For the overall prevalence of primary problems, see Table 4.
2. Resolution of Problems. Of those Californians who reported having a problem with their health insurance plan in the last year, 52% reported that their problem had been resolved and 42% reported that their problem had not been resolved. The problems that are significantly more likely to be resolved are problems with being forced to change doctors (71% resolved), problems with billing or payment of claims or premiums (53% resolved), and problems with not getting the most appropriate care or what was needed (53% resolved). The problems that are significantly less likely to be resolved are problems with the health insurance plan denying care or treatment (40% resolved) and not covering important benefits needed (38% resolved).

3. Satisfaction with the Resolution and Handling of Problems. Of those Californians whose problems were resolved, 6% stated that the resolution exceeded their expectations and 43% stated that the problem was resolved satisfactorily. An additional 35% were not completely satisfied with the resolution; 13% were not at all satisfied with how it was resolved. (Table 14) Regarding how their health insurance plan handled

Table 14: Californians’ Satisfaction with the Resolution of Problems with Their Health Insurance Plan.\(^{22}\)

| % of Those Reporting that Their Problem with Their Health Plan Was Resolved (n=670)\(^{23}\) |
|-------------------------------------------------|-----------------|
| The resolution of the problem exceeded expectations | 6% |
| The problem was resolved satisfactorily | 43% |
| The problem was acceptably resolved, although not completely satisfied | 35% |
| Not at all satisfied with how the problem was resolved | 13% |
| No opinion | 4% |

---

\(^{21}\) The question read, “I am going to read some things people can do when they have a problem with their health insurance plan. Please tell me which of the following you did to complain or to try to resolve this difficulty.”

\(^{22}\) The question read, “Which of the following best describes how satisfied you were with how the problem was resolved?”

\(^{23}\) Due to rounding error, numbers may not add to 100%.
their complaints, 29% of Californians who reported having had a problem with their health insurance plan in the last year were either dissatisfied (18%) or very dissatisfied (11%). (Table 15)

Table 15: Californians’ Satisfaction with Their Health Insurance Plan’s Handling of Complaints.  

<table>
<thead>
<tr>
<th>% of Those Who Reported Having Had a Problem with Their Health Plan in the Last Year (n=1,281)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
</tr>
<tr>
<td>Satisfied</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
</tr>
<tr>
<td>Dissatisfied</td>
</tr>
<tr>
<td>Very dissatisfied</td>
</tr>
<tr>
<td>No opinion</td>
</tr>
</tbody>
</table>

E. Impact of Problems

1. Financial Impacts. Of those Californians who reported having a problem with their health insurance plan in the last year, 27% (approximately 1.8 million Californians) had an associated financial loss. Of those whose problem involved financial loss, 33% (approximately 599,000 Californians) lost in excess of $500. (Table 16) The problems that are significantly more likely to involve financial loss are reported in Table 17.

Table 16: Californians’ Financial Loss Associated with Problems with Their Health Insurance Plan.  

<table>
<thead>
<tr>
<th>% of Those Who Reported Having Had a Problem with Their Health Plan in the Last Year (n=1,281)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported a financial loss associated with problem with health plan</td>
</tr>
<tr>
<td>Amount of financial loss (for those who reported a financial loss):</td>
</tr>
<tr>
<td>Less than $50</td>
</tr>
<tr>
<td>$50 to &lt;$200</td>
</tr>
<tr>
<td>$200 to &lt;$500</td>
</tr>
<tr>
<td>$500 to &lt;$1,000</td>
</tr>
<tr>
<td>$1,000 to &lt;$5,000</td>
</tr>
<tr>
<td>&gt;$5,000</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Table 17: Problems with the Health Insurance Plan that Are More likely to Involve a Financial Loss.

<table>
<thead>
<tr>
<th>Problem with Health Plan in Last Year</th>
<th>% Reporting a Financial Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your plan not covering some important benefits you needed</td>
<td>47%</td>
</tr>
<tr>
<td>Misunderstandings over health care benefits or coverage</td>
<td>45%</td>
</tr>
<tr>
<td>Being denied care or treatment</td>
<td>41%</td>
</tr>
<tr>
<td>A problem with billing or payment of claims or premium</td>
<td>37%</td>
</tr>
</tbody>
</table>

24 The question read, “Overall, how satisfied are you with how your health insurance plan handled your complaints?”
25 The question read, “Did your problem with this involve any financial loss to you or your family? (If “Yes”) How much was your financial loss due to this problem?”

32 Managed Health Care Improvement Task Force
2. Lost Time from Work. Of those Californians reporting a problem with their health insurance plan in the last year, 20% (approximately 1.3 million Californians) report that they lost time from work due to the problem. Of those, 27% (approximately 350,000 Californians) report that they lost more than five days of work. (Table 18) The problems that are more likely to be associated with lost time from work are problems with being denied care or treatment (38% report lost time from work), delays in getting needed care (35% report lost time from work), and not receiving the most appropriate medical care or what was needed (34% report lost time from work).

| % of Those Who Reported Having Had a Problem with Their Health Plan in the Last Year (n=1,281) |
|---------------------------------------------------------------|------------------|
| Lost any time from work                                        | 20%              |
| # of days lost (for those who lost time from work):            |                  |
| Lost 1 day                                                     | 32%              |
| Lost 2 days                                                    | 19%              |
| Lost 3 to 5 days                                               | 17%              |
| Lost more than 5 days                                         | 27%              |
| No answer                                                      | 5%               |

3. Health Impacts. Of those Californians who reported a problem with their health insurance plan in the last year, 32% (approximately 2 million Californians) reported that their problem caused them to experience pain and suffering that continued longer than it should have. In addition, 22% (approximately 1.4 million Californians) reported that the difficulty led to the worsening of their health condition and 6% (approximately 400,000 Californians) reported that it led to permanent disability and affected their daily living activities. (Table 19)

Problems that are significantly more likely to lead to increased pain and suffering, other conditions not previously present, the worsening of the person’s health condition, and permanent disability include problems with being denied care or treatment, not receiving the most appropriate medical care or what was needed, delays in getting needed care, and difficulties in getting a referral to a specialist. (Tables 20 and 21)

<table>
<thead>
<tr>
<th>Of Those Who Reported Having Had a Problem with Their Health Plan in the Last Year, % Answering “Yes” (more than one answer possible) (n=1,281)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I experienced pain and suffering that continued longer than it should have.”</td>
</tr>
<tr>
<td>“The difficulty led to other conditions not previously present.”</td>
</tr>
<tr>
<td>“The difficulty led to the worsening of my health condition.”</td>
</tr>
<tr>
<td>“The difficulty led to permanent disability and affected my daily living activities.”</td>
</tr>
</tbody>
</table>

---

26 The question read, “Did the problem cause you to lose time from work? (If “Yes”) How many days were lost due to the difficulty?”

27 The exact question read, “Please tell me whether any of the following did or did not apply to [your problem]: (a) There was the potential for injury, but no injury actually occurred. (b) I experienced pain and suffering that continued longer than it should have. (c) The difficulty led to other conditions not previously present. (d) The difficulty led to the worsening of my health condition. [Asked only of those who answered “yes” to (d)] the difficulty led to permanent disability and affected my daily living activities.” Respondents did not have the option to indicate that there was no potential for injury.
Table 20: Problems that Are Significantly More likely to Lead to:
- Increased Pain and Suffering or
- Other Conditions Not Previously Present

<table>
<thead>
<tr>
<th>Problem with Health Plan in Last Year</th>
<th>% of Those with the Problem Who Reported that the Problem Led to Pain and Suffering Continuing Longer than It Should Have</th>
<th>% of Those with the Problem Who Reported that the Problem Led to Other Conditions Not Previously Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being denied care or treatment</td>
<td>64%</td>
<td>41%</td>
</tr>
<tr>
<td>Not receiving the most appropriate medical care or what you needed</td>
<td>57%</td>
<td>31%</td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>57%</td>
<td>28%</td>
</tr>
<tr>
<td>Difficulty in getting a referral to a specialist</td>
<td>54%</td>
<td>27%</td>
</tr>
<tr>
<td>Transportation problem</td>
<td>48%</td>
<td>28%</td>
</tr>
<tr>
<td>Difficulty with selecting a doctor or hospital</td>
<td>43%</td>
<td>25%</td>
</tr>
<tr>
<td>A language or communication problem</td>
<td>38%</td>
<td>X</td>
</tr>
<tr>
<td>Forced to change medications</td>
<td>37%</td>
<td>26%</td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>37%</td>
<td>X</td>
</tr>
<tr>
<td>Your plan not covering some important benefits you needed</td>
<td>36%</td>
<td>20%</td>
</tr>
<tr>
<td>Doctors, nurses, administrators or other staff were insensitive or not helpful</td>
<td>X</td>
<td>22%</td>
</tr>
</tbody>
</table>

X = This problem is not a statistically significant factor in this category.

Table 21: Problems that Are Significantly More likely to Lead to:
- Worsening of Health Condition or
- Permanent Disability and Effects on Daily Living Activities

<table>
<thead>
<tr>
<th>Problem with Health Plan in Last Year</th>
<th>% of Those with the Problem Who Reported that the Problem Led to Worsening of Health Condition</th>
<th>% of Those with the Problem Who Reported that the Problem Led to Permanent Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being denied care or treatment</td>
<td>50%</td>
<td>15%</td>
</tr>
<tr>
<td>Not receiving the most appropriate medical care or what you needed</td>
<td>45%</td>
<td>11%</td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>40%</td>
<td>11%</td>
</tr>
<tr>
<td>Difficulty in getting a referral to a specialist</td>
<td>39%</td>
<td>10%</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>39%</td>
<td>15%</td>
</tr>
<tr>
<td>Forced to change medications</td>
<td>38%</td>
<td>X</td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>33%</td>
<td>X</td>
</tr>
<tr>
<td>Your plan not covering some important benefits you needed</td>
<td>30%</td>
<td>X</td>
</tr>
<tr>
<td>Doctors, nurses, administrators or other staff were insensitive or not helpful</td>
<td>30%</td>
<td>X</td>
</tr>
</tbody>
</table>

X = This problem is not a statistically significant factor in this category.

F. Choice of Health Insurance Plan
Over 80% of Californians stated that having the choice of more than one plan was important (27%) or very important (54%) to them (Table 22). However, 23% said that they had no choice of plans (Table 23). Californians with the choice of at least three plans (49% of insured, adult Californians) were statistically significantly less likely to report having a problem with their health insurance plan in the last year, compared to those with the choice of only one or two plans (48% versus 41%; the population mean was 42%) (Table 24).
70% of insured, adult Californians favor the idea of giving all employees a choice of health insurance plans, with at least one plan allowing employees to choose any doctor they want (Table 25). Under this proposal as described in the interviews, employers would not be required to make any additional payments, but employees would pay some additional money for insurance that allows them to choose any doctor they want. The median additional amount respondents were willing to pay for this option (of the 68% who specified an amount above zero) was between $11 and $25 per month. Depending on the structure of such a plan (e.g., the size of the deductible and co-pay), this amount may be insufficient to cover the additional cost of the option.

Table 22: Importance of Having the Choice of More than One Health Insurance Plan.

<table>
<thead>
<tr>
<th>Importance of Choice</th>
<th>General Insured Population (n=1,201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Important</td>
<td>54%</td>
</tr>
<tr>
<td>Important</td>
<td>27%</td>
</tr>
<tr>
<td>Neither Important or Unimportant</td>
<td>3%</td>
</tr>
<tr>
<td>Somewhat Unimportant</td>
<td>4%</td>
</tr>
<tr>
<td>Not Important</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 23: Number of Plans Offered.

<table>
<thead>
<tr>
<th>Number of Plans Offered</th>
<th>General Insured Population (n=1,201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 plan (No choice)</td>
<td>23%</td>
</tr>
<tr>
<td>2 plans</td>
<td>18%</td>
</tr>
<tr>
<td>3 to 5 plans</td>
<td>37%</td>
</tr>
<tr>
<td>More than 5 plans</td>
<td>12%</td>
</tr>
<tr>
<td>Not sure</td>
<td>11%</td>
</tr>
</tbody>
</table>

Table 24: Relationship between Choices Offered and Likelihood of Having a Problem.

<table>
<thead>
<tr>
<th>Number of Plans Offered</th>
<th>% Who Reported Having Had a Problem with Their Health Plan in the Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 plan (No choice)</td>
<td>45%</td>
</tr>
<tr>
<td>2 plans</td>
<td>50%</td>
</tr>
<tr>
<td>1 or 2 plans</td>
<td>48%**</td>
</tr>
<tr>
<td>3 to 5 plans</td>
<td>41%</td>
</tr>
<tr>
<td>More than 5 plans</td>
<td>40%</td>
</tr>
<tr>
<td>3 or more plans</td>
<td>(41%)</td>
</tr>
<tr>
<td>Population Mean</td>
<td>42%</td>
</tr>
</tbody>
</table>

(** = statistically significantly higher; () = statistically significantly lower)

The question read, “How important is it to you to have the choice of more than one health insurance plan?”

Due to rounding error, numbers may not add to 100%.

The question read, “How many different health insurance plans did you have to choose from?”

Due to rounding error, numbers may not add to 100%.
G. Californians' Views on Key Policy Issues

1. Direct Access to Specialists. 44% of insured adult Californians would be willing to pay an additional fee out of their own pocket each time they went to see a specialist, if they could go to the specialist without first having to get approval or a referral from their own personal doctor or health insurance plan. 37% of insured Californians would be willing to pay $10 or more and 15% would be willing to pay more than $20 each time they went to see a specialist without prior authorization. (Table 26)

Table 26: Californians' Willingness to Pay for Direct Access to Specialists.

<table>
<thead>
<tr>
<th>Willingness to Pay:</th>
<th>General Insured Population (n=1,201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favor Policy</td>
<td>44%</td>
</tr>
<tr>
<td>Nothing</td>
<td>46%</td>
</tr>
<tr>
<td>Less than $10 per visit</td>
<td>12%</td>
</tr>
<tr>
<td>$10 to $20 per visit</td>
<td>22%</td>
</tr>
<tr>
<td>More than $20 visit</td>
<td>15%</td>
</tr>
<tr>
<td>Don't know</td>
<td>5%</td>
</tr>
</tbody>
</table>

2. Physician Incentives Not to Refer to Specialists. 53% of insured, adult Californians think that health insurance plans in California should not be allowed to lower their payment to doctors if the plan or the medical group believes the doctor makes too many referrals to specialists. 33

Table 25: Support and Willingness to Pay for Choice of Plan that Allows Choice of Any Doctor.

<table>
<thead>
<tr>
<th>Willingness to Pay:</th>
<th>General Insured Population (n=1,201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favor Policy</td>
<td>70%</td>
</tr>
<tr>
<td>Nothing</td>
<td>23%</td>
</tr>
<tr>
<td>Less than $5 per month</td>
<td>5%</td>
</tr>
<tr>
<td>$5 - $10 per month</td>
<td>20%</td>
</tr>
<tr>
<td>$11 - $25 per month</td>
<td>20%</td>
</tr>
<tr>
<td>$26 - $50 per month</td>
<td>13%</td>
</tr>
<tr>
<td>$51 - 100 per month</td>
<td>6%</td>
</tr>
<tr>
<td>More than $100</td>
<td>4%</td>
</tr>
<tr>
<td>Don't know</td>
<td>9%</td>
</tr>
</tbody>
</table>

32 The question read, “Some employers in California today offer only one health insurance plan to their employees. Some people have proposed that all employees be given a choice of plans, with at least one plan allowing employees to pick any doctor they want. Under this proposal, employers would not be required to make any additional payments, but workers would pay some additional money for insurance to allow them to pick any doctor they wanted. Do you favor or oppose this idea? How much more would you be willing to pay each month out of your own pocket for a health insurance plan that allowed you to pick any doctor you wanted?”

33 The question read, “Some people in California think that one of the problems with managed care health insurance plans is that people cannot go directly to see specialists they need without first having to get approval or a referral from their own personal doctor or their health insurance plan. Would you be willing to pay an additional fee out of your own pocket each time you went to see a specialist, if you could go to the specialist directly without having to get any approvals or referrals? (If “Yes” or “Not sure”) How much more would you be willing to pay each time out of your own pocket to be able to go directly to a specialist without having to get any referrals or approvals?”

34 The question read, “Do you think health insurance plans in California should be allowed to lower their payments to doctors if the health insurance plan or medical group believes the doctor makes too many referrals to specialists?”
3. Who Consumers Trust to Provide Information. 64% of insured, adult Californians stated that they would trust a private, not-for-profit agency the most to provide consumers with neutral and complete information about specific health insurance plans, hospitals and doctors in California. 13% would trust a state government agency to provide such information. (Table 27)

**Table 27: Who Consumers Trust to Provide Information.**

<table>
<thead>
<tr>
<th>Preferred Agency</th>
<th>General Insured Population (n=1,201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private, not-for-profit agency</td>
<td>64%</td>
</tr>
<tr>
<td>State government agency</td>
<td>13%</td>
</tr>
<tr>
<td>Private, for-profit agency</td>
<td>7%</td>
</tr>
<tr>
<td>None</td>
<td>7%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10%</td>
</tr>
</tbody>
</table>

H. Experiences of Californians Who Have a Chronic Condition and/or Have Been Hospitalized in the Last Year

1. Satisfaction with Their Health Insurance Plan. As with the general insured population, the majority of Californians who have a chronic condition and/or have been hospitalized in the last year are satisfied with their current health insurance plan (81%). This group and the population of insured Californians who have both a chronic condition and have been hospitalized in the last year are significantly more likely to report being very satisfied with their plan, compared to the general insured population. These two groups are also significantly less likely to be neutral about their plan. The level of dissatisfaction is approximately equal across all groups. (Table 28)

**Table 28: Seriously/Chronically Ill Californians’ Satisfaction with Their Health Insurance Plan.**

<table>
<thead>
<tr>
<th></th>
<th>General Insured (n=1,201)</th>
<th>Total Chronic Condition and/or Hospitalized (n=1,227)</th>
<th>Chronic Condition AND Hospitalized (n=181)</th>
<th>Chronic Condition (not hospitalized) (n=785)</th>
<th>Hospitalized (no chronic condition) (n=110)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Satisfied</td>
<td>33%</td>
<td>40%*</td>
<td>46%*</td>
<td>38%</td>
<td>36%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>44%</td>
<td>41%</td>
<td>38%</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>Neither Satisfied nor dissatisfied</td>
<td>11%</td>
<td>8%</td>
<td>5%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>7%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>No Opinion</td>
<td>3%</td>
<td>(1%)</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
</tr>
</tbody>
</table>

[* = statistically significantly higher, compared to General Insured population; ( ) = statistically significantly lower, compared to General Insured population]

2. Problems Seriously/Chronically Ill Californians Report with Their Health Insurance Plan in the Last Year. Overall, the proportion of adult, insured Californians who have a chronic condition and/or have been hospitalized in the last year who reported having a problem with their health insurance plan in the last year (46%) is not statistically different from the general insured population (42%). However, two subgroups are significantly more likely to report having had a problem with their health insurance plan in the last year, compared to the general insured population: 1) those who have both a chronic condition and have been hospitalized in the last year (53%) and 2) those who have been hospitalized but have no chronic condition (55%). (Table 29)

35 The question read, “Who would you trust the most to provide consumers with neutral and complete information on specific health insurance plans, hospitals, and doctors in California?”
36 Due to rounding error, numbers may not add to 100%.
37 Due to rounding error, numbers may not add to 100%.
The seriously/chronically ill population and all of its major subgroups are significantly more likely to report having had problems with being denied care or treatment in the last year. Otherwise, the likelihood of reporting specific problems varies across subgroups. Those who have a chronic condition, regardless of whether or not they have been hospitalized, are significantly more likely to report being forced to change medications and having transportation problems. Those who have both a chronic condition and have been hospitalized in the last year are significantly more likely to report problems with health professionals being insensitive or not helpful. Those who were hospitalized in the last year but have no chronic condition are significantly more likely to report problems with billing or payment of claims or premiums. (Table 29)

Table 29: Problems Californians with Serious/Chronic Illness Report Having with Their Health Insurance Plan in the Last Year.

<table>
<thead>
<tr>
<th></th>
<th>General Insured (n=1,201)</th>
<th>Total Chronic Condition and/or Hospitalized (n=1,227)</th>
<th>Chronic Condition AND Hospitalized (n=1181)</th>
<th>Chronic Condition (not hospitalized) (n=785)</th>
<th>Hospitalized (no chronic condition) (n=110)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Problem</td>
<td>42%</td>
<td>46%</td>
<td>53%*</td>
<td>44%</td>
<td>55%*</td>
</tr>
<tr>
<td>Care/Services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not receiving the most appropriate medical care or what you needed</td>
<td>11%</td>
<td>11%</td>
<td>17%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Doctors/nurses/administrators/staff insensitive or not helpful</td>
<td>11%</td>
<td>12%</td>
<td>20%*</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>10%</td>
<td>12%</td>
<td>17%</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Difficulty in getting a referral to a specialist</td>
<td>10%</td>
<td>10%</td>
<td>8%</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>Benefits/Coverage:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan not covering important benefits needed</td>
<td>13%</td>
<td>14%</td>
<td>17%</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Misunderstandings over benefits or coverage</td>
<td>10%</td>
<td>10%</td>
<td>11%</td>
<td>10%</td>
<td>16%</td>
</tr>
<tr>
<td>Being denied care or treatment</td>
<td>3%</td>
<td>7%*</td>
<td>9%*</td>
<td>6%*</td>
<td>7%*</td>
</tr>
<tr>
<td>Choice:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty selecting a doctor or hospital</td>
<td>8%</td>
<td>7%</td>
<td>11%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>7%</td>
<td>7%</td>
<td>9%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Forced to change medications</td>
<td>4%</td>
<td>9%*</td>
<td>13%*</td>
<td>9%*</td>
<td>5%</td>
</tr>
<tr>
<td>Claims/Payment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A problem with billing or payment of claims or premiums</td>
<td>13%</td>
<td>14%</td>
<td>14%</td>
<td>12%</td>
<td>27%*</td>
</tr>
<tr>
<td>Access:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language or communication problem</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>4%</td>
<td>8%*</td>
<td>13%*</td>
<td>7%*</td>
<td>7%</td>
</tr>
</tbody>
</table>

[* = statistically significantly higher, compared to General Insured population]

3. Primary Problems Reported by Seriously/Chronically Ill Californians. As with the general insured population, Californians with a serious/chronic illness who reported having had more than one problem with their health insurance plan in the last year were asked to identify a single biggest problem. There were statistically significant differences for those insured Californians who have both a chronic condition and have been hospitalized in the last year. Compared to the general insured population, those Californians are significantly more likely to report having transportation problems, insensitive or unhelpful health profes-
sionals, not receiving the most appropriate medical care, being forced to change medications, and being denied care or treatment. They were also significantly less likely to report their plan not covering important benefits and difficulties getting a referral to a specialist. (Table 30)

Table 30: Primary Problems Reported by Californians Who Have a Chronic Condition AND Have Been Hospitalized in the Last Year

<table>
<thead>
<tr>
<th>Primary Problem with Health Plan</th>
<th>Primary Problem for General Insured Population (for those reporting a problem) (n=1,281)</th>
<th>Primary Problem for Chronic Condition AND Hospitalized Population (for those reporting a problem) (n=95)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care/Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not receiving the most appropriate medical care or what you needed</td>
<td>(6%)</td>
<td>10%*</td>
</tr>
<tr>
<td>Doctors/nurses/administrators/staff insensitive or not helpful</td>
<td>(10%)</td>
<td>14%*</td>
</tr>
<tr>
<td>Difficulty in getting a referral to a specialist</td>
<td>9%*</td>
<td>(4%)</td>
</tr>
<tr>
<td>Benefits/Coverage:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan not covering important benefits needed</td>
<td>14%*</td>
<td>(9%)</td>
</tr>
<tr>
<td>Being denied care or treatment</td>
<td>(2%)</td>
<td>4%*</td>
</tr>
<tr>
<td>Choice:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced to change medications</td>
<td>(5%)</td>
<td>9%*</td>
</tr>
<tr>
<td>Accessibility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation problems</td>
<td>(8%)</td>
<td>16%*</td>
</tr>
</tbody>
</table>

[* = statistically significantly higher; ( ) = statistically significantly lower]

4. Problems Reported by Seriously/Chronically Ill Californians, by Type of Managed Care Plan. As with the general insured population, Californians who have a chronic condition and/or have been hospitalized in the last year who are in IPA/Network model HMOs are significantly more likely to report having had a problem with their health insurance plan in the last year (53%) than those in Staff/Group model HMOs (39%). There is no statistically significant difference for those in PPOs. The prevalence of specific problems varies by managed care model type. (Table 31)

- **Care/Services:** Seriously/chronically ill Californians in IPA/Network model HMOs are significantly more likely to report experiencing delays in getting needed care and difficulty with getting a referral to a specialist, compared to those in PPOs.

- **Benefits/Coverage:** Seriously/chronically ill Californians in PPOs are significantly more likely to report a problem with their plan not covering important benefits and misunderstandings over benefits or coverage, compared to those in Staff/Group model HMOs. Those in IPA/Network model HMOs are also significantly more likely than those in Staff/Group model HMOs to report having had misunderstandings over benefits or coverage.

- **Choice:** Seriously/chronically ill Californians in IPA/Network model HMOs are significantly more likely to report having had a problem with being forced to change doctors, compared to those in Staff/Group model HMOs and PPOs.

---

38 Only those problems for which there were statistically significant differences between populations are reported.
• **Claims/Payment:** Seriously/chronically ill Californians in PPOs and IPA/Network model HMOs are significantly more likely to report having had a problem with billing or payment of claims or premiums, compared to those in Staff/Group model HMOs.

• **Accessibility:** There are no significant differences in primary problems across managed care plan types for this category.

**Table 31: Comparison of Problems Reported by Californians with Serious/Chronic Illness in Different Managed Care Plan Types.**

<table>
<thead>
<tr>
<th></th>
<th>Staff/Group HMO (n=193)</th>
<th>IPA/Network HMO (n=571)</th>
<th>PPO (n=149)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problem</td>
<td>(39%)</td>
<td>53%*</td>
<td>46%</td>
</tr>
<tr>
<td>Care/Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delays in getting needed care</td>
<td>12%</td>
<td>14%*</td>
<td>(7%)</td>
</tr>
<tr>
<td>Difficulty in getting a referral to a specialist</td>
<td>9%</td>
<td>12%*</td>
<td>(3%)</td>
</tr>
<tr>
<td>Benefits/Coverage:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan not covering important benefits needed</td>
<td>(9%)</td>
<td>15%</td>
<td>20%*</td>
</tr>
<tr>
<td>Misunderstandings over benefits or coverage</td>
<td>(5%)</td>
<td>12%*</td>
<td>16%*</td>
</tr>
<tr>
<td>Choice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>(4%)</td>
<td>10%*</td>
<td>(5%)</td>
</tr>
<tr>
<td>Claims/Payment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A problem with billing or payment of claims or premiums</td>
<td>(5%)</td>
<td>17%*</td>
<td>24%*</td>
</tr>
</tbody>
</table>

[* = statistically significantly higher than (); ( ) = statistically significantly lower than *]

5. **Experiences Related to Hospitalization.** Of those insured Californians who were hospitalized in the past year, 67% reported that they were discharged at about the right time. However, 23% reported that they had been discharged either much sooner (9%) or a little sooner (14%) than they should have been. (Table 32) In addition, 21% of those hospitalized stated that they needed extra help at home, such as nursing care or help with their medications, after they left the hospital. Of the 21% who needed extra help, 27% reported that they did not get the help they needed. (Table 33)

**Table 32: Californians' Reports Regarding Hospital Length of Stay.**

<table>
<thead>
<tr>
<th>% of Those Who Were Hospitalized in the Last Year</th>
<th>(n=434)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged much sooner than should have been</td>
<td>9%</td>
</tr>
<tr>
<td>Discharged a little sooner than should have been</td>
<td>14%</td>
</tr>
<tr>
<td>Discharged at about the right time</td>
<td>67%</td>
</tr>
<tr>
<td>Discharged a little later than should have been</td>
<td>4%</td>
</tr>
<tr>
<td>Discharged much later than should have been</td>
<td>2%</td>
</tr>
<tr>
<td>Not sure</td>
<td>4%</td>
</tr>
</tbody>
</table>

39 Only those problems for which there were statistically significant differences across managed care plan types are reported.

40 The question read, “In the past 12 months, have you been an (overnight) patient in a hospital for at least one day or longer? (If “Yes”) Thinking about your most recent hospital stay, would you say that you were discharged from the hospital much sooner than you should have been, a little sooner than you should have been, at about the right time, a little later than you should have been, or much later than you should have been?”

40 Managed Health Care Improvement Task Force
Table 33: Californians’ Need for Home Care after Hospitalization.  

<table>
<thead>
<tr>
<th>% of Those Who Were Hospitalized in the Last Year (n=434)</th>
</tr>
</thead>
</table>
| Needed extra help after discharge:                         | 21%  
| Of those who needed extra help:                             |  
| Got the needed help:                                       | 73%  
| Did not get the needed help:                               | 27%  
| Did not need extra help after discharge:                   | 76%  
| Not sure if needed extra help after discharge:             | 3%   

The Task Force voted not to vote on this paper.

---

41The question read, “After you left the hospital (on this last stay), did you need any extra help at home, which you could not get from family or friends, such as nursing care or help with your medications? (If “Yes”) Did you get the help you needed or not?”
I. The Current Health Care Market and California Oversight

Health care services are not commodities or like other consumer goods or services. Health care has a special moral status and therefore a particular public interest. Most people consider it unacceptable for others to suffer, to be disabled, or to have shortened lives for lack of access to at least basic medical care. Thus, we have many public programs intended to respond to people's need for care. The markets for health services and health care work imperfectly for many reasons, such as the incentive effects of health insurance that undermine cost-consciousness, the very high cost of information and the asymmetry of knowledge between practitioner and patient, and the wide variations among people in medical risks that make pooling of risks difficult. Health care is often a matter of life and death or disability. Government action is needed to protect public safety. Enabling access to care, assuring quality of care and controlling the cost of care are important public policy problems in part because so much of health care is paid for by taxpayers.

Thus, there are many important roles for government in the financing and regulation of health care and health insurance, including consumer protection; improving the market for health coverage so that competitive incentives keep costs down, quality high, and access to care available; and providing leadership by being a responsible purchaser of health care benefits. One of the roles of government is to protect consumers by creating the conditions for markets to serve consumers well. These conditions include the rule of law (including laws against fraudulent or deceptive practices), securing property rights, defining liability, licensing facilities and professionals, contract enforcement, and anti-trust. The complexity of health insurance contracts makes necessary special rules to ensure there is a meeting of minds between buyers and sellers that lead to the reasonable expectations of reasonable persons being met. Another is maintenance of an acceptable level of quality. Ways the government can improve the market for health coverage include requiring or encouraging the pooling of risks, helping to create an information infrastructure, enabling comparative information, facilitating desirable structural change, considering anti-trust actions, and not creating barriers to market entry. Because of its size and authority, government's role as purchaser is also important.

Nationally, we now spend over a trillion dollars on health care annually, and in California, health care is one of our largest and most dynamic industries. As health care has become a larger proportion of the overall economy, more public and private entrepreneurs have become involved in the industry, developing market innovations that often do not fit neatly into the outdated categories of business and insurance models that have traditionally been regulated. Particularly over the last decade, various forms of managed care companies (health maintenance organizations “HMOs”, preferred provider insurance, referred to as preferred provider organizations “PPOs”, point-of-service plans “POS”, etc.) have become increasingly involved in managing not only the business elements of health delivery, but the clinical elements as well. As competitors struggle for market position, integration and consolidation among the various entities involved in health care delivery has intensified.¹

¹ See Figure 1, which places the California regulatory structure in the context of the currently-consolidating health care marketplace.
Federal Health Care Regulatory Structure

(Federal HMO Act, Health Care Financing Administration, Department of Labor, etc.)

California Health Care Regulatory Structure

Models of Health Care Delivery

- HMO
- POS
- PPO
- FFS

Key Regulatory Agencies

1. Department of Corporations
2. Department of Insurance
3. Department of Health Services

*Other hospital regulators at the state level include the Bureau of Narcotic Enforcement, Bureau of Radiological Health, CalEPA, CalOSHA, Office of Emergency Services, and State Board of Equalization. At the federal level, hospital regulators include the Department of the Treasury, Environmental Protection Agency, Equal Employment Opportunities Commission, Federal Communications Commission, Federal Emergency Management Agency, Food and Drug Administration and Nuclear Regulatory Commission.
Figure 2. State Health Care Oversight Related to Managed Care

Note: In addition to these agencies, other hospital regulators include the Bureau of Narcotic Enforcement, Bureau of Radiological Health, CalEPA, CalOSHA, Office of Emergency Services, and State Board of Equalization.
### Figure 3. CALIFORNIA’S MANAGED HEALTH INDUSTRY: CURRENT STATE REGULATORY OVERSIGHT JURISDICTION

<table>
<thead>
<tr>
<th>Industry Segment</th>
<th>Financial Intermediaries</th>
<th>Providers</th>
<th>Facilities</th>
<th>Facilities</th>
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<td>I. REGULATORY FUNCTION</td>
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<td>PREPAID HEALTH PLANS</td>
<td>INDIVIDUAL CLINICIANS</td>
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<td>A. Licensure</td>
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<td>DOC</td>
<td>DCA Health Boards</td>
<td>DOC (if bear risk) Health Board</td>
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<td>DHS</td>
<td>DIR (workers’ comp.) Health Board</td>
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<tr>
<td>B. Monitoring/ Auditing</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS (Medi-Cal)</td>
<td>DOC (if bear risk)</td>
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<td></td>
<td></td>
<td>DIR (workers’ comp.) Health Board</td>
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<tr>
<td>C. Operational Modifications</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS</td>
<td>-</td>
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<tr>
<td>D. Complaints</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS</td>
<td>DCA Health Boards</td>
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<td>DCA Health Boards</td>
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<tr>
<td>E. Enforcement</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS (Medi-Cal)</td>
<td>DCA Health Boards</td>
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<td>II. PUBLIC POLICY GOALS</td>
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<td>A. Financial Solvency</td>
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<td>B. Quality of Care</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS (Medi-Cal)</td>
<td>DCA Health Boards</td>
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<td>DOI</td>
<td>DOC</td>
<td>DHS (Medi-Cal)</td>
<td>DHS (Medi-Cal)</td>
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<tr>
<td>D. Access</td>
<td>Market</td>
<td>DOC</td>
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<td>E. Affordability</td>
<td>Market</td>
<td>DHS (Medi-Cal)</td>
<td>Market</td>
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</tr>
</tbody>
</table>

**KEY**
- *DOI:* Department of Corporations.
- *DOC:* Department of Insurance.
- *DCA Health Boards:* Boards under the Department of Consumer Affairs that license and regulate health professionals.
- *DHS:* Department of Health Services
- *Market:* Private Marketplace
- *DIR:* Department of Industrial Relations
- *CMAC:* California Medical Assistance Commission

*Many new managed care organizations that are not risk-bearing have virtually no state oversight currently.*

*Clinics - If business is licensed under the private physician’s license, regulation is by Medical Board based primarily on complaints; if licensed by DHS as a clinic, regulation includes periodic audits as well.*
The state of California utilizes a regulatory structure primarily designed in the 1970s, when managed care organizations were responsible for financing the health care of at most a few percent of Californians, to oversee a rapidly evolving industry that has grown many-fold and now covers well over half of all Californians (see Figure 2 and its accompanying matrix of functions, Figure 3). The industry and recent federal law have evolved business forms beyond the definitions that govern existing lines of California government jurisdiction. Consolidation among state regulators could benefit both business, in terms of having a streamlined regulatory structure, and consumers, in terms of having a more sophisticated and accessible oversight organization.

The operations of managed care organizations are controlled by many government and private entities. Health care service plans (i.e., HMOs) are regulated by the Department of Corporations (DOC), the lead agency for health plan regulation, under the Knox-Keene Health Care Service Plan Act of 1975. The DOC administers the Knox-Keene Act primarily by conducting or overseeing health care service plan quality and solvency audits; reviewing, approving or denying health care service plan applications for Knox-Keene licenses, and material modifications and amendments thereto; receiving and resolving consumer complaints; requiring plans to resolve compliance problems; and taking enforcement actions such as cease and desist orders, financial penalties, and court filings. The other predominant form of managed care currently in California is Preferred Provider Insurance (PPI), commonly referred to as Preferred Provider Organizations (PPOs), which when self-funded by employers and managed by third party administrators is not regulated at the state level. The remainder of PPOs are delivered by indemnity insurance companies and regulated under the California Insurance Code, which is enforced by the California Department of Insurance.

The operations of health care service plans and other managed care organizations are also controlled by many other entities, governmental and private. The Department of Health Services (DHS) contracts with some of them to serve Medi-Cal beneficiaries. Its Audits and Investigations Division performs fiscal and medical audits of Medi-Cal managed care organizations. Its Licensing and Certification program licenses the facilities managed care uses. The Department of Industrial Relations (DIR) oversees managed care organizations offering managed care services for work-related injuries and illnesses. The health professionals’ boards of California, under the Department of Consumer Affairs (DCA), license health professionals such as doctors, nurses and chiropractors who work for managed care organizations. The Managed Risk Medical Insurance Board (MRMIB) contracts with many managed care organizations involved in Access for Infants and Mothers (AIM) and The Health Insurance Plan of California (HIPC). The single largest customer for many health service plans is the California Public Employees Retirement System (CalPERS) that purchases coverage for 1,000,000 California public employees, retirees and dependents. Health care service plans are also overseen by the Health Care Financing Administration (HCFA) for the federal Medicare program to the extent they serve Medicare beneficiaries and by the federal Office of Personnel Management (OPM) that purchases coverage for over nine million federal employees, retirees, and dependents.

These and other government agencies also regulate other health professionals, facilities, and health insurance arrangements. Under the present regulatory structure, however, there is no direct regulation of many medical groups/IPAs as entities by a government agency. Rather, most medical groups/IPAs are regulated indirectly by the Knox-Keene plans with which they contract. In addition, in order for medical groups to accept full capitation contracts, some have received limited licensure from the DOC which require meeting Knox-Keene standards.

The private sector supplements these state and federal regulatory functions through a variety of quality measurement and accreditation organizations that help employers and consumers to evaluate their purchases by providing information. Their efforts, as well as their counterparts that are internal to managed care organizations, are also intended to be used by providers, provider groups and plans to improve quality of care and service. In addition, large purchasers, including government, can use their substantial

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2 The background paper further details the current complex federal and state oversight structures.
negotiating power to influence positively the health care system, in particular by providing consumers with the ability to choose the best value plan for their needs, through appropriate information, incentives and choices.

II. Improving the Regulatory Process

The Task Force heard and received testimony that there is public dissatisfaction with the current state of managed care regulation. The creation of this Task Force suggests that the Legislature, the Governor, and many citizens believe that there may be some deficiency in the structure or operations of the regulation of the managed care industry. The primary body of law governing the managed care industry in California, the Knox-Keene Act of 1975, has now grown through amendments to two hundred and six pages, and yet it has failed to satisfy the dissatisfied. This certainly calls into question the current regulatory process, regulatory organization, and the most appropriate solution. Attention needs to be focused on the capabilities and limitations of the existing regulatory organization to carry out the intent of existing law in a satisfactory manner, and changes should be implemented to improve the effectiveness of existing regulation.

A. Adequate Attention

The Department of Corporations, housed within the Business, Transportation and Housing Agency, is the primary regulator for business in California. As such, it regulates many kinds of businesses, not just health care service plans. Therefore its leader does not focus 100% of his or her attention on health care service plans or other emerging health care issues. Recently, DOC’s leader has been a securities lawyer. This made sense in 1975 when the Knox-Keene Act was passed because health care service plans were few and small, not large enough to warrant their own regulatory entity. Now, more than half of all Californians are enrolled in health care service plans and, as an industry, they are among the largest in the state. Given the size, the complexity, and the high degree of public interest, health care service plans ought to have their own regulatory entity, headed by a person or a board who devotes his or her complete attention to the industry and who has had substantial experience and expertise in health services.

B. Appropriate Leadership

The appropriate leadership of the new state entity for regulation of managed care could be either an appointed individual or an appointed board, with a full-time individual with day-to-day responsibility. The Task Force chose not to make a recommendation on this question, and it was approximately evenly divided on its preference for an individual versus a board. Those that prefer an individual leader argue that the new regulatory authority would not be a legislative body so should not be controlled by a voting board, but rather an individual who could be better held accountable for implementation of the statute. Supporters of a board argue that such a body would provide continuity and stability, a public process and therefore confidence in the decision-making, and greater independence from political interference.

In either case, the ideal leadership of the new state entity for regulation of managed care should have a deep understanding of health care and a well-founded strategic sense of how the industry should evolve, a solid grounding in the health care market. The leadership should have the ability to prioritize law enforcement and to work on a pro-active basis with the industry, employers and consumer groups to define and solve broad system problems. The right person or people must understand medical quality management and how to create conditions that foster quality improvement. The leadership must also understand sympathetically the culture and values of health care. They should be qualified to make judgments as to whether proposed innovations are in the public interest, and if they are, to “fast track” their approval.

3 Throughout this paper, the term “state entity for regulation of managed care” refers to the DOC or its successor. When used in the plural form “state entity(ies)”, it refers to DOC and DOI or their successor. The “new state entity” refers specifically to the successor entity recommended in this paper.
C. Compassionate Face
By fulfilling its legal obligation to enforce the law according to the Knox-Keene Act, the DOC often appears insensitive. While compassion might not be something one expects from a government agency, the style of securities law enforcement seems inappropriate when a loved one's life or health is involved. A letter in response to an inquiry that states that no violation of law has been found might be quite appropriate in a matter of securities law, a body of laws and rules that has fairly clear lines and in which the issue is whether or not someone played by the rules. Only money, not lives, is at stake.

For parents, for example, who have lost a child and want to know whether she received the standard of care (a subjective judgment), whether she was cared for by appropriately qualified practitioners, and, if not, what corrective action will be taken, an appropriate response would include (1) reasons why the regulatory authority understands a plan to be or not to be in compliance with the law, (2) reference to contact with a qualified practitioner and the answers he or she provided to their questions, and (3) if their charges were correct, information about the corrective actions taken.

D. Streamlining Regulation
The regulatory process is needlessly cumbersome and complex. The DOC and other regulators appear to have missed numerous opportunities for streamlining. Cooperation among agencies with private organizations doing similar work could be improved.

A particular example is the regulation of medical groups, IPAs and other entities bearing risk in contracts with Knox-Keene regulated plans. The solvency and the quality of these entities are a matter of legitimate public interest and concern. The average medical group contracts with 15 health plans. The medical groups understandably do not want to share financial information with the health plans with which they are negotiating for payments, and they understandably do not want 15 financial audits per year. Moreover, they understandably feel overburdened by numerous quality audits that disrupt their work and add to their costs. To avoid such redundancy, The Medical Quality Commission and the Pacific Business Group on Health launched an effort to evaluate directly performance of physician groups. Their Physician Value Check Survey measures clinical quality and member satisfaction. Such private sector “regulation” should be embraced and built upon by the public sector to ensure all groups are included.

E. Developing Capabilities to Meet the Challenges of Accelerating Industry Change
Despite the best efforts of the legislative process, there remains lack of clarity. While the lack of prescription in the Knox-Keene Act allows some flexibility, and the intention of the DOC is to avoid inconsistency and resolve it when found, apparent and actual inconsistencies inevitably exist. In addition, to DOC-regulated health care service plans, some decisions seem inconsistent, subjective, arbitrary, or very different from those that have been imposed on other health care service plans. Plans have also experienced delays when they have submitted material modifications to their filings. Delays are costly to health care service plans and consumers because approval often would enable plans to provide a new product or a product to a new service area.

III. Recommendations
Regulatory organization must consider not only who should be the regulator, but also what segments of the industry they should regulate, and how. The three elements are interdependent and cannot be intelligently treated in isolation. The yardsticks against which any regulatory organization option, including the status quo, must be measured include fairness, capability and expertise, accountability, efficiency, strict enforcement, a systems approach, continuity and stability, adaptability to encourage innovation, and low net fiscal cost.

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4 While the Task Force did not attempt to discern whether a pattern of insensitivity by the DOC exists, it heard and received testimony from several unhappy citizens who feel they have experienced insensitive treatment.
There are, at present, several pressures on the existing regulatory structure. These include new federal legislation allowing new market forms (e.g., Medical Spending Accounts and Provider Service Organizations); the market development of hybrid models that no longer fit neatly into current regulatory oversight structures; and growing public concerns about quality.

There is, therefore, an unusual opportunity to begin to transition to an integrated and sophisticated oversight structure that can keep up with this rapidly changing, dynamic marketplace. Inherent in the following recommendations is the belief that regulatory authority should ultimately be able to address the contracting, solvency, and other financial aspects of regulation as well as to evaluate clinical quality of care and medical practice issues and recognize and promote conditions for quality improvement and innovation.

1. Streamline Regulatory Oversight
   (a) A new state entity for regulation of managed health care should be created to regulate health care service plans currently regulated by the DOC and to phase-in the regulation of other entities over time, consistent with these recommendations (1.a-f). Appropriate health staff of the DOC will be transferred to the new regulatory entity.

   (b) Medical groups and other provider entities that bear significant risk should be directly regulated by the new state entity for solvency and quality. Within a year, the Governor and Legislature should study and recommend to the public as to the method for consolidated, direct regulation by this new entity, of medical groups/IPAs and other provider entities in the state that are not currently directly regulated and who bear significant risk, on the basis of solvency and quality, to the extent they can be shown to be contributing to medical decisions (i.e., not coverage decisions determined contractually by an employer).

   (c) Within one year, the Governor and the Legislature should study the feasibility and benefit of consolidating the health care quality review functions of all state governmental agencies within the new entity.

   (d) Within two years, the Governor and the Legislature should study the feasibility and benefit of consolidating into the new state entity the regulation of other health insurers providing insurance through indemnity, PPO and Exclusive Provider Organization (EPO) products currently regulated by DOI.

   (e) Subsequently, the merits of folding into the new state entity other regulatory functions (e.g., those that regulate providers, clinicians, and medical facilities) should be examined. However, further consolidation should be phased-in in a manner that minimizes disruption of essential regulatory functions. Any proposed consolidation should weigh the potential benefit and detriment to the public and consider the impact on the stability of the organization.

   (f) Any health-related regulatory authority or related government entity not incorporated into this new state entity should develop enhanced electronic capabilities to share information and work together with other oversight entities.

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5 Task Force members suggested through an informal questionnaire that the new entity be named, if led by a board, the “California Managed Care Authority (CMCA)” or, if led by an individual, the “California Office of Health Care Oversight (COHCO)” More appropriate names might include reference to a Board (e.g., the California Managed Care Board) or to a Department (e.g., the California Department of Health Care Oversight) respectively.
2. Provide Appropriate Leadership
   (a) The new oversight organization should be led either:

   (1) by a board that would review and approve major policy and regulatory matters, comprised of five or more individuals having specified qualifications, appointed to staggered terms, with a majority appointed by the Governor and at least one member each appointed by the Assembly and the Senate, working with a full-time Chairperson of the Board who has day-to-day operating responsibility and authority and who is an individual of stature in the health services field who can command respect and exercise strategic leadership, appointed by Governor, or

   (2) by an individual of stature in the health services field who can command respect and exercise strategic leadership, appointed by the Governor and confirmed by the Senate.

   In either case, the leadership of the organization should have a sympathetic understanding of the problems of patients and their families and an understanding of the health care market.

   (b) An advisory committee should be established that includes the leaders of other health regulatory agencies as ex-officio/non-voting members, health care experts, and stakeholders.6

3. Adopt Appropriate Principles for Regulation
   The following principles should guide regulation by the oversight entity: (a) regulation should be as efficient and streamlined as possible, (b) regulation should be conducted in cooperation with other public and private bodies that also regulate or purchase from health care service plans and other health insurers to the maximum extent possible, and (c) regulation should recognize and expedite approval of beneficial innovations (i.e., those that consumers want, improve quality, or save costs without causing harm), (d) regulation should be fair, predictable and strictly enforce the laws to ensure high quality standards are met and that low performers improve or be removed from the pool of choices available to consumers.

4. Streamline Regulation of Medical Groups/IPAs
   The state entity for regulation of managed care should be given the authority and responsibility to facilitate the existing oversight of medical groups, IPAs and other entities that enter into risk contracts with Knox-Keene regulated health plans, including as priorities solvency and quality audits (as described below) but also considering oversight of other issues such as the credentialing process, monitoring of provider compensation arrangements and their disclosure, dispute resolution processes, and other areas if necessary. This oversight should be exercised in a way that would reduce cost for providers and health plans. For example, the regulatory authority should consider and work together with ongoing streamlining efforts of accreditation and other private organizations.

5. Streamline Solvency Audits
   Currently, health plans audit provider organizations to determine whether they are fiscally solvent and capable of assuming risk. This creates burdens for provider organization that might contract with many different plans and difficulties because health plans may seek information that medical groups consider proprietary.

   (a) In order to facilitate the development of this information in a manner that is less burdensome, a provider organization should be able to request that the state entity for regulation of managed care oversee one solvency audit on a periodic basis that would meet the requirements of all contracting health plans.

   (b) The state entity for regulation of managed care may contract, where appropriate, the authority to audit provider organizations by subcontracting with independent, third-party organizations, such as

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6 The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
accounting firms, that meet standards the regulatory entity establishes through a competitive process.

(c) The oversight entity should convene a stakeholder-working group, including provider organizations that contract with multiple health plans and the health plans with which they contract to develop acceptable, specific solvency standards and financial documentation. The solvency standards may vary by size and type of organization, amount of risk assumed, or other pertinent factors.

6. **Streamline Quality Audits**

   In order to comply with Knox-Keene standards for health plan quality, health plans must audit the quality of the provider organizations with which they contract.

   (a) In order to facilitate the collection of standardized data and quality processes necessary to audit quality in an efficient manner, a provider organization should be able to request that the state entity for regulation of managed care oversee one quality audit of that data on a periodic basis (e.g., annually) that would determine compliance with the quality standards of all contracting health plans. The regulatory authority would need to provide that the audits establish whether provider organizations treat different plan members differently. When standardized data is not available, health plans may use other information to ensure quality of care.

   (b) The state entity for regulation of managed care may contract, when appropriate, for audits of medical groups with independent, qualified, third-party organizations that meet standards the state entity for regulation of managed care establishes.

   (c) The cost of the single quality audit should be shared among all the health care service plans with which a provider organization contracts. This would save health care service plans and providers time and money.

7. **Adopt Principles for Public/Private Collaboration**

   The Task Force makes numerous recommendations that encourage state entity(ies) for regulation of managed care and for data collection to work in collaboration with, and not duplicate the efforts of, private sector initiatives and the data collection efforts of private purchasers or accrediting bodies. The Task Force endorses these efforts to the extent the following are satisfied, where the private activity is being conducted to accomplish a public purpose.

   (a) There must be full disclosure upon request of all survey processes, methodologies and investigative results—the data collection protocols and results should be publicly available to the same extent they would be if the effort were conducted by the state entity itself.

   (b) Private data collection standards, protocols and results of data collected must be available to the public in a timely manner at no or low cost to the extent that data satisfies public oversight requirements. The cost (if any) to the public should be nominal and reflect only the costs of copying and distribution.

   (c) The collaboration with private entities by the state regulatory bodies should not limit or impede the public processes by which the state determines which data should be collected and how quality should be monitored.

   (d) The state entity for regulation of managed care or other appropriate agencies should ensure that any privately collected results relied upon by the state to satisfy its requirements are valid.
8. Promote Inter-departmental and Private Sector Coordination and Eliminate Redundancy

Until oversight is consolidated, government departments, in addition to the state's managed care regulatory authority, that regulate health insurers that offer indemnity, PPO, and EPO products (e.g., DOI, US DOL) or oversee health services for different populations (e.g., DHS, Division of Workers' Compensation, US HCFA), should coordinate activities and streamline information sharing. The state entity(ies) for regulation of managed care should also coordinate with private sector quality measurement and accreditation bodies to develop solvency, accounting and quality standards to ensure that they satisfy their respective requirements with regard to the scope of issues covered by the audit.

Government departments should seek to avoid duplication of audits conducted by independent third-party, government-approved auditors. Carriers that are in the business of both indemnity insurance and HMO coverage should not be subjected to duplicative business audits by the Department of Insurance and the new state entity for regulation of managed care. Health insurers offering indemnity, PPO, and EPO products should be subject to regulatory review by other departments only in those areas where the program differs from Knox-Keene Act requirements or exceeds those requirements.

9. Meet the Challenges Presented by Accelerating Industry Change

(a) The state entity for regulation of managed care should define and publish formal policies and procedures regarding filing formats, filing requirements, interpretive guidelines for plans and counsel regarding how requirements apply in critical areas, and an approval process that contains quality control and “consistency control” checks. With criteria set up front, health care service plans could plan effectively and modify applications to improve likelihood of approval. Furthermore, with standard decision criteria, the regulatory authority's regulators would become more efficient.

(b) The state entity for regulation of managed care should take steps to improve efficiency and consistency of its decisions. Steps may include the following: (1) upgrading information technology capabilities; (2) expediting the hiring of additional staff provided for by the budget augmentation; (3) setting guidelines for and requiring counsel to participate in training about policies and interpretations; (4) setting standards for health care service plan documents; (5) consistently assigning counsel to the same plans (but with enough rotation to inhibit conflicts of interest); (6) reviewing workload allocations; and (7) educating staff about the health services industry and managed health care.

(c) Legislation should be passed that would allow health care service plans to consolidate minor amendments, as defined by the state entity for regulation of managed care, that occur during the year into one annual filing.

(d) The recent DOC budget augmentation should be evaluated to determine its impact on responsiveness and to assess the need for additional or reallocated funds, given proposed steps for streamlining.

(e) Health care service plans should be allowed to consider new product material modifications approved, if the state entity for regulation of managed care does not “act” as defined by Knox-Keene Act Section 1352(b) by approving, disapproving, suspending or postponing approval within a timeframe (e.g., 60, 90, or 180 days) designated in advance by the regulatory entity. As under current law, any such order may not be issued without the approval of the supervising counsel and assistant commissioner. If the state entity for regulation of managed care requires changes to any aspect of the material modification after the designated period, the health care service plan should be required to make those changes prospectively, but should not be subjected to departmental disciplinary actions.
The Findings Section was adopted 24-0 while the recommendations were individually adopted as follows:

Recommendation No. 1(a) & (b) — Adopted 20-6
Recommendation No. 1(c) — Adopted 25-0
Recommendation No. 1(d) through 1(f) — Adopted 20-6
Recommendation No. 2 — Adopted 26-0
Recommendation No. 3 — Adopted 27-0
Recommendation No. 4 — Adopted 22-0
Recommendation No. 5 — Adopted 23-0
Recommendation No. 6 — Adopted 26-0
Recommendation No. 7 — Adopted 27-0
Recommendation No. 8 — Adopted 25-0
Recommendation No. 9(a) through 9(d) — Adopted 25-0
Recommendation No. 9(e) — Adopted 22-2
Expanding Consumer Choice of Health Plans
Findings and Recommendations

I. Principles

In a system of managed health care plans that limit patients’ choices of providers, choice of health plan at the individual or family level is very important. Choice may be or is required: (1) to maintain ongoing provider-patient relationships, (2) to facilitate patient willingness to work with his or her provider, (3) to improve consumer satisfaction with health plans and the health system (studies show that people with choice are more satisfied), and (4) to allow competition at the individual subscriber level to discipline price.

For these reasons, ideally every individual or family should have a multiple choice of health plans that includes a variety of HMOs, PPOs, and other options such as is provided to state and other public agency employees participating in the California Public Employees Retirement System. Achieving the full benefits of competition would also require every individual and family to have economic responsibility for premium price differences, comparative quality information, and some standardization of benefits within groups.

II. Choice in California Today

In California today, more employed individuals have choice of plans than the national average, though employees of smaller firms are less likely to have choices than employees of larger firms, according to KPMG Peat Marwick data. Data provided to the Task Force by KPMG indicates that approximately 55% of employed individuals in California whose employers provide health care coverage are offered a choice of two or more plans by their own employer. Taking into account options through both spouses’ employers would increase substantially the proportion of those offered multiple plan choices. On this basis, the Managed Health Care Improvement Task Force public survey found that approximately 75% of consumers in California who knew the number of choices they were offered reported that they had a choice of more than one plan (See Task Force paper on Public Perceptions and Experiences with Managed Care).

Even though Californians have greater choice of plans than the national average, fewer working Californians have access to a health plan that provides unlimited choice of provider than workers nationally. In addition, where employees have a choice of plan, it is often a choice of plan model type rather than multiple choices within one model. This is positive in that some individuals in a group might prefer, for example, an HMO, while others prefer a PPO. However, choices among plan model types set up a less competitive situation among health plans because individuals are less willing to switch among them than among plans of the same model type.

III. Obstacles to Choice

Individuals (not in groups) theoretically have an unlimited choice of coverage options, as long as they are willing to shop around and pay the market price. However, in practice their choice may be much more limited due to reasons of access (e.g., plans often will not sell individual policies to persons who are or are

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1 Throughout this paper the term health plan is used to mean health insurance arrangements offered by an insurer, employer, health maintenance organization (HMO), or other managed care organization, also known as health benefits financial intermediaries.

perceived to be unhealthy or high risk individuals). It has proven particularly difficult to guarantee access to coverage and choice of plans to unaffiliated individuals in a system of voluntary health insurance because of the particularly acute problem of adverse selection in the individual market and attendant premium increases or “death spirals” that can occur when no rate structure is established and public reinsurance is not in place. Some states have attempted to adopt mitigating protections against this occurrence as part of health insurance reform initiatives, but for political reasons many have not been able to put the safeguards into their market reforms that would make them more stable (such as open enrollment periods, the use of pre-existing condition exclusion periods, and statewide reinsurance). In the absence of such safeguards, The State of Washington, experienced a 72% average increase in its state-sponsored Basic Health Plan premiums from 1997 to 1998; and maternity rates seven times greater than the general population in 1998, after implementation of guaranteed issue in the individual market that replaced the state’s high risk pool and included just a three-month pre-existing condition exclusion period. The impact of guaranteed issue on premium increases in Massachusetts was also significant.

Employers in the small group market typically offer choice of plan least often because (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burdens when offering multiple plans, and (3) employers prefer to offer their whole group to one insurer in exchange for the best rates possible today, even though this may weaken the health plan’s incentive to reduce rates in the future (unless an employer is willing to switch plans, which some may be).

In 1993, AB 1672 established rules in the small group market (currently 2-50 employees) in response to problems of access to choice of plans. Data indicates that employers in the mid-size market also offer their employees few choices of health plans. Some have suggested that an expansion of these rules to the mid-size market (groups of 51-100) would encourage formation of purchasing groups and ensure a wider array of choices offered within employment groups. A recent University of California report and health insurance agents indicate that some mid-size employers have difficulties accessing coverage due to risk selection practices of some insurers. Proponents also suggest that issues such a premium rate limitations and disclosure requirements could be tailored to meet the needs of mid-size employers in order to achieve greater choice while mitigating the impact on rates, available product designs, and variety of health delivery systems. There is not, however, a clear consensus that access to coverage options is a major problem in the mid-size market.

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4 “Approaches for Providing/Financing Health Care for the Uninsured: An Assessment of State Options and Experiences”, Alpha Center, August 1997.
5 The State of Washington’s Insurance Commission had not approved rate increases since 1993 in this market so this rate increase reflects several years of increasing costs.
6 Personal communication from Gary Christenson, head of the Washington Health Care Authority, November 21, 1997.
8 KPMG Peat Marwick data suggests that 42% of covered employees in firms of 50-199 have no choice, compared to 66.4% of covered employees in firms of 1-49 and 21.9% in firms of 200-999.
10 California Association of Health Underwriters, “Questions and Answers About CAHU’s Position on SB-393/SB-1281”, May 7, 1997. In addition, MRMIB indicates that it cannot expand the HIPC to offer mid-size employers more choice unless small group reforms are extended to the mid-size market. The California Small Business Association along with some health plans, agents and brokers, medical association and consumer groups support mid-size market reforms.
11 Industry representatives oppose expanding small group reforms as unnecessary. They argue that such restrictions may reduce the current choice of product designs available in the mid-size market if health plans sought to avoid the requirement to offer, market, sell, and distribute information on all products to all employers. In addition, they argue that increased regulation of health plans in this market could encourage more employers to self-insure, enabling them to avoid all state regulation of their health benefits.
IV. Purchasing Groups

One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level.

“Purchasing group” is the generic term used to describe several types of organizations defined by law. California law distinguishes between two types of purchasing groups: purchasing alliances and marketing groups. Marketing groups, in general, act like purchasing alliances, but do not contract directly with plans or employers and do not transfer funds among them. The Department of Corporations (DOC) regulates marketing groups, and the Department of Insurance (DOI) regulates purchasing.

The Health Insurance Plan of California (HIPC), established in 1993 through AB 1672, is a state-run purchasing alliance, open to all small employers with between two and 50 employees, specifically designed to address the administrative problems small employers have in offering access to coverage and multiple choice of plans. However, HIPC growth has been disappointing relative to the size of the small group market. After four years of operation, it covers only about 130,000 people. Theories abound about the reasons behind the limited growth of the HIPC. They include (1) insufficient or inappropriate marketing effort; (2) lack of broker/agent support; (3) the fact that purchasing groups are a new idea, the virtues of which may not be well appreciated or understood by many; and (4) the fact that the HIPC may offer too much choice which may be overwhelming to some. The HIPC is in the process of being privatized over the next several years, pursuant to the provisions of AB 1672.

With existing purchasing group activity, California has more employees in purchasing groups than any other state. However, despite this activity, purchasing groups are not available in many segments of the market. One barrier to entry in the mid-size market may be the lack of market rules, which may expose purchasing groups to adverse risk selection by non-participating insurers, who could deny or discourage enrollment by setting high premiums for employers with unattractive risk profiles, driving them disproportionately into the purchasing groups.

Marketing groups that testified before the Task Force indicated that the regulatory hurdles to becoming a marketing group through the DOC are high. Challenges arise because (1) employers contracting with health plans through a marketing group must contract with each plan separately, (2) health plans participating in marketing groups can not jointly file coordinated documents with the regulatory authority, rather each plan must file separately, and (3) participating plans are required to disclose to employers and employees details of all the benefit packages they offer even if an employer only provides coverage through a purchasing group that offers standard benefit packages. DOC requirements differ from those associated with becoming a purchasing alliance under the DOI. However, plans participating in purchasing alliances must also disclose details of all benefit packages they offer.

V. Recommendations

A. Expand Choice of Plan

Expanding consumer choice of plan is a widely-supported goal among Task Force members and the public. For example, a case can be made that a desirable minimum standard for choice would be two closed-end HMOs (so that there is price competition in this low-priced segment, and so people desiring or needing a low-priced plan have a choice), plus one wide access product (e.g., POS, PPO) (so that anyone who chooses can access any provider, and so nobody is an involuntary HMO member). This is, in effect, what the 1973 HMO Act required.

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\[12\] Testimony presented or given to the Managed Health Care Improvement Task Force by Benefits Alliance and California Choice.
However, there is little consensus about how to expand choice of plans. This Task Force considered recommending that the federal government require employers that offer coverage to offer employees a choice of plans, but rejected the idea because it would unfairly burden employers who voluntarily provide coverage and might cause them to reduce or drop coverage.

1. The Task Force recommends that public and private purchasers should, whenever feasible, offer consumers a choice of high quality health plans, including choices through purchasing groups where accessible. In addition, the US Congress and the California State Legislature should continue to seek ways to expand coverage and choices of plans.

B. Expand Purchasing Groups
One way to expand individual choice of plans is to expand access to purchasing groups.

2. The Task Force recommends that the state make it a matter of public policy to facilitate and encourage the development of purchasing groups (both marketing groups and purchasing alliances) for small and medium size employers. The applicable state entity for regulation of managed care should work continuously to simplify the process of, and eliminate barriers to, purchasing group formation and make recommendations for changes to the Legislature if necessary. Appropriate measures for the DOC and DOI may vary.

3. The Task Force recommends that guaranteed issue, plan design disclosure, and premium rating limitations for employers with 51-100 employees like those in effect for the 2-50 group market be enacted so that purchasing groups can form, flourish, and obtain a wide variety of participants in the mid-size market, protected from the adverse selection they would be likely to suffer without these provisions.

C. Expanding Access to Providers and Treatment
Refer to Task Force paper on Physician-Patient Relationship for a recommendation to improve continuity of care for consumers undergoing treatment and the Task Force paper on Dispute Resolution Processes for recommendations to establish independent third-party review.

4. A working group of stakeholders should be convened to examine the issue of how to increase consumer choice of providers on a cost neutral basis.

The Task Force adopted the Findings Section 24 - 2 while the recommendations were adopted individually as follows:

Recommendation No. 1 — Adopted 24-0
Recommendation No. 2 — Adopted 23-0
Recommendation No. 3 — Adopted 17-7
Recommendation No. 4 — Adopted 23-2

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33 The Department of Corporations, the Department of Insurance, or their successor.
34 The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
Minimizing Risk Avoidance Strategies Findings and Recommendations

I. Findings
Fixed periodic per capita, or “capitated” payments by purchasers to health plans and health plans to providers (i.e., medical group/IPAs, hospitals and other providers), if not adjusted for the medical needs of different patients, gives health plans and providers an incentive to avoid enrolling and developing expertise to care for the sickest patients.

These incentives result in “adverse selection”, i.e., a competitive disadvantage for academic medical centers and other providers with reputations for excellence that attract the sickest patients. Moreover, the lack of risk adjustment attenuates price competition among health plans, as plans receiving unfavorable selection are not able to compete with plans getting favorable selection on a level playing field.

Currently, health plans may use stop loss coverage, carve outs, global case rates, and other mechanisms to protect providers from financial exposure to high cost cases. In addition, what is needed to combat the problem of adverse selection is diagnosis-based “risk adjustment”, i.e., to adjust capitation payments to compensate health plans and providers for enrolling and caring for patients with more costly medical conditions, enough to eliminate incentives for skimming. According to Cardinal Bernardin, Archbishop of Chicago, “If we do not, we will witness a morally repugnant system in which plans will compete to avoid caring for the sick, thus avoiding a central purpose of healthcare altogether.”

A consensus has emerged among leading experts that good enough methods are now available and ought to be put into practice. For a variety of important reasons, risk adjustment should begin to be implemented as soon as possible. Because of problems of data availability, it will take several years to complete implementation.

Risk adjustment suffers from a collective action problem. In order for risk adjustment to change the incentives of a large health plan, many firms, very large firms, or some large purchasing groups need to introduce it. One employer acting on its own can not correct the incentives of unadjusted capitation. Collective action by purchasers, including the state, is needed to influence this vitally important change.

In addition, to encourage health plans to contract with the best providers and to encourage providers to develop expertise in treating the sickest patients, the adjusted payments must be passed through the health plans to their contracting medical group/IPAs, hospitals and other providers. By leveling the playing field, risk adjustment can be expected to improve price competition among plans.

II. Recommendations
The California Managed Health Care Improvement Task Force recognizes that risk adjustment entails some extra cost and effort in the short run, and despite that, endorses risk adjustment as worth the addi-
ional investment. We base this recommendation on the reasoned analysis that in the long run, risk adjustment will save society resources by redirecting the incentives to providing more efficient, higher quality care for all patients.

Therefore, the Task Force recommends that California stimulate action to adopt risk adjustment while maintaining patient confidentiality, where technically feasible:

1. The Task Force recommends that the CalPERS Board of Administration be urged that CalPERS, preferably in combination with the University of California and PBGH, with its nearly three million members, take the lead in introducing risk adjustment to the California market. The Task Force recommends implementation of a state-of-the-art (i.e., to the degree they have significant predictive power, diagnosis, socio-economic, and other variables) risk adjustment system within three years. CalPERS should report to the Legislature in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why. The Task Force believes this would be in the best interests of California public employees, and would be a great public service to the people of California.

2. The California Department of Health Services (DHS) should be instructed to seek to join with the Health Care Financing Administration (HCFA, administrator of the Medicare and Medicaid programs) in a cooperative project with beneficiaries to explore expanded efforts to do risk adjustment for services to Medi-Cal beneficiaries. DHS should be required to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why.

3. Similarly, DHS should be instructed to participate in HCFA-sponsored risk adjustment demonstration projects for managed care plans serving Medicare beneficiaries as and when such demonstration projects are proposed.

4. The Task Force recommends that the state explore with the federal Office of Personnel Management a California pilot project for risk adjustment of premiums for health plans serving federal employees in California in the Federal Employees Health Benefits Program (FEHBP).

5. Upon implementation by CalPERS of a risk adjustment mechanism, requiring all purchasing groups to risk adjust payments to participating plans within a reasonable timeframe should be considered.

6. As soon as technically feasible, health plans should be required as a matter of licensure to risk adjust payments to their at-risk, contracting, treating providers in addition to using other mechanisms that appropriately compensate for risk (e.g., stop loss coverage, carve outs, global case rates); and when premiums are risk adjusted, to flow through those risk adjustments to the at-risk, treating provider as well.

7. Major purchasers, including the state, and foundations are strongly encouraged to make moving forward the science of risk adjustment (and the ability to monitor its impact on clinical outcomes for different populations) a high priority through funding and support.

8. The state entity for regulation of managed care should be charged with overseeing these efforts and reporting on progress annually to the Legislature and Governor.

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4 The term "state entity for regulation of managed care" refers to the Department of Corporations or its successor.
The Task Force adopted the Findings Section with 17 affirmative votes [21 voting members were present] while the recommendations were adopted individually as follows:

- Recommendation No. 1 — Adopted 17-0
- Recommendation No. 2 — Adopted with 20 affirmative votes
- Recommendation No. 3 — Adopted 19-0
- Recommendation No. 4 — Adopted with 20 affirmative votes
- Recommendation No. 5 — Adopted with 17 affirmative votes
- Recommendation No. 6 — Adopted with 19 affirmative votes
Standardizing Health Insurance Contracts
Findings and Recommendations

I. Health Insurance Contracts

Health insurance contracts are extremely complex and difficult to interpret, even by experts. This complexity is inherent in the nature of the subject and not necessarily the result of any deliberate action on the part of health plans or the employers whose health plan contract decisions may add to the complexity. The complexity of health plan contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance.

Complexity offers insurers opportunities to exercise strategies that promote their economic advantage. While all health plans may not employ these strategies or may not employ them intentionally, but rather to accommodate consumer or employer demand, these strategies can put upward pressure on the price of health care coverage. Strategies include (1) product differentiation that makes comparisons difficult, decreases the incentive for health plans to offer lower prices, and raises switching costs by making it more "expensive" in terms of time for example, for a consumer to switch plans to save money; (2) market segmentation that may reduce competition by dividing customers into distinct groups, with each insurer marketing products to attract different segments from those chosen by competitors; (3) risk selection by designing products that are unattractive to high risk persons; and (4) coverage exclusions, not readily apparent in health plan contracts or read by most individuals.

II. Standardization to Simplify, Compare, and Reduce Costs

To assist consumers, major purchasers have standardized health plan contracts. In order to offer both HMOs and PPOs, purchasers must vary the cost-sharing requirements of contracts. However, a standardization policy can seek to make contracts as similar as possible. Standardization will increase understanding, reduce administrative costs, and facilitate consumer comparison of plans.

Implementation of standardization has proven difficult at the level of detail. Issues regarding definitions and coverage exclusions will continue to challenge attempts to standardize until greater clinical agreement exists. Despite its challenges, standardization has worked successfully for major purchasers in California. However, while large employers and employer coalitions have the resources to assist their members adequately without assistance from regulators, small groups and individuals do not. Recently, Congress passed a law dictating that only approved reference packages could be sold in the “Medi-Gap” market for supplemental Medicare insurance. Indications so far are that this market is now working much better for consumers.

Standardization need only apply within sponsored groups, i.e., the set of people choosing among a set of plans; it does not need to apply among them, i.e., across employers purchasing separately. The principle of standardization does not imply that small business must be offered the same packages as large employers. Standardization need not and should not be complete or mandatory, as this would reduce choice and stifle innovation.

1 In this paper, the term “health plans” refers to any health insurance arrangement or health benefits financial intermediary.
A. Concerns Regarding Standardization
Standardization has been criticized as denying people choice of product features. Certainly, there is need for choice: consumers want it, and it provides a source of constant innovation. Options and innovation often benefit consumers, and standardization should not preclude them. However, because of the potential for risk selection (for example, the only consumers who will want coverage for durable medical equipment are those who know they need it), some standardization is desirable. Whole groups must make a decision as to whether or not they want a particular type of coverage, and if they do, they need to apply this standard uniformly to all plans serving their members.

Controlled departures from complete standardization are possible and desirable, for example, but must be balanced against the benefits of standardization, with special care not to select risks and segment markets.

B. Standardization Options
There is a continuum of pro-standardization policies that the state could adopt. From the most prescriptive to the least, they include, but are not limited to:

- A uniform, national contract, as is the case of Medicare.
- A “Medi-Gap” solution. This would involve a set of standard coverage options and a requirement that, at least in certain markets (e.g., small group market), insurers offer only those products.
- A set of “endorsed, standard reference packages,” designed and updated periodically in consultation with the Major Risk Medical Insurance Board (MRMIB), small business associations, small group purchasing organizations, consumer organizations, health plans, and providers, and reviewed and approved by the state entity(ies) for regulation of managed care. Health plans could be required upon request of employers and consumers, to provide a clear and concise comparison between any plan they offer in the small group or individual market and one of the reference contracts.

III. Recommendations
Non-standard health plan contracts add to financial and other costs associated with switching plans, help to segment markets, and decrease the incentive for health plans to offer lower prices, thus raising prices to purchasers and consumers. Market efficiency can be enhanced by standardization within large groups and by making endorsed standard reference contracts available for comparison in the small group and individual market.

1. The state entity(ies) for regulation of managed care should be directed to adopt a pro-active policy toward the development of standard reference health plan contracts that can be used by buyers and sellers by reference, that health plans can offer on a fast track basis through the regulatory process.

2. (a) The state entity(ies) for regulation of managed care should be directed to develop a set of five (5) standard reference health plan contracts in each of the HMO, POS, PPO, and indemnity product lines, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices.

(b) This should be done in consultation with the Major Risk Medical Insurance Board, and stakeholders.3

2 Throughout this document, the state entity(ies) for regulation of managed care refers to the Department of Corporations, the Department of Insurance, or their successor.
3 The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
(c) On a biennial basis, the state entity(ies) for regulation of managed care should re-examine standard contracts and adopt modifications as appropriate.

(d) Small business would not be required to limit its choices to these standard packages, but in addition would be able to select any other contract health plans offered. In effect, approval by the state entity(ies) for regulation of managed care for the standard contracts would be “fast-tracked.”

(e) Health plans should be required to publish and provide upon request by employers or consumers, a clear and concise comparison between any product they offer in the small group or individual market and one of the reference contracts.

3. (a) The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group to develop a standard outline and definitions of terminology for evidence of coverage (EOC) and other documents to facilitate consumer comparison and understanding.

(b) The working group should include the major stakeholders and should build on previous accomplishments by organizations such as the California Public Employees Retirement System, Pacific Business Group on Health, and the Health Insurance Plan of California. The regulatory entity should convene the working group on a biennial basis to consider modifications.

(c) When consensus has been achieved, the regulatory entity should promulgate proposed rules for consideration and adoption, subject to notice and comment proceedings.

The Task Force adopted the Findings Section with 20 affirmative votes while the recommendations were adopted individually as follows:

Recommendation No. 1 — Adopted with 19 affirmative votes
Recommendation No. 2(a) thru (d) — Adopted with 19 affirmative votes
Recommendation No. 2(e) — Adopted with 16 affirmative votes
Recommendation No. 3 — Adopted with 25 affirmative votes
New Quality Information Development
Findings and Recommendations

I. Findings
The purpose of this paper is to identify ways in which the state can improve the quality-related information collected and available for consumers, providers, health plans, employers, policy makers and others. A well-informed and well-educated public with appropriate choice and access to quality health care is key to improved health. The current array of health care quality information is insufficient. Limitations include the following:

- Comparative data are scarce, and paper charts are not amenable to large-scale quality of care evaluations.
- Risk adjustment is needed to level the playing field for analyzing clinical outcomes, and to reduce adverse selection. (See the Task Force paper on Minimizing Risk Avoidance Strategies.)
- Consumers, patients and purchasers do not have enough of the right sorts of information necessary to make informed decisions about health care options related to treatments, providers, plans, or carriers.

Providers are hampered in their ability to deliver excellent care by limited data to support evidence-based medicine. State efforts at data collection have been limited because each data element is included in statute, collected elements are confined to the hospital discharge abstract and reporting cycles are long. These limitations impede the timeliness and usefulness of resulting information. To improve these shortcomings we recommend the following actions. Wherever possible, efforts should be coordinated among all levels of government and with the private sector.

There will be significant initial investment cost attached to expanding and enhancing the information about the quality of health care in California. The investment is necessary if we are to improve the quality of health care, managed or unmanaged. Moreover, by helping providers to learn which therapies work and which do not, improved data can contribute to reduced cost in the long run by eliminating ineffective or harmful therapies. Data should be collected and reported only if it can help providers improve the quality of care, reduce the cost of care (without reducing the quality of outcomes) and/or help consumers or purchasers choose among health plans and providers, or among treatment options.

II. Recommendations
A. Transition from a Statutory to a Regulatory Approach to Data Collection
1. (a) The Task Force recommends that the state health data programs be given the authority to request specific new data elements from health plans and providers to support new quality measurement initiatives. Broad data guidelines should be set by the Legislature, but the state programs should be given the flexibility to innovate. The state entity(ies) for regulation of managed care should approve data requests (e.g., data elements) and make specific findings regarding cost and benefits.

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1 “Health plans,” refer to any health insurance arrangements, also known as health benefits financial intermediaries.
2 The state entity(ies) for regulation of managed care refer to DOC, DOI, or their successor.
(b) The state entity(ies) for regulation of managed care should be authorized to convene an advisory body composed of stakeholders, to evaluate specific data requests. Such requests should balance the cost and value of information to be provided. Redundant information requests should be reconciled. The advisory body should encourage data requesters to employ valid and reliable statistical sampling techniques when feasible. The state entity(ies) for regulation of managed care should coordinate data requests from all requesters to avoid duplication.

B. Advance Implementation of Electronic Medical Records

Electronically storable and retrievable encounter and clinical data are needed so that medical group/IPAs and providers can monitor and improve their own practices, so health plans can monitor groups, so purchasers and accreditation organizations and the regulatory authority can monitor health plans and so purchasers and health plans can implement adequate risk adjustment mechanisms across health plans and providers.

2. (a) The Task Force recommends that the state entity(ies) for regulation of managed care be aware of, participate in, and actively help where possible, ongoing private and public sector efforts, such as those that have been initiated collectively by Pacific Business Group on Health (PBGH), National Independent Practice Association Coalition (NIPAC), American Medical Group Association (AMGA), California Medical Association (CMA), California Healthcare Association (CHA) and California Association of Health Plans (CAHP), to develop standardized eligibility, enrollment and encounter data.

(b) The state entity(ies) for regulation of managed care should strongly encourage, by providing leadership and coordination, that components of electronic medical records (starting with encounter data), based on systems that permit easy sharing and exchange of data be phased in with a target date of 2002-2004 depending on the size and resources of the medical group/IPAs, health plans, clinics and hospitals.

(c) This strategy should include strict provisions for maintaining patient privacy and confidentiality including fire walls between individual patient data and employers. The state entity(ies) for regulation of managed care should impose severe penalties for individuals or organizations if they abuse the release of individual patient data. (See also the Task Force paper on Physician-Patient Relationship)

(d) The Task Force recommends to the President and the U.S. Congress that the federal government should assume responsibility for establishing technical standards for electronic communication of health care information (such as uniform identifiers for patients and providers and uniform language and data definitions), standards for confidentiality and standards for information security. Federal initiatives in these areas will help ensure compatibility and comparability of information across states. This will assist the study of health outcomes regionally and nationally.

C. Collect Health Information at the Treatment Level

3. (a) The Task Force recommends that health care information be collected and disseminated not only at the health plan level, but at the treatment level including hospital, clinic, medical group/IPA, ambulatory center, home health and nursing home levels. Information should emphasize and compare outcomes whenever possible and make specific findings as to the value and the cost of the collection and dissemination of the data. (See the Task Force paper on Consumer Information, Communication and Involvement.) Information should be reported by local geographic area where people are likely to seek and receive health care services. The state entity(ies) for regulation of managed care should either disseminate the above health plan and treatment level information to

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3 The intention of the Task Force is that stakeholders include, but are not limited to, consumers groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
the public or assure that private dissemination of this information occurs and is widely available and
easily accessible.

(b) The Task Force recommends that the state entity(ies) for regulation of managed care be aware of,
participate in and actively help where possible, ongoing private sector efforts to develop and distrib-
ute these data.

D. Ensure Basic Safety Standards for Patient Care

There are some instances when quality information should be monitored to ensure the basic safety of the
public. Collecting, monitoring, auditing and most of all improving clinical care based on these data serves
a greater public good and should be required by public regulation and required by private accreditation.

4. The Task Force recommends that the state entity(ies) for regulation of managed care in coordination
with OSHPD and DHS, create a blue ribbon panel (to include stakeholders and private accrediting
organizations such as JCAHO and NCQA) to study and report by June 1, 1999 on ways to help
improve patient safety in health care by reducing errors, adverse events and adverse outcomes.
Specific areas to study should include variations in number and rates of adverse drug events, hospital
and surgical infection rates, patient falls and pressure ulcers, and variations in risk-adjusted mortality
and morbidity rates for major surgeries and treatments.

The Findings Section was adopted 26-0 while the recommendations were individually adopted as
follows:

Recommendation No. 1 — Adopted 21-0
Recommendation No. 2 — Adopted 19-2
Recommendation No. 3 — Adopted 17-1
Recommendation No. 4 — Adopted 24-0
Improving the Dispute Resolution Process in California’s Managed Care System
Findings and Recommendations

I. Statement of the Issue
While managed care plans and their providers strive to prevent conflicts, disputes related to coverage, claims, medical necessity and other issues will be an inevitable part of any health care system. An efficient and effective dispute resolution process is an essential element of any health care delivery system and can play a crucial role in bolstering public confidence. It is especially important in managed care health plans that use prior authorization as a method for controlling utilization. There is a wide perception and concern among consumers, advocates, providers, purchasers, and health plans that some disputes take too long to resolve, current processes are not well understood, disputes are not resolved efficiently, and information that could be gleaned from the process is not consistently used to improve either specific plans or the overall system.

II. Essential Elements
An efficient and effective dispute resolution process must accomplish the following:

• Consumers need to be given the information and support necessary to understand their rights and responsibilities and the dispute resolution process and how to navigate it; they must not fear that exercising their rights would result in negative repercussions.

• When problems arise, efforts should be made to resolve them as quickly and as close to the point of service as possible.

• Some consumers will need assistance when they have problems, and assistance should be available, both from inside the health plan and externally.

• Formal processes must be fair, must treat like consumers alike, and must be perceived as fair by all parties in order to maintain support for the system; they must provide adequate opportunity for a full hearing, have consistent decisions, communicate findings to the consumer along with the basis for those findings, utilize qualified decision-makers, and reach decisions by applying the facts of the case using explicit standards.

• Formal processes must be efficient for consumers, providers, and plans, with severity of the issue recognized in timing and procedural standards.

• Formal processes must provide finality.

• Any process should both resolve individual issues and systematically provide information for quality improvement and monitoring.

1 Throughout this paper, the term “health plans” refers to any health insurance arrangement or health benefits financial intermediary, unless otherwise specified (e.g., Knox-Keene regulated health plans).
III. Current Dispute Resolution Processes

Currently, limited data exists relating to consumers' problems, the severity of those problems, and the relationship of problem experience to consumers' complaints and resolution. The Department of Corporations (DOC) is required to publish an annual report that provides data on complaints that come to the DOC through its toll-free hotline. In addition, Knox-Keene plans must report information about complaints pending longer than 30 days. Two recent surveys conducted, one for the Task Force and the other for three foundations, shed new light on consumer experience and problems. These surveys find from 27% to 42% of consumers have experienced problems with their health plan in the past year, and of those, approximately half contact their health plan. Surveys conducted by several large purchasers also provide some insight. One CalPERS-PBGH study found that of the 26% of members with a complaint or problem in 1995, 52% were dissatisfied with the way it was handled by their health plan.

When a consumer has a complaint or grievance, his or her physician is often the most likely source of help and information. Beyond going to their physicians, the formal grievance process available to consumers varies greatly by sponsor/purchaser (e.g., individual, employer, Medicare, Medi-Cal), health plan, health plan product (e.g., HMOs, preferred provider organizations “PPOs”, traditional, unmanaged, fee-for-service “indemnity”), and type and severity of grievance. In general, health plans' grievance and appeals processes include two levels of review within the plan. If members are dissatisfied with the result of internal processes, depending on their specific circumstances, many health plans require members to proceed to binding arbitration processes. Several laws require, and several accreditting and other organizations recommend, certain elements of the dispute resolution process. Besides the formal grievance process in health plans, there may be external grievance structures available to consumers that parallel or supplement these processes.

IV. Observations on Health Plan Practices

Task Force staff and those Task Force members in the dispute resolution group examined health plans' current grievance processes, albeit not enough to draw firm conclusions, and found lack of consistency, ineffective communication, variable reporting, and some positive examples of use of complaint data for quality improvement.

V. Recommendations

From a consumer's perspective, whenever a plan denies a patient or his or her physician's request, he or she should be able to enter the grievance process (i.e., this is the point at which the patient receives information about the basis upon which a decision is made). This paper addresses issues related to the grievance process from the consumer's perspective. In addition, the paper makes some recommendations regarding utilization review because of the close link between utilization review decisions and adequate information for consumers to enter a formal grievance process.

A. Collaborative Development and Non-Duplication of Effort

1. Any of the recommendations below would benefit from a collaborative process in which the state entity(ies) for regulation of managed care, health plans, purchasers, providers, consumer advocates

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5 For example, enrollees in Knox-Keene regulated plans may file a complaint with the DOC prior to binding arbitration or after binding arbitration, Health and Safety Code Section 1368(b)1B. Denials of care for Medicare enrollees must be systematically reviewed by an outside entity. Medi-Cal provides an administrative appeals process for denials.
6 The term “state entity(ies) for regulation of managed care” refers to the DOC or the DOC and DOI or its/their successor.
and other stakeholders’ form a working group to develop the detailed terms of the proposal. In addition, many recommendations reflect existing law applied to specific populations (e.g., Medicare or Medicaid), to those health plans regulated by Knox-Keene, or standards privately developed (e.g., by accreditation bodies). Where requirements already exist, we recommend building on existing standards rather than creating completely new ones. Similarly, recommendations are intended to recognize and build on existing community resources.

B. Broad Application

2. The Task Force recommends that the recommendations in this paper apply broadly.

(a) The Task Force strongly encourages voluntary adoption and implementation of the recommendations and existing law and relevant accreditation standards by purchasers, employers, and plan administrators in those situations where ERISA preemptions restrict the regulation and oversight of health plan processes.

(b) The Task Force recommends that employers voluntarily include Task Force dispute resolution standards and those set forth in existing law and relevant accreditation standards in contract obligations for health plans.

(c) The Task Force recommends that the US Department of Labor, to the maximum extent feasible under federal law, amend its regulations, procedures and oversight pertaining to employer-sponsored ERISA health benefit plans to conform to (or, if not legally feasible, at least complement) California’s implementation of Task Force dispute resolution recommendations and existing law and relevant accreditation standards. The state’s entity for regulation of managed care should be directed to take the lead in consulting and coordinating with the US Department of Labor to facilitate this goal.

C. Consistency and Common Standards for Internal Plan Grievance and Appeals Processes

Individual consumers move among health plans and types of plans. Employers may change coverage, or consumers may move in and out of Medi-Cal, change jobs, get Medicare coverage, or select different individual coverage. Because of this fluidity, and because an essential element of all dispute resolution processes should be to treat like consumers alike, enrollees in all types of plans (HMOs, PPOs, POS, and indemnity) should have equivalent or consistent procedural rights and protections, regardless of type of plan or purchaser. While there may be greater perceived need for grievance processes in health plans with more selective networks and greater restrictions, consistency among dispute resolution processes would help all consumers. A consistent process would require consumers to learn only one basic system, and it would provide for better information and quality improvement. This would enable consumers to advocate more effectively for themselves, potentially improving satisfaction with results.

3. The Task Force recommends that consistent standards regarding dispute resolution processes for all health plans be developed and adopted, to the extent the power exists to do so. The development of these standards should include consultation with health plans, medical groups/IPAs, consumers, consumer advocates, regulators, and other stakeholders. The goal of these deliberations should be to establish mandatory complaint processes that encourage resolution as close to the point of service as possible, to structure balanced and efficient processes, and to elicit reporting that is comparable and equitable. Those standards should include (where they are not already required) the following:

(a) Application to Provider Groups. If a medical group/IPA or other provider organization provides services to a health plan’s member or enrollee, the provider group should meet the statutory standards required of health plans, as required under current Knox-Keene law. For example, timing requirements would include complaint processing time at the medical group/IPA level.

The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
(b) Timing Requirements. Turn-around time for resolving complaints at all levels of the dispute resolution process should be consistent, with time adjusted for severity of problem.

(1) Currently, Knox-Keene regulated health plans are required to resolve whenever possible and respond to non-urgent grievances within 30 days. The Task Force recommends that all plans (e.g., including non-Knox-Keene plans) be required to resolve non-urgent complaints within 30 days, except under special circumstances (e.g., when complex medical issues need to be re-searched), when the time frame may be longer.

(2) Currently Knox-Keene regulated health plans must resolve or respond to urgent complaints (defined as a situation in which the standard time frame could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function as determined by a physician) within five days. The state entity for regulation of managed care should examine this requirement and recommend (and provide rationale) to the Governor and the Legislature within two years as to whether all plans should be required to respond within 72 hours (as required by the Health Care Financing Administration) instead of the five days currently required.

(c) Periods of Limitation. Currently, Knox-Keene regulated health plans have an affirmative obligation to notify consumers of periods of limitations within which consumers must submit a grievance or appeal. These minimum periods of limitation should be standard across plans. The state's entity for regulation of managed care should establish minimum standards through a rulemaking. The ultimate minimum standard should include a provision for good cause exception. Periods of limitations should have no bearing on consumers' ability to access the state's entity for regulation of managed care for assistance.

(d) Communication of Processes. There should be consistency in how health plans inform consumers regarding how to use dispute resolution processes before and upon “grievable incidents.” In addition, the state's entity(ies) for regulation of managed care, in consultation with health plans, should provide examples of well-prepared appeals for a variety of issues and make them available to consumers upon request.

(e) Consumer Participation. Plans should provide opportunities for members to participate in the grievance process in person, at least at one time, to the extent possible.

(f) Full and Complete Explanations of Grievance or Appeals Decisions. If an in-plan physician's recommendation is denied by an organization (whether medical group/IPA or health plan), the physician should be notified and the patient should receive written notice, both of which should include the decision that was made, the reasons for the denial, the specific health plan contractual provision on which the decision is based (if applicable), the information that was reviewed in making the decision, any expert opinions or guidelines relied upon, and information and instructions on how to appeal the decision and timing. Where explanations touch on quality of care issues, precautions should ensure that peer review processes are protected from intrusion.

(g) Terminology and Data Collection. The state entity(ies) for regulation of managed care should develop in collaboration with stakeholders, and phase-in with all deliberate speed, standard definitions to be used by health plans and the state entity(ies) for regulation of managed care for the

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8 Knox-Keene Act, Section 1368.01(a).
9 Consumers enrolled in Knox-Keene regulated plans, after a 60-day period following submission of a grievance, are entitled to appeal to the Department of Corporations if their grievance remains unresolved at the plan level.
10 Knox-Keene Act, Section 1368.01(b).
11 The Knox-Keene Act currently requires the disclosure of the grievance system and the DOC hotline.
12 When a Knox-Keene regulated health plan denies coverage for treatment, the plan must give the patient and provider the specific clinical criteria, if any, that was used in the denial (Section 1363.5).
meaning of terms commonly used in grievance processes, categories for reporting complaint types, and minimum standards for data collection by types of complaints.13

(h) Public Reports. Currently Knox-Keene plans must report complaints pending longer than 30 days, track their resolution, analyze the complaints, and use the information for quality improvement. In addition, after standard grievance terminology has been agreed (see recommendation 3.(g) above), the state entity(ies) for regulation of managed care should develop in collaboration with stakeholders and implement additional public reporting requirements (phased-in if necessary).

Data reported to the state entity(ies) for regulation of managed care should be reliable and comparable, and the state entity(ies) for regulation of managed care should publish plan-specific and aggregate data on a periodic basis that should include data on all health plans. This data should be reported with the entity’s(ies’) own complaint and request for assistance data. In determining the amount and nature of the information to be reported, the state entity(ies) for regulation of managed care and stakeholders should consider, for example:

- aggregate numbers, types, length of time to resolution, and disposition of issues raised by condition or type of complaint, sorted by plan and medical group/IPA for groups over some size threshold (e.g., percent of enrollees, number of doctors, or top five groups per plan);

- a summary of the reasons decisions were upheld or overturned, including the basis upon which decisions are reached for particular types of complaints;14 and

- the cost, comparability and validity of the data.

No such report should in any way impinge on patient confidentiality or peer review.

(i) Facilitate Consumer Contact With Regulators. The state entity(ies) for regulation of managed care should provide a single statewide “800” number that seamlessly transfers consumers to the appropriate agency.

D. Consumer Empowerment

4. To be educated and empowered, consumers in all types of plans need full information on their rights and how to exercise them. Information should include a “bill of rights and responsibilities” received on enrollment, describing the complaint processes (as is required under current law for Knox-Keene plans). Also, when a denial or “grievable incident” occurs, appropriate information should be provided to the patient. In order to avoid increasing legalistic aspects of physician-patient relationships and to prevent increasing paper flow, current law should be reviewed to ensure the following standards exist for all consumers:

(a) Health plans and medical groups/IPAs should direct members to the appropriate next steps at every stage where a member expresses disagreement with a provider or plan decision as well as provide adequate explanation of the patient’s rights and the basis of the decision.15

(b) If a patient disagrees with his or her health care practitioner, the patient should be given at least oral notice (not necessarily in writing), of the availability of, and access to, a second opinion and the grievance process. When the decision of the medical group/IPA or plan differs from that of the patient’s physician, the patient should be given oral notice, or written notice upon request.

13 DOC has already developed common complaint categories for its hotline for the classification of types of complaints.

14 The Task Force considered requiring plans to establish case-by-case precedents. While the Task Force believes that establishing consistency and making public the basis of health plan decisions, members think that requiring case-by-case precedents have limited applicability, could be overly burdensome on health plans, and potentially limit plans’ discretion to resolve issues quickly and efficiently through compromise as close to the point of service as possible.

15 The Knox-Keene Act requires such notices at every stage.
(c) Health plans should be required to pay for second opinions from physicians within the consumer's health plan, and if there is no separate, qualified network provider, by a qualified out-of-network provider.

E. Consumer Assistance Through Plans

5. While the goal of the dispute resolution process should be to educate and empower consumers to be their own advocates, some consumers need assistance exercising their rights. Physicians can serve as important patient advocates. In addition, plans must have adequate internal systems and information to provide assistance. Such internal assistance may be particularly important for vulnerable populations. The Task Force recommends that private accreditation and quality audit standards, where applicable, should require plans to demonstrate support to consumers seeking to appeal, including coaching them on how to navigate the grievance process, adequate explanation of denial, and access to supporting documentation.

6. The Task Force encourages health plans to examine and adopt best practices as this will enhance member retention. Some exemplary efforts include the following:

- seeking the opinion of outside specialists in the relevant medical specialty for issues related to medical necessity or experimental and investigational treatments; and

- allowing members to attend reviews in person, or if the member can not (e.g., member is out of the area) or is not welcome to attend in person (e.g., member has a history of being abusive), by teleconference.

F. External Consumer Assistance

Because even the best health plan’s or provider’s internal processes will not be perfect, some consumers will also need an independent external resource to go to for information and assistance. In addition, some consumers fear retribution from their provider or plan and are reluctant to pursue assistance from their employers. Currently, external resources exist (e.g., the DOC’s toll-free hotline), but access to these resources varies greatly based on the individual consumer’s circumstances. Appropriate activities performed by external resources may include developing and distributing educational material, providing referrals to existing resources, counseling, advising and assisting consumers on problem resolution at every stage in the process (except litigation), and dealing with plan and state regulatory entities.

7. (a) The Task Force recommends that two pilot, independent external assistance or external ombudsman programs in different regions of the state be authorized, for which state funding should be secured. Such pilot programs should be used to assess how best to serve all health care consumers, how best to inform consumers of the existence of such external assistance programs, how to use existing assistance resources most effectively, and how to educate consumers to use (but not overuse) services. The pilot projects should include an evaluation of the potential impact on premiums and the value of the services to individual consumers and the health care system relative to the costs. The pilot programs should be coordinated with the Sacramento-area independent assistance program (the Health Rights Hotline), and with existing, targeted health care assistance programs (such as the Health Insurance Counseling and Advocacy Program (HICAP), the Long-Term Care Ombudsman program, and the US Department of Labor’s evolving efforts to assist enrollees in employer-sponsored ERISA plans). They should complement and not duplicate existing services provided by health plans, other existing external resources, or regulatory bodies. The pilot programs should have common data collection and evaluation systems and publicly shared data regarding complaints to identify systemic problems.
G. Independent Third Party Review
8. The state entity for regulation of managed care should be directed to establish and implement by January 1, 2000 an independent third-party review process that would provide consumers and health plans with an unbiased, expert-based review of grievances pertaining to delays, denials, or curtailment of care based on medical necessity, appropriateness, and all “experimental-investigational treatments.” The specific details should be developed through a collaborative process, which should consider the following issues:

- whether access to independent review requires support of a provider in the consumer’s health plan or any health professional;
- what should be the standard for decisions, and what should be considered expert evidence;
- how to ensure the decision-maker has adequate independence and appropriate expertise;
- what, if any, access thresholds (e.g., internal process exhaustion requirements, financial or “merit,” seriousness of a case as determined by external guidelines, nominal fees) should apply.

H. Arbitration Standards
9. Health plans should be required to establish arbitration standards that include the following:

(a) Arbitration systems used by plans should provide for expeditious resolution of disputes, including rapid selection, or default appointment, of neutral arbitrators. Judicial intervention should not be necessary to ensure the appointment of arbitrators.

(b) An arbitration award should be accompanied by a written opinion. Copies of written opinions (excluding personal and confidential, and patient and provider identifying information), including award amounts, should be available to the public upon request through the state entity(ies) for regulation of managed care.

(c) The state entity(ies) for regulation of managed care should be authorized to prohibit a plan from requiring a party to continue to participate in arbitration if the plan was found by the regulator to have engaged in willful misconduct in the proceeding.

I. Assessment
10. Health plans, providers, foundations, consumer groups, etc., should be encouraged to assess the efficacy of the full range of dispute resolution mechanisms including, but not limited to, non-binding arbitration, mediation, and neutral fact-finders. The use of such mechanisms should be linked to publicly disseminated independent evaluation of how well they meet the principles set forth in the list of “Essential Elements” above.

The Findings Section was adopted 23-0 while the recommendations were individually adopted as follows:

Recommendation No. 1 — Adopted 16-0
Recommendation No. 2 — Adopted 20-0
Recommendation No. 3 & 3(a) — Adopted 19-0
Recommendation No. 3(b) — Adopted 20-0
Recommendation No. 3(c) — Adopted 23-0
Recommendation No. 3(d) — Adopted 24-0
Recommendation No. 3(e) — Adopted 22-1

16 All Department of Insurance and Knox-Keene regulated health plans are required by AB 1663 to use an external review process for experimental treatments involving terminal conditions. California was a leader with this legislation.
Recommendation No. 3(f) — Adopted 25-0
Recommendation No. 3(g) — Adopted 23-0
Recommendation No. 3(h) — Adopted 22-0
Recommendation No. 3(i) — Adopted 21-0
Recommendation No. 4 — Adopted 22-0
Recommendation No. 5 — Adopted 23-0
Recommendation No. 6 — Adopted 26-0
Recommendation No. 7 — Adopted 20-0
Recommendation No. 8 — Adopted 22-0
Recommendation No. 9 & 9(a) — Adopted 20-2
Recommendation No. 9(b) — Adopted 16-2
Recommendation No. 9(c) — Adopted 18-7
Recommendation No. 10 — Adopted 23-1
Financial Incentives for Providers in Managed Care Plans
Findings and Recommendations

I. Findings

Physicians and other appropriately-licensed health professionals operating within the scope of their practice (i.e., health practitioners or providers) are motivated by many incentives. Compensation arrangements are one important factor that may impact the quality and cost of care. Other, arguably more, important factors at work include professional ethics and providers’ desire for the esteem of their peers. These incentives drive practitioners to give good care and work hard regardless of how they are paid.

All compensation arrangements contain incentives, which may have positive and negative effects. Under fee-for-service (where payment occurs only if service is rendered), health practitioners have incentives to provide at least the care, and sometimes more care than, patients need. Payment on a capitation basis (where prepayment for the potential use of services occurs regardless of whether or not care is rendered) may create incentives to provide appropriate care, or to provide less care than needed. Compensation through salary provides an incentive to provide appropriate care, but may impede productivity. Many providers participate in bonus and withhold incentive arrangements which may be designed to encourage quality and consumer responsiveness, or may be weighted excessively toward financial considerations.

There is almost an infinite array of compensation arrangements. These arrangements are often very complex and therefore, in most instances, may not be amenable to regulation. Nor is there direct conclusive evidence of the relationship between specific financial arrangements and adverse outcomes. However, some arrangements are not in the public interest and should be restricted because they create too great an incentive to deny necessary medical care. In general, the greater the intensity of incentives, the more likely they are to affect specific clinical decisions. Of particular concern are incentives that place individual or small groups of health practitioners at risk for the cost of referrals for their patients. Stop-loss insurance, reinsurance, and especially risk adjusted payments to providers can alleviate some of the potential problems associated with capitation.

According to one national survey of physicians and managed care plans, approximately half of all American physicians have at least some patients whose insurance plans place the physician at some financial risk. Health plans reported an average of 12% as the maximum percentage by which an individual primary care physician’s annual income may vary each year as a result of financial incentives.1

Both federal law2 (applicable to Medicare and Medicaid patients) and state law3 prohibit arrangements that are an inducement to limit or reduce necessary services to an individual enrollee. Federal law also requires that physicians who are placed at substantial financial risk have specified stop-loss protection.

Though the information is complex, patients and enrollees may benefit from disclosure of financial incentives by health plans and medical group/IPAs. State law requires health plan disclosure of incentives. Federal law (for Medicare and Medicaid patients) requires disclosure of incentive arrangements where physicians are placed at substantial financial risk. Disclosure by individual practitioners may also benefit

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2 Sections 4204(a) and 4731, OBRA 1990, Public Law 101-508; and HCFA Regulations 42CFR, Section 417.479.
3 AB 2649, 1996, is now part of the Health and Safety Code, Section 1367.10.
patients provided it is done in a manner that is sensitive to the provider-patient relationship. Practical implementation of further disclosure requirements may be difficult, though worth exploring.

Health plans, purchasers, government entities, and accreditation agencies have not sufficiently researched and identified provider compensation arrangements that produce the most appropriate care and best outcomes.

II. Recommendations
1. Health plans should be required to disclose to the public specific information about the scope and general methods of payment made to their contracting providers of health care services and the types of financial incentives used to enable consumers to evaluate and to compare plans. Disclosure should use clear and simple language, including a suggestion that if an individual wishes to know more about their providers' or provider groups' method of reimbursement, they can ask their medical group/IPA, provider, or health plan.

2. The state entity for regulation of managed care should conduct a pilot project with a variety of health plans, their contracting medical groups, other provider groups, and consumer groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The state entity for regulation of managed care should report results back to the Legislature to consider how best to approach provider group disclosure.

3. Provider groups and health practitioners should be required to disclose the scope and method of compensation and financial incentives they receive, upon the request of a patient. Provider groups should also be required to disclose the methods of compensation and incentives paid to their subcontracting providers.

4. (a) Health plans and provider groups should be prohibited from adopting an incentive arrangement in which an individual health practitioner receives a capitation payment for a substantial portion of the cost of referrals for that practitioner’s patients. (Aggregated or pooled risk arrangements of, for example, five or more practitioners should be excluded from the prohibition in 4(a) and the requirements in 4(b).)

(b) The state entity for regulation of managed care should be required to review and approve the following types of incentive arrangements:

- where an individual health practitioner receives an incentive tied to a substantial portion of the cost of referrals of that practitioner’s patients or
- where a very small group (e.g., fewer than five) receives such an incentive or a capitation payment for a substantial portion of the cost of referrals for the group’s patients.

These arrangements should not be approved in the absence of a determination that there is a patient panel of sufficient size to spread risk, sufficient time over which the capitation or incentive applies, and adequate provisions to assure quality care and to protect against high risk cases through stop-loss or risk adjustment.

(c) The state entity for regulation of managed care should ensure that health practitioners who contract with health plans, who treat commercial patients, and who are at substantial financial risk (as currently defined by federal law) obtain stop-loss coverage, maintain sufficient reserves, or have other verifiable mechanisms for protecting against losses due to adverse risk. This provision should

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4 Throughout this paper, the “state entity for regulation of managed care” means the Department of Corporations or its successor agency.
5 For purposes of this discussion, referrals do not include services performed in a provider’s office.
be administered in a manner that minimizes the administrative burden on practitioners and plans to the extent possible.

5. Sponsored purchasing groups, such as the Pacific Business Group on Health, and accreditation organizations, such as the National Committee for Quality Assurance, should review provider incentive compensation arrangements (including non-financial incentives) for the purpose of identifying best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment and compensation arrangements that continue to include rewards for quality care, consumer satisfaction, and other non-financial factors.

6. An advisory group should be convened by the state entity for regulation of managed care, including major stakeholders to review provider compensation arrangements, identify best practices, and practices in need of improvement, and advise the state entity for regulation of managed care regarding the need for changes in regulatory oversight.

7. The state entity for regulation of managed care should develop internal expertise in assessing compensation arrangements.

The Findings Section was adopted 22-0 while the recommendations were individually adopted as follows:

Recommendation No. 1 — Adopted 16-5
Recommendation No. 2 — Adopted 19-0
Recommendation No. 3 — Adopted 21-1
Recommendation No. 4 — Adopted 20-0
Recommendation No. 5 — Adopted 20-0
Recommendation No. 6 — Adopted 24-0
Recommendation No. 7 — Adopted 23-0

The intention of the task force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
Physician-Patient Relationship
Findings and Recommendations

I. Findings

The physician-patient relationship is fundamental to health care delivery. Cardinal Bernardin, in a statement given to the American Medical Association House of Delegates in 1995, shortly before his death from pancreatic cancer, described the physician-patient relationship as a covenant. He stated:

The moral center of the doctor-patient relationship is the very essence of being a doctor. It also defines the outlines of the covenant that exists between physicians and their patients, their profession, and their society. The covenant is a promise that the profession makes—a solemn promise—that it is and will remain true to its moral center. In individual terms, the covenant is the basis on which patients trust their doctors. In social terms, the covenant is the grounds for the public’s continued respect and reliance on the profession of medicine.¹

The physician-patient relationship is multi-faceted, making an understanding of the impact of managed care difficult. In addition, physicians are not the only providers who may have a significant relationship with a patient. The covenant described above as well as the other issues discussed in this paper are not exhaustive and in general may be applied to all appropriately-licensed health professionals, operating within their scope of practice (“practitioners” or “providers”).

Although the effects are inherently difficult to study, beneficial relationships between physician and patient have been shown to decrease and/or shorten hospitalizations, lower utilization of resources, enhance compliance, and improve satisfaction among patients and physicians.² ³ There is also some evidence about the impact of external factors on the physician-patient relationship. The availability of a choice of health plans⁴ increases patients’ satisfaction with their physicians.⁵

Views of physicians and patients, as well as physician-patient relationships have evolved over time. Recently, however, the nature of the physician-patient relationship has changed. The increased presence of third-party payers in the health care system over the last 30 years has eroded the trust between physician and patient.⁶ Managed care has added sources of doubt. Important factors that appear to have contributed to this decline in trust include issues related to (a) continuity with providers, (b) the coordinating role of the primary care provider and utilization review, (c) informing patients of all options, (d) financial incentives, (e) physician availability, and (f) quality improvement programs and patient confidentiality.

⁴ Throughout this paper, the term “health plans” refers to any health insurance arrangement or health benefits financial intermediary.
A. Continuity with Provider

A continuous relationship with a health care practitioner provides familiarity with patient medical histories. As a result, providers can react quickly in emergencies, make knowledgeable decisions, and handle many situations on the telephone. In addition, studies have shown that patients staying with the same physician for long periods are less likely to be hospitalized, more likely to have lower costs, and to be more satisfied. Many HMOs attempt to formalize this relationship through the designation of primary care physicians or providers (PCPs). Several features of HMOs and the health insurance market, however, tend to make continuity of care difficult to maintain. These include closed HMO panels (if the enrollee or provider leave the plan), termination of provider contracts, changes in coverage by employers, and lack of choice and information.

B. Coordinating Role of the Primary Care Provider and Utilization Review

Additional factors affecting the physician (or other provider)-patient relationship is the coordinating role of the PCP and utilization review. The model is based on the United Kingdom’s general practitioner and was designed with the intent of improving quality and reducing costs by coordinating care through one provider. Although studies have shown that as many as 30% of procedures are medically unnecessary, denying access to care — whether necessary or not — strains the physician-patient relationship. Conflict may result when HMOs, medical groups/IPAs, or physicians deny referrals to specialists, referrals to procedures, and referrals to care outside the HMO network.

C. Informing Patients of All Options

Providers should help patients to make informed decisions based on the advantages and disadvantages of each option and the patient’s personal preferences. Although “gag clauses” have been banned in California and management guidelines are generally intended as recommendations, there is still some fear that improper discussion or behavior related to treatment options may result in contract termination by the health care plan or medical group/IPA.

D. Financial Incentives

While providers are principally motivated by professional ethics and desire for the esteem of their peers, they also face financial incentives. All compensation arrangements contain incentives that may have positive and negative effects. An important issue is whether or not patients have access to information about how their medical care is paid for (see Provider Financial Incentives paper). Several forms of compensation arrangements in managed care, including capitation and risk pools, shift financial risk for caring for patients from health plans to providers. Although these structures may create incentives for providers to limit unnecessary care and reduce costs, they also have the potential to reward providers for denying medically appropriate care. This form of compensation may also reduce patient satisfaction and erode trust between patients and physicians.

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11 Center for Studying Health System Change and Mathematica Policy Research Inc., nationwide survey of physicians.
14 Op-Cit., Blumenthal, D, 1996.
E. Health Care Practitioner Availability
When people are sick, they want to see their health care practitioner and expect their practitioner to be available; they want appointments to be available within a reasonable time frame, and to be long enough for evaluation and treatment. Adequate practitioner availability can prevent miscommunication, non-communication, disputes, and grievances. Current law requires Knox-Keene regulated health plans to restrict physician panels to 2,000 patients per PCP. Availability, however, may depend on the skill of the practitioner and the health of the patient panel. Many managed care organizations use advanced practice nurses and physician assistants to provide preventive, primary and secondary care and reserve physicians’ time to care for patients with complex disease processes. All patient visits have a medical and emotional impact on patients. Shorter visits that may be medically acceptable can still be a source of patient dissatisfaction.

F. Quality Improvement Programs and Patient Confidentiality
Purchasers have largely driven quality measurement and improvement efforts. While not universal and still under development, these quality measurement efforts offer feedback to providers to improve, and information to purchasers and consumers to judge quality and service. Quality improvement programs have resulted in increased paperwork which requires the investment of significant time and effort, the benefits of which may not be readily apparent to those required to provide the data. Several experts have noted that trust in physicians’ decisions is increasingly supplemented by evidence such as that provided by disclosure of quality improvement and measurement results. However, the current system lacks a systematic mechanism for assessing and informing patients about the experience and competence of their health care delivery system and personal physician. Quality improvement and similar efforts as well as the delivery and payment of care require confidential patient information, the use of which must be balanced with respect for patient privacy.

II. Recommendations
A guiding principal for the recommendations of this Task Force, and health care system change in general, should be an evaluation of the effect of the proposed change on the covenant of the physician-patient relationship described by Cardinal Bernardin, and the relationship between patients and other health professionals.

A. Continuity with Providers
In addition to recommendations in the Consumer Information, Communication and Involvement paper (regarding research into the feasibility, utility and cost of creating a “Super Directory” of providers to ensure consumers know whether a particular provider or group is available to a member of a plan), the following recommendation could further address continuity issues:

1. (a) Existing law requires plans to have policies in place allowing for continuity of care when enrollees involuntarily change health plans. In addition, health plans and medical groups/IPAs should be required to enable consumers who are undergoing a course of treatment for a chronic, acute, or disabling condition (or who are in the second or third trimester of a pregnancy) when they involuntarily change health plans or when a provider is terminated by a plan or medical group/IPA (for other than cause) to continue seeing their current providers, at the patient’s option, until the course of treatment (or postpartum care) is completed, up to a maximum of 90 days or until the patient’s condition is such that the patient may be safely transitioned to a new provider.

16 Item H(i) Primary Care Providers in Commissioner's Rule 1300.51(d) in Title 10, California Code of Regulations.
17 Felt-Lisk S, "How HMOs Structure Primary Care Delivery," Managed Care Quarterly, 1996; 4(4), 96-105.
(b) Providers who continue to treat such patients should be required to accept the plan's out-of-network or PPO rate for such care as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

B. Coordinating Role of the Primary Care Provider and Utilization Review
In addition to recommendations in the Practice of Medicine paper (regarding modification of prior authorization procedures) and in the Dispute Resolution paper (regarding disclosure and procedures related to referral denials), the following recommendation could further address coordination issues:

2. Health plans should be required to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and that is life-threatening, degenerative, or disabling may receive an extended, prolonged, or permanent referral to a specialist. Such referrals should be conducted in a manner that maintains coordination of services (e.g., updating the PCP, sharing of medical records, agreeing on shared treatment plans, and agreeing on the respective roles of each practitioner).

C. Informing Patients of All Options
Recommendations related to informing patients of all options are included in the Standardizing Health Insurance Contracts paper (regarding disclosure of information in the Evidence of Coverage and other documents) and in the Consumer Information, Communication, and Involvement paper (regarding disclosure about the medical centers to which a health plan sends patients for conditions requiring specialty care, and regarding disclosure by plans and medical group/IPAs upon request of treatment guidelines or authorization criteria for a given condition).

D. Financial Incentives
Recommendations related to financial incentives are included in the Task Force paper on Provider Financial Incentives.

E. Health Care Practitioner Availability
In addition to recommendations in the Risk Avoidance paper (regarding risk adjustment), the following recommendation could further address health care practitioner availability issues:

3. If a patient is specifically assigned to or chooses a primary care provider and the provider's medical group/IPA or health plan directs that patient for an appointment to another physician, advanced practice nurse or physician assistant, the patient should be informed verbally and should consent prior to the appointment.

F. Quality Improvement Programs and Patient Confidentiality
In addition to recommendations in the Task Force paper on New Quality Information Development (regarding advances in implementation of electronic medical records), in the paper on Consumer Information, Communication and Involvement (regarding public-private collaboration to encourage the gathering of additional standardized patient satisfaction and quality data), and in the Government Regulation and Oversight paper (regarding streamlining of medical group/IPA quality audits), as well as numerous recommendations that include consideration of the patient confidentiality, the following recommendations could further address quality improvement programs and patient confidentiality:

4. As information relevant to quality of care becomes available, providers, regardless of financing and delivery system, should include relevant information at every level of care in the informed consent process. To the extent information is known, accurate, and reliable, a health care practitioner or hospital should make available upon request relevant information regarding his, her, or its experience and/or qualifications regarding the course of care a patient is considering.
5. (a) Federal reforms related to confidentiality of patient information and patient access and rights with respect to their medical records should be monitored, and state law should be consistent. In addition, state law should be reviewed to ensure confidentiality of individually-identifiable health care information and patient access and rights with respect to access to their medical records, while allowing health plans, provider groups, and providers to undertake activities required by law, including the provision of health care, outcomes research, risk adjustment and research to advance evidence-based medicine, payment for services, peer review, quality assurance, utilization review, and investigation of grievances. When disclosure is required, no greater amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure. Otherwise, information should not be released unless authorized by patient consent or by law.

(b) No health plan or any of its contractors should be allowed to require an enrollee, as a condition for securing health care services, to sign a release or consent form which waives any individually-identifiable, medical information confidentiality protections for the purpose of using such information for commercial purposes.

The Findings Section was adopted 24-1 while the recommendations were individually adopted as follows:

Recommendation No. 1 — Adopted 26-0
Recommendation No. 2 — Adopted 24-0
Recommendation No. 3 — Adopted 25-0
Recommendation No. 4 — Adopted 25-0
Recommendation No. 5(a) — Adopted 23-0
Recommendation No. 5(b) — Adopted 21-0
Consumer Information, Communication and Involvement
Findings and Recommendations

I. Introduction
Rapid changes in the health care delivery system have resulted in elevation of the importance of consumer information and involvement. The potential benefits of managed care, namely lower costs, higher quality of care and greater consumer satisfaction will be realized only in a system characterized by active and meaningful consumer participation.

This paper addresses the interrelated issues of consumer information and involvement in the health care system. A brief section on communication of consumer information is also included to highlight the importance of the format in which information is made available or presented to consumers. The paper is structured in two parts: the first will present background, principles and recommendations for improving managed care through better and more accessible consumer information, and the second will do the same for effective consumer involvement.

II. Information and Communication
A. Consumer Information and Managed Care
The historical physician-patient relationship, which was characterized by the professional authority of the physician and a relationship based upon trust, has been altered by the introduction of managed care. According to Bradford Gray of Yale University, this relationship has also been “strained in recent decades by exploding health care costs, accompanied by much publicity about malpractice crises, fraud and abuse, inexplicable variations in patterns of care and high levels of inappropriate services.”1 Gray also notes that managed care has added sources of doubt in the trustworthiness of physicians by introducing compensation arrangements that may create conflicts of interest, introducing external parties into the physician-patient relationship and implementing rules that limit the alternatives that doctors can offer patients.2 (See the Task Force paper on the Physician-Patient Relationship.) In an environment in which a third party can intervene, the patient needs access to and an explanation of information relevant to the decision about appropriate treatment. In addition, with the health care delivery system’s shift from a focus on treatment to prevention, consumers need knowledge about health promotion activities in general and about their own health status. These shifts imply a need for health care information, communicated in an effective manner.

In managed care, the consumer becomes an advocate for him or herself and a “partner” in his or her care. In this new role, the consumer needs access to a range of information on health plans and providers. While a great deal of information is provided to consumers by health plans and/or submitted by health plans to regulatory authorities, the extent to which consumers are able to use this information to compare health plans and make effective decisions is unclear. In addition, much information that consumers need to participate effectively in their health care remains unavailable to them.

California consumers have long voiced concerns about the availability of information on managed care organizations collected and disseminated by state oversight agencies. In a 1992 study, the California

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2 Ibid.
Auditor General found that the DOC had been lax about maintaining its public access files, responding to complaints and performing required monitoring visits.\(^3\) In a 1996 report, Consumers Union documented the difficulties consumers have in obtaining information from the DOC.\(^4\) This report noted that although the Knox-Keene Act requires the DOC to educate and inform consumers about HMOs,\(^5\) DOC provides consumers with little information to assist them in choosing or using health plans.

Consumer advocacy groups and private organizations use a combination of government-generated and market-generated information to provide consumers with health care system information and various types of “rankings,” generally at the health plan level. A broad range of resources have also been developed to educate consumers on clinical issues and help them respond to their role in the managed care system. A great deal of information that was until recently considered “professional” has been brought into the public domain. Resources designed to help consumers access information and educate themselves about a broad range of clinical issues are provided in print and via media such as videotapes and Internet sites. Examples of these initiatives range from “ask the doctor” email forums to consumer-focused clinical education and decision-making tools to patient advice/peer groups for people with specific conditions and diseases.

**B. Communication of Consumer Information**

While health plans, providers and independent monitoring organizations currently collect a great deal of data on performance of health care organizations, this information is often not translated into measures that are useful to consumers. In addition, lack of standardization of information collection and dissemination has made it difficult for purchasers, health plans and advocacy groups to provide consumers with useful, relevant information for plan and provider selection.

Recent studies reveal significant problems in communication of basic managed care information to consumers. The vast majority of consumers do not currently understand even the fundamental operations of the plan in which they are enrolled (e.g. how managed care plans differ from traditional, unmanaged fee-for-service indemnity insurance).\(^6\) In addition, a recent study of the “readability” of health insurance literature and contracts found that the average document was written at a reading level of third/fourth year college to first/second year graduate school.\(^7\) In contrast, the results of the 1992 Adult Literacy Survey conducted by the US Department of Education indicated that writing directed at the “general public” should be at the seventh or eighth grade level.\(^8\)

Communication of plan features and requirements in terms and language understandable by enrolled consumers will enhance both efficiency of operations and consumer satisfaction with managed care plans. Employer coalitions, such as the Pacific Business Group on Health (PBGH), have made the most extensive and successful efforts at providing such information to date.

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\(^4\) Hamburger E, “A Shot in the Dark: The Department of Corporations Fails in its Job to Educate and Inform Consumers about Choosing an HMO,” Consumers Union of the US, Inc., West Coast Regional Office, April, 1996.

\(^5\) California Health and Safety Code 1342(b) (West 1996).


\(^7\) Hochhauer M, letter to the Editor, Health Affairs, September/October 1997, p 220.

III. Principles and Recommendations for Consumer Information

A. Principles for Consumer Information

The following principles should guide development of recommendations regarding consumer information in health care:

- Full and accurate disclosure of appropriate information can serve to foster best practices.
- Consumers’ ability to understand differences in quality among health plans and providers is critically important to efficient functioning of the health care delivery system.
- Consumers’ ability to choose among and effectively use health plans and providers is critically important to efficient functioning of the health care delivery system.
- Consumers should have unbiased, standardized information about health plans, medical group/IPAs and providers.
- Dissemination of accurate, useful information will enhance consumer trust in the managed care system and drive quality improvement by health plans and providers.

B. Recommendations for Consumer Information

1. In addition to the recommendation in the Task Force paper on Standardizing Health Insurance Contracts the state entity(ies) for regulation of managed care should convene a working group to develop a standard outline and definitions of terminology for the Evidence of Coverage (EOC) and other plan documents, we recommend the following:

The state entity(ies) for managed care should create and update at least annually a “standard product description” in a format to facilitate direct comparison of health plans by consumers, designed with input from stakeholders, in as non-political a process as possible. The CalPERS format could be considered as a model for this document. The state entity(ies) for regulation of managed care should require health plans to use the standard format to present information about any product they offer.

This standard benefit characteristics document should include a statement on how drug formulary decisions are made; should describe key elements of the plan’s grievance procedure (including a description of any arbitration processes); should include independent (i.e. not self-reported) “exit polling” information on number disenrolling and primary reasons for disenrollment, when available; and should offer, for each plan or medical group/IPA with which the plan contracts, a brief but specific description of the referral and authorization process, and the process through which medical decisions are made. The state entity for regulating managed care should make these descriptions available to consumers at a nominal charge and should make this information available on the internet.

2. Health plans should be required to submit to the state entity(ies) for regulation of managed care information on approximately 10 major health conditions or illnesses requiring referrals to specialty centers (e.g. bone marrow transplants, coronary artery bypass grafts). Data should be reported on an annual basis for the prior year, and should include, for each condition or procedure: where and from which medical center the patient received care; how many of the procedure in question the center to which the patient was sent performed in that year; and, when risk-adjusted outcomes become

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9 Throughout this paper, the term "state entity(ies) for managed care refers to DOC, DOI or their successor.
10 The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans and purchasers.
available, outcomes measures. Data should be presented at the plan level, and where appropriate at the medical group or IPA level. Provisions should be made to ensure that data is presented in such a way that patient confidentiality is maintained. This information should be made available to consumers and organizations upon request.

3. Upon request by an enrollee or a member of the public, all health plans and medical group/IPAs should be required to make available at a nominal charge copies of any written treatment guidelines or authorization criteria for a given condition.11

4. Health plans should be required to update the information for their participating providers12 on the internet continuously, and to update and make it available in print at specified locations at least quarterly. This information could then be made available to consumers through employee benefits offices, libraries and consumer advocacy and assistance organizations. Health plans should be required, upon member or potential enrollee request by telephone to provide information for their participating providers, e.g. to indicate whether a particular provider or provider group is a member of the plan's network, to indicate whether a participating primary care provider is accepting new patients or to provide a list of plan-approved specialists of a certain type in a certain geographic area.

The state entity(ies) for regulation of managed care should research and report on the feasibility, utility to the consumer and cost of creating a “Super Directory” of physicians and other primary care providers (e.g. advanced practice nurses), hospitals, clinics and medical group/IPAs participating in health plans, indicating which plans or groups they contract with. The purpose of this directory would be to ensure that consumers receive accurate information on whether a particular provider, group, hospital, or clinic will be available to him or her as a member of the plan. Primary care providers' entries should indicate which medical groups or IPAs they belong to, whether or not they are accepting new patients, and to what facilities or specialists their patients may be referred. This information should be made available to all consumers at the time of enrollment and renewal and to individual consumers at any time upon request.

Every effort should be made to minimize additional paper flow: paper copies of the Super Directory should be made available at a limited number of public sites, and an emphasis should be placed on development of electronic technologies for updating and providing information (e.g. automated telephone systems, internet).

5. The state entity(ies) for regulation of managed care's report on grievances should be expanded to include more detailed and meaningful information on grievances. The DOC currently provides information on complaints (in DOC terminology “requests for assistance” or RFAs) filed with the Department in writing, after the plan has had 60 days to resolve the problem. Current information provided by DOC includes a report on the number of complaints by type of complaint and plan.

The Task Force recommends that the report be expanded to include an indication of the severity and urgency (as defined by threat to life and health) of the complaint and whether and what action was taken by the plan and/or DOC in response to the complaint. This additional information is critical if consumers are to be able to use the complaint information in choosing a plan. This recommendation would provide an improvement in disclosure to consumers using information that is already available to DOC. Because measures of grievance severity and urgency may not have been developed by regulatory agencies or health plans to date, the Task Force recommends that a collaborative effort to develop such measures be undertaken.

11 Please note that The Task Force paper on Provider Financial Incentives presents several specific recommendations regarding disclosure of information about financial arrangements and payment mechanisms to consumers.

12 Throughout this paper, the term “provider” refers to physicians and other appropriately licensed health professionals operating within their scope of practice.
See the Task Force paper on Dispute Resolution for additional recommendations on reporting and disclosure of grievance information, including a recommendation which provides for expansion and publication of public reports on complaints and grievances filed with health plans.

6. The state entity for regulation of managed care should encourage and support, to the extent possible in collaboration with private sector efforts, gathering of additional standardized patient satisfaction and quality data at the provider group level (for groups and IPAs exceeding a certain size threshold) as well as the plan level. This effort should not duplicate current initiatives, but should include health plans and groups who have not been included in surveys and reporting efforts to date and should expand on measures currently being collected. The PBGH/Medical Quality Commission “Physician Value Check” could be considered as a model for medical group/IPAs, and the FACCT13 framework is one example of a model for collection of data at the plan level.

7. The Task Force recommends that employers who pay a portion of employees’ health benefits coverage begin to increase awareness that dollars spent on health benefits are a part of employees’ total compensation by including such payments as a separate line item on employee pay stubs. Employers may choose appropriate alternatives—such as reporting on total compensation and/or health insurance premiums for each employee—which achieve the goal of increasing employee awareness of the cost and value of health benefits. Employers should be encouraged to collect information from their employees on their experiences and problems with health plans and medical group/IPAs so that this information can be used in the plan negotiation process.

IV. Consumer Involvement

Formal consumer involvement mechanisms are necessary to ensure that consumers have a “voice” in shaping the health delivery system and their role in it. While most health plans have some member involvement mechanisms in place, few have implemented extensive programs for consumer feedback that have proven effective. Most consumer activity within health plans has focused on issues such as review of marketing materials and grievance procedure policy development. Most health plans acknowledge that while they attempt to obtain member input on print materials, they do very little formal testing of educational and marketing materials to determine whether consumers understand or can effectively use them.

Ombuds programs, member advisory committees, and tools such as the “Consumer Feedback Loop”14 have been developed to allow all parties in the system to obtain and benefit from the input of members. (An example of information gathered in a representative Consumer Feedback Loop is included as an attachment to the background paper for this report.) While purchasers, health plans, providers and consumers have all recognized the benefits of such involvement mechanisms, because the spirit of the Knox-Keene provisions for consumer information and involvement are not being achieved, strong incentives will likely be necessary if plans and providers are to seek active participation of members in formulation of policies, marketing materials, product design and plan operations and evaluation.

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13 The Foundation for Accountability (FACCT) is a not-for-profit coalition dedicated to helping consumers make better health care decisions. FACCT has released measures that attempt to create a relevant, comprehensive picture of quality of care for specific conditions—like asthma or diabetes, lifetages—like pediatrics or end of life, and population status—like health status over 65 or health risk behaviors. FACCT creates comparative information by organizing and weighting data from HEDIS, FACCT measurement sets, the Agency for Health Care Policy and Research’s CAHPS, the Joint Commission on Accreditation of Healthcare Organizations’ ORYX and public health databases.

14 The Consumer Feedback Loop, a tool developed by California Health Decisions, is a model for improving health care quality that involves patients, purchasers and health plans in a consumer-driven process of research, solutions, change and evaluation. The Consumer Feedback Loop is a process that fosters cooperative efforts towards quality improvement. Its goal is to shape change in a health care delivery system or structure around the best interests of the consumer.
Under Knox-Keene, HMOs are currently required to:

- Establish a governing body which is composed of at least one third subscribers or enrollees or
- Establish a standing committee which is responsible for public policy participation and whose recommendations and reports are regularly and timely reported to the board. The membership of the committee shall be at least 51% subscribers/enrollees,
- Describe the mechanism by which enrollees/subscribers can express their views on public policy matters, and
- Establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan and incorporate these procedures into the plan’s bylaws.

A. Consumer Values
Attempts to improve upon the current level and nature of consumer information and involvement should be driven by an understanding of consumer values. Advocates and studies have characterized seven consumer values that relate to the health care delivery system:15

- Affordability: Quality health care at a reasonable price. Members most often cite affordability as their primary purchasing criterion and express a fear of losing access to quality care because costs are too high for their employers or themselves.
- Choice: Consumers are allowed to choose their health care providers, ideally at each of three levels: the plan, the medical group/IPA and the physician or other health care provider working within their scope of practice. Consumers often feel that they do not have the information they need to make informed choices.
- Accountability: Consumers enrolled in a plan are presented with clearly identified agents and processes through which to resolve problems. Members are concerned that accountable organization resolves problems in a pre-stated and timely manner.
- Personal Responsibility: The managed care operating environment expects consumers to become “partners” in health care. Member involvement includes two discrete dimensions: a greater level of self-care, behavior modification and preventive activities and member responsibility for some of the “navigation” and coordination of their health services.
- Fairness: Members feel that all patients are treated with the same care and that medical decisions are just. Members generally talk about fairness on a global level; they not only seek fairness for themselves and their families, but feel that there should be at least a minimum threshold of care available to all people.
- Dignity/Respect: Physicians and health plans treat patients as capable and explain conditions, treatment options and patient responsibility clearly.
- Quality: Consumers understand and have relatively easy access to services and obtain good medical outcomes given their condition.

15 These values have been developed by California Health Decisions, and are described in more detail in its “Condition Critical Project” report.
B. Special Features of the Health Care Market

In addition, several features of the health care market render health plans different from and more deserving of state-mandated forms of governance than organizations that produce or provide other goods and services:

- Health care is more personal in nature than other goods and services; decisions about health care and treatment can involve significant bodily harm and/or be life threatening. Consumer expectations for regulation in health care are higher than they are for most other goods and services.

- Consumers have a compelling interest in provision for and protection of public health.

- Consumers are “obligatory users” of the health care system (i.e. many sick and/or pregnant consumers must use the system whether they want to or not).

- Health care is characterized by imbalances in availability of information to consumers more significant than that in most other industries.

V. Principles and Recommendations for Consumer Involvement

Principles for Consumer Involvement

The following guiding principles serve as the basis for recommendations as to how increased consumer involvement can improve the managed care system.

- Member/patient involvement in managed care decision making, including member participation in product design, development of marketing materials and quality improvement processes will improve managed care quality and enhance consumer service and satisfaction.

- Member/patient involvement mechanisms (such as Consumer Feedback Loops, ombuds programs, member advisory committees and member participation in policy and committee structures) should be created and employed to improve the overall efficiency of plans and medical group/IPAs.

- Strong public and private incentives, in addition to the market-driven need to attract and retain customers are necessary to ensure that health plans and provider groups develop organized systems of consumer involvement and advocacy.

- Health plans will enhance consumer trust by formally including consumer input into policies and practices across all levels of the plan. The Task Force strongly encourages health plans and consumer groups to work together to design workable mechanisms for doing so. State government should exercise its considerable bargaining power as a health care purchaser by ensuring that members' interests are incorporated into health plan design and operations.

Recommendations for Consumer Involvement

The Task Force recommends the following revisions to requirements for health plan under Knox-Keene to increase consumer involvement in health plans' governance and/or operations:

1. (a) Establish a governing body which is composed of at least one third members or enrollees and ensure that sufficient resources are made available to educate enrollee board members so that they can participate effectively. Enrollee board members should neither be employees of nor have a significant financial interest in the organization or competitor organization, or

(b) Establish a member advisory committee(s) to ensure that members' values and needs are integrated into the design, implementation, operations and evaluation of the plan administrators. This committee(s) shall communicate and advocate for members' needs and serve as a resource for the
governing body and HMO/plan administrators. It shall be responsible for establishing mechanisms and procedures for enrollees to express their views and concerns about the HMO/plan, including the viewpoints of enrollees who are members of vulnerable populations. The plan attributes/functions this committee(s) may address include but are not limited to: benefits and coverage, member communications, quality assurance, marketing and grievance resolution, and

(c) Upon request by the state entity(ies) responsible for regulating managed care or accrediting organizations:

(i) Describe the mechanisms and lines of accountability used for obtaining and incorporating member feedback into policies and practices across all member-related departments/divisions, and

(ii) Demonstrate how member feedback has been incorporated into plan policy, operations and evaluation.

2. The Task Force recommends that purchasers and employer groups (including government entities) that contract for health care should exercise their bargaining power to encourage health plans to ensure that medical and other provider groups develop and utilize mechanisms of consumer feedback.

3. The Task Force recommends that accrediting bodies develop standards regarding health plans’ and provider groups’ utilization of validated, reasonable consumer feedback in policy development and implementation.

4. The Task Force encourages collaborative efforts among government, foundations, health plans, provider groups and purchasers to fund expansion of organized systems of consumer involvement.

5. The Task Force recommends that the state entity(ies) for regulation of managed care have member advisory committees responsible for ensuring that managed care plan members’ values and needs are integrated into the collection of information from and regulation of managed care organizations.

The Findings Sections was adopted 19 to 0 while the Recommendations were adopted individually as follows:

**Recommendations for Consumer Information:**
Recommendation No. 1 — Adopted 20-0
Recommendation No. 2 — Adopted 22-0
Recommendation No. 3 — Adopted 19-2
Recommendation No. 4 — Adopted 23-0
Recommendation No. 5 — Adopted 17-1
Recommendation No. 6 — Adopted 22-0
Recommendation No. 7 — Adopted 17-2

**Recommendations for Consumer Involvement:**
Recommendation No. 1 — Adopted 20-0
Recommendations No. 2 through 5 — Adopted 22-0
I. Introduction
A. Organizations Are Making Medical Decisions
Today, health care practitioners and patients who agree on a course of necessary care may have that course altered either by delay or denial by an HMO or its utilization management designee. In theory, the opportunity to measure an impending medical decision against outcomes research, practice guidelines and relevant clinical algorithms should ultimately work to patients' benefit. Some have argued that prior authorization/concurrent review is a key element separating managed care from traditional unmanaged, fee-for-service "indemnity" insurance. In addition to controlling costs, prior authorization/concurrent review can, in some cases, strengthen the quality of care by identifying procedures, tests or other treatments that may be unnecessary or contribute to errors. But the evidence of effectiveness is mixed.

The perception that treatment decisions are being reviewed by an appropriately credentialed physician, with adequate knowledge of the case at hand, is also mixed. In some cases, care may be compromised when a practitioner for adults is asked to render a pediatric opinion. Some have argued that certain children and adults with chronic diseases would benefit from receiving their primary care from specialists in the chronic disease (Please see the Task Force paper on Physician-Patient Relationship). While major stakeholders in the health care industry may disagree, the public perception is that the health plan reviewers are a heterogeneous group with mixed qualifications and that prior authorization/concurrent review sometimes focuses too heavily on cost and causes inappropriate delays or denials in care without due medical cause.

B. Cost Matters When Practicing Medicine
Purchasers, employers and consumers want slower growth in the cost of medical care and less costly health benefit arrangements (please see the Task Force paper on Impact of Managed Care on Quality, Access and Cost). Yet, everyone expects maximum care when they become sick. Some consumers are not confident that they are receiving the highest quality of care when health plans and providers endeavor to practice cost-effective medicine by limiting selected services (see the Task Force paper on Physician-Patient Rela-
tionship). Legislators are trying to respond to constituents who have become mistrustful of the health care system.

C. In the Face of Limited Industry Action, Legislators Respond

Unfortunately, the concern has been raised that legislators, while trying to solve these problems, are practicing medicine. Nationally and locally politicians are implicitly if not explicitly, legislating medical practice. The respected New England Journal of Medicine has declared that “medical imperialism is obsolete.”7 The Task Force believes that the practice of medicine is a multi-disciplinary, multi-professional, team effort and that physicians are no longer the sole arbiters of medicine. However, neither Congress, nor the California Legislature nor health plan executives who are not health care providers licensed to practice in the State of California, should be medical practice team members. Appropriately credentialed professionals practicing scientific, evidence-based medicine should be the arbiters of cost-effective medical care. They should also be responsible for continuously improving the quality of medical care.

D. Variation in Practicing Medicine Clouds What is Medically Necessary

A basic premise is that physicians and other providers want to practice excellent, high quality medicine. Yet research shows wide variations in both medical practice and resource use, without evidence of corresponding differences in either medical need or health outcomes.8 Significant practice pattern variation, however, raises important and complex questions. “Which rate of surgery or therapy is right?” “Are some patients being treated more conservatively with the same or better outcomes?” “Do certain rates of surgery or therapy reflect patient preferences and values more than others?” “What is the effect on a population’s health?” Variation also suggests that providers sometimes differ on what is medically necessary. In addition, some patients may want unnecessary services (See the Task Force paper on Impact of Managed Care on Quality, Access and Cost). Behavior of both health care practitioners and patients is frequently driven by the inherent uncertainty in medical care. The need to reduce this uncertainty and consequent variation is compelling and challenging.

The practice of medicine depends on the interrelationship among diagnostic evaluations, clinical judgments, surgery, therapies and drugs, and the interaction and communication between providers and patients. A review of a provider’s pattern of medical decisions is very valuable when it can be done over a long enough period of time and with enough treatment and outcome data points to be able to statistically evaluate the provider’s delivery of care. This evaluation should be done using state of the art information about clinical outcomes relative to the resources prescribed. This evaluation would provide a more scientific basis for establishing medically necessary, high quality care and accountability for medical practice.

II. Findings and Recommendations

A. Modify Prior Authorization/Concurrent Review

Decision quality should be improved by encouraging the use of practice guidelines, clinical pathways, careful selection and pre-credentialing of providers, retrospective utilization review and outcomes research in medical decision making. If a provider’s referral patterns are appropriate and outcomes are good, the provider should be considered to have demonstrated exemplary practice and the HMO should cease to require prior authorization/concurrent review for a finite period of time. Many alternatives to prior authorization/concurrent review are possible. There is room in the marketplace for a variety of innovative, incremental and expedited referral programs.9 10 However, for innovations to occur, better data interchange

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is needed. Many health plans delegate utilization review and management to their contracting medical
groups/IPAs and other independent utilization management designees. Those health plans that delegate
this responsibility cannot monitor quality and compliance without encounter data. To be useful, encoun-
ter data should include diagnoses and procedures at the treatment level, information which medical
group/IPAs have to date viewed as proprietary. Health plans should create incentives for medical groups
and IPAs to provide such data. Ideally, the private sector will correct this data communication problem.

Purchasing groups should be encouraged to work with the scientific advisory arms of the health plans and
medical group/IPAs to implement specific practice guidelines, clinical pathways and outcome studies for
modifying the prior authorization/concurrent review process. Realistically, encounter data at the patient
and provider level will have to be available for the above to occur. Patients with catastrophic diseases
deserve special consideration. For example, in certain cancer cases treatment and therapy is time sensitive,
and delays or denials of care can have severe and unintended consequences. In many of these cases there
are existing, accepted and respected clinical guidelines. Prior authorization/concurrent review should not
be a barrier to care in these cases. In all situations, it is important to recognize that medical science and
practice are constantly changing and a rigid codification of medical practice through attempted legislation
should be avoided.

1. Recommendation to Modify Prior Authorization/Concurrent Review
(a) The Task Force recommends that health plans incorporate provider pre-credentialing and the use of
practice guidelines, clinical pathways, retrospective review (as opposed to prior authorization/concurrent
review) and outcomes-based data into their established utilization monitoring processes.

(b) The Task Force recommends to the health plans, medical groups/IPAs and their designees, that they
develop utilization monitoring processes based on statistically valid data on patterns of care and patient
outcomes, or professional consensus, that are sensitive to the needs of various populations, including
vulnerable populations. These data sets or professional consensus may then form the basis on which
alternatives to prior authorization can be based (See Task Force paper on New Quality Information
Development).

(c) The Task Force recommends to the health plans and their designees that they develop and implement
strategies that allow health care practitioners who demonstrate an exemplary practice profile to practice
medicine with automatic approval for a defined scope of practice. A probationary period of up to, but not
more than, two years may be employed to assess provider utilization in determining eligibility for auto-
matic approval status. Plans may continue to require providers to obtain verification of eligibility, coverage
and approval for the setting in which the procedure is to be performed.11 Health plans may develop
appropriate and periodic review mechanisms to ensure that providers continue to demonstrate an exem-
plary practice.

(d) The Task Force recommends to the health plans and their designees that they eliminate prior authori-
zation and concurrent review for patients with catastrophic conditions being treated by pre-credentialed
providers for which outcomes based protocols have been developed and broadly accepted (e.g., pediatric
oncology).

(e) The Task Force recommends that there be a review and report by the year 2000 on how the private
sector has modified the prior authorization/concurrent review process to recognize exemplary care or an
equivalent modification. (The report should include consideration of whether the state entity(ies) for

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11 Eligibility is a distinct concept from coverage. Eligibility refers to the criteria that an employer uses to determine whether or not to offer
health benefits to an employee as well as the criteria that a health plan uses to determine whether a patient is entitled to benefits through
their employer. In the plan's case, the plan would want to know if a patient was still employed by Company A and whether the premium
had been paid. Coverage refers to the list of benefits delineated by contract between Company A and the plan. This list usually includes
hospital care, physician services, routine exams, maternity care, prescription drugs, etc.
regulation of managed care should consider making the necessary changes a requirement of health plan licensure or accreditation.

(f) Where prior authorization/concurrent review is required, denials of care must include a review by appropriately qualified, credentialed individuals.

B. Improve Formulary Effectiveness

Ideally, the appropriate practice of medicine effectively integrates clinical judgment, diagnostic evaluations, surgery, therapies and drugs to form and inform clinical pathways, practice guidelines, and outcomes research. Pharmaceutical prescribing practices and costs are an important and much debated component of this process. Pharmaceutical costs are rising rapidly; formularies are one tool to manage them. To lower pharmaceutical costs and maintain affordable drug coverage, a case can be made that the individual physician’s choice of drugs should be informed, guided and perhaps constrained by a committee of his or her peers. Flexibility should be built into this process to allow for individual physician and patient variation. It is not appropriate to apply strict population standards to individual patients when prescribing drugs. Some drugs work for some patients, but not for others. The involvement of physicians in formulary development is key to changing physician practice.

Provider groups in California have an average of 15 managed care contracts. This means that when prescribing a drug, a physician may have to consult several if not 15 drug formularies. Providers have to figure out which health plan covers their patient, then which drugs are in its formulary, and then spend time on the phone requesting exceptions. This is bound to raise administrative costs and complexity and reduce efficiency and effectiveness. The situation can be worse – indeed bordering on the impossible – for the doctor in individual practice who belongs to several IPAs, each of which contracts with 15 different managed care plans.

2. Recommendation to Improve Formulary Effectiveness

(a) Consumers should be ensured that they will be fully informed of their rights to prescription drugs offered by a health plan, and those rights should include, but not be limited to the following:

(1) All health plans and their designees (whether pharmaceutical benefits managers or medical groups) that offer prescription drug benefits and use a formulary, must periodically publish their formulary drug lists and make them available to any member of the public upon request subject to reasonable costs.

(2) All health plans and their designees (whether pharmaceutical benefits managers or medical groups) that offer prescription drug benefits and use a formulary must publish a description of the process by which their formulary is developed and reviewed.

(3) Health plans and their designees (whether pharmaceutical benefits managers or medical groups) must have in place, and make known to consumers and providers, timely exception processes by which a physician or a patient (with his or her physician’s support) may secure quick approval for medically necessary non-formulary drugs.

(4) When a health plan removes a drug from its formulary, it should be required to allow the patient to continue receiving the removed drug for an ongoing condition unless the treating physician prescribes a new agent or the drug is no longer considered safe and effective for the patient’s medical condition based on appropriate medical evidence.

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100 Managed Health Care Improvement Task Force
(5) The state entity(ies) for regulation of managed care should be directed to investigate periodically and report publicly on health plan and contracting medical group compliance with these recommendations.

(b) Health plans that develop a formulary for their members should include input from practicing plan physicians with relevant expertise, input from specialty societies and other relevant data when composing the formulary.

C. Clarify the Benefit Language in Health Insurance Contracts

Benefit language has traditionally relied on vague terms with no precise meaning. Health plans have covered most things thought to be “medically necessary” or “appropriate” by providers or that met a “community standard.” Since no consensus exists as to how to make benefit language more precise, it is important to define the criteria by which medical necessity is applied so that it can lead to improved quality, improved health outcomes, improved functional outcomes and better adherence to the scientific basis of treatment decisions. Further study is needed in this area.

Debate about coverage and treatment decisions is not complete without more discussion about experimental treatments and therapies. The Friedman-Knowles bill (AB 1663) passed in 1996, makes provision for appeals after an experimental treatment decision is denied. However, the question remains as to when a treatment crosses the line from experimental to accepted and non-experimental. It would be desirable for an independent, expert review panel of physicians and health plans to review the scientific findings to determine when there is sufficient evidence to reclassify therapies from experimental to proven treatments, which are to be included in the standard of clinical care. Presently, a consistent, industry-wide process for this evaluation does not exist.

3. Recommendation to Clarify Benefit Language in Health Insurance Contracts

(a) Create a “blue ribbon” public/private work group of major stakeholders15 to study and recommend changing the benefit language in health plan contracts. The panel should have a state-wide strategy for implementing benefit language changes within two years. The state should require that implementation of these changes, where feasible, be phased-in within two subsequent years. Among the issues the panel should consider are:

- For most consumers the decision to pay for care is synonymous with the decision to receive care, since few consumers can afford to purchase most care out of pocket.
- Benefit definitions should consider the needs of seniors, children, individuals with disabilities and other vulnerable populations and should consider the objective of maximizing functional capacity and the inclusion of benefits to maintain function and to slow or prevent deterioration of function.
- Revisions of benefits criteria should consider the impact of reducing or eliminating coverage for care.
- Studies of the issues inherent in changing benefit language should consider the transition from vague, imprecise terms to language intended to maximize quality outcomes, health outcomes, functional outcomes and the scientific underpinnings of treatment decisions while controlling costs.

(b) The state entity(ies) for regulation of managed care should convene an appropriate panel representing all stakeholders and having appropriate clinical expertise to accept, catalogue and organize data concerning agreement on standard of care and medical appropriateness in reference to treatment issues.

This panel can review data presented as evidence-based or consensus-based pertaining to clinical modalities. By defining standard of care and medical appropriateness, this panel could also define experimental

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15 The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
care and could help determine when sufficient data become available for a new clinical approach to transition treatments from experimental to clinical standard of practice. The panel could further catalyze needed clinical trials where appropriate data have yet to be developed for making such determinations. This panel could also encourage all payors to identify and support experimental protocols in certain circumstances of life threatening or limiting illnesses.

The Findings Section was adopted 23-1 while the Recommendations were individually adopted as follows:

Recommendation No. 1(a)-(d) — Adopted 28-0
Recommendation No. 1(e) — Adopted 27-0
Recommendation No. 1(f) — Adopted 28-0
Recommendation No. 2 — Adopted 28-0
Recommendation No. 3 — Adopted 20-1
Vulnerable Populations
Findings and Recommendations

I. Introduction

“As members of human communities, we are all potentially vulnerable.”
LuAnn Aday

“Better-integrated and better-organized systems of care promise potentially high quality and effective care, but only if a commitment is made at the outset to strong quality assurance, a service ethic that cares for the whole person, and outreach to those in the community who are most in need.”
Joyce Dubow

A. Definition of Vulnerable

Serving the special needs of vulnerable populations creates a unique challenge for managed care organizations, be they health plans or provider organizations contracting on a prepaid capitated basis. Managed care does have a great potential for better serving vulnerable beneficiaries by providing more effective management, coordinating multiple medical and social services, and exercising greater flexibility in providing the care that beneficiaries may require. However, the capacity of a plan to provide appropriate care for persons with chronic or complex illnesses and circumstances depends to a large extent on the way the plan is organized and financed. Appropriate staffing and coordination of services is as critical to quality of care, as is adequate risk adjustment to the financial stability of plans.

Traditionally, society has recognized vulnerable individuals and groups and supported public health and treatment-oriented programs and services to address their needs. The interface of managed care plans with the public health and other safety-net providers for at-risk persons is of major concern for all vulnerable groups. In this paper the Task Force makes both recommendations that apply to all vulnerable populations, and recommendations that are specific to populations that receive care through government’s contractual relationships with providers.

As government payors move larger portions of Medicare and Medicaid beneficiaries into managed care, the need to address safeguards for vulnerable populations has come to the collective forefront of federal and state policy-makers’ agendas. At stake is the health status of beneficiaries who must rely on regulatory safeguards and governmental oversight to protect their general interest through contractual requirements negotiated with managed care health plans.

The movement of significant beneficiary pools from traditional unmanaged fee-for-service “indemnity” insurance plans to managed care also has an effect on the commercial health plan industry and the provider community. Commercial and public health plans participating in Medi-Cal and Medicare must make significant investments in provider network development, information systems, and clinical quality and utilization management. These demands place at risk an entire safety-net system of care which might not be able to manage the transition cost. At greatest risk is the county health care infrastructure. Counties may be unable to compete for members who may, for the first time, be presented with recognizable choices, not just of health plans but of private and public delivery systems.

1 Aday, L, At Risk In America: The Health and Health Care needs of Vulnerable Populations in the United States, 1993.
2 Dubow, J, “Medicare Managed Care: Issues for Vulnerable Populations”, Public Policy Institute of the AARP.
3 The term “health plans” refers to any health insurance arrangement or health benefits financial intermediary.
4 Interview Dr. Helen Rodriguez-Trias, Task Force member and Mary Dewane, CEO CalOPTIMA.
The true power of the payor to cause the managed health care industry to change has been greatly enhanced by the sheer size of the populations being moved into prepaid health plans. The impact on the behavior of both public and private health systems now thrown into direct competition for health plan membership will be significant.

There are a number of vulnerable populations, some of whom are highlighted in this report. They include the following:

- Frail elderly
- Adults with disabilities
- Children with disabilities
- High risk pregnant women
- Foster children
- Chronically ill, HIV/AIDS
- Socially and economically disadvantaged, culturally isolated
- Suffering mental illness
- Chemically dependent.

These populations present a unique challenge to managed care organizations and, to a great degree, will serve as the public’s litmus test as to whether managed care can and will be the principal model of health care delivery beyond the year 2000.

B. Problems of Vulnerable Populations in Managed Care Settings

The results of Miller and Luft’s recent study on managed care versus indemnity performance indicates that health maintenance organizations (HMOs) produce better, the same, and worse quality of care depending on the particular organization and particular disease. However, three of the five observations with significant negative HMO results focus on chronically ill, low-income enrollees in worse health, impaired or frail social HMO (SHMO) demonstration enrollees, and Medicare home health patients, many of whom have chronic conditions and diseases. While it is true that some quality of care results that show better or mixed HMO quality are also at least partially based on data for patients with chronic conditions and diseases, and that there are many valid cautions against over-interpreting the results, the fact that three significantly negative HMO quality of care results were for Medicare HMO enrollees with chronic conditions and diseases raises cause for concern. In addition, based on the interviews with the many advocates and foundations contributing to this report, some managed care arrangements may raise issues with respect to the following challenges that need to be addressed in serving these populations:

- Under-treating patients with chronic illness
- Restrictions in seeking specialists
- Lack of expanded systems of care and limited benefits definition
- Discontinuity of treatment
- Lengthy time frames for authorization
- Lack of consumer understanding
- Providers’ failure to diagnose accurately.

II. Recommendations

An overarching principle of all the recommendations referring to vulnerable populations is acknowledging that they are the best and most effective advocates and arbiters of their own care. Best practices must be based on their inclusion in decision making, standard setting, and quality improvement.

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5 Miller R and Luft H, “Does Managed Care Lead to Better Or Worse Quality of Care?”, Health Affairs, September/October 1997.
A. Recommendations from Other Report Sections Particularly Important to Vulnerable Populations

Like all health care consumers, vulnerable populations need appropriate quality care, reliable information, effective systems to resolve disputes and the assurance that there will be effective private and public sector oversight. However, in many cases the issues facing vulnerable populations are more complex and require special attention. Because of this, many of the recommendations made by the Task Force in other sections of this report have special relevance for vulnerable populations. What follows is a reiteration of those recommendations from other sections that have particular importance to vulnerable populations.

- Health plans should be required to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive an extended, prolonged, or permanent referral to a specialist. Such referrals should be conducted in a manner that maintains coordination of services (e.g., updating the PCP, sharing of medical records, agreeing on shared treatment plans, and agreeing on the respective roles of each practitioner). [Physician-Patient Relationship recommendation]

- Health plans and medical groups/IPAs should be required to enable consumers who are undergoing a course of treatment for a chronic, acute, or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan or medical group/IPA for other than cause (at the patient's option) to continue seeing their current providers until the course of treatment (or postpartum care) is completed, up to a maximum of 90 days or until the patient's condition is such that the patient may be safely transitioned to a new provider. [Physician-Patient Relationship recommendation]

- Health plans should be required to ensure that contracting health practitioners who treat commercial patients and who are at substantial financial risk (as currently defined by federal law) obtain stop-loss coverage, maintain sufficient reserves, or have other verifiable mechanisms for protecting against losses due to adverse risk. This provision should be administered in a manner that minimizes the administrative burden on physicians and plans to the extent possible. [Financial Incentives for Providers in Managed Care Plans recommendation]

- Sponsored purchasing groups, such as Pacific Business Group on Health, and accreditation organizations, such as National Committee for Quality Assurance, should review provider incentive compensation arrangements (including non-financial incentives) for the purpose of identifying best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment and compensation arrangements that continue to include rewards for quality care, consumer satisfaction, and other non-financial factors. [Financial Incentives for Providers in Managed Care Plans recommendation]

- The state entity for regulation of managed care should conduct a pilot project with a variety of health plans, their contracting medical group/IPAs, other provider groups, and consumer groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The entity should report results back to the Legislature to consider how best to approach provider group disclosure. [Financial Incentives for Providers in Managed Care Plans recommendation]

- California should stimulate action to adopt risk adjustment while maintaining patient confidentiality, where technically feasible. [Minimizing Risk Avoidance Strategies eight recommendations]

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6 Throughout this paper, the term "state entity for regulation of managed care" refers to DOC or its successor. In its plural form, state entity(ies) refers to DOC, DOI or their successor.
• State to create a “blue ribbon” public/private work group of major stakeholders to study and recommend changing the benefit language in health plan contracts. Benefit definitions should consider the needs of seniors, children, persons with disabilities and other vulnerable populations and should consider the objective of maximizing functional capacity and the inclusion of benefits to maintain function and to slow or prevent deterioration of function. [Improving the Delivery of Care and the Practice of Medicine recommendation]

• Health plans should incorporate provider pre-credentialing and the use of practice guidelines, clinical pathways, retrospective review (as opposed to prior authorization/concurrent review) and outcomes-based data into their established utilization monitoring processes. Processes should be developed based on statistically valid data on patterns of care and patient outcomes, or professional consensus, that are sensitive to the needs of various populations, including vulnerable populations. These data sets or professional consensus may then form the basis on which alternatives to prior authorization can be based. [Improving the Delivery of Care and the Practice of Medicine recommendations]

• The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group to develop a standard outline and definitions of terminology for Evidence of Coverage (EOC) and other documents to facilitate consumer comparison and understanding. The working group should include the major stakeholders. [Standardizing Health Insurance Contracts recommendation]

• The state entity(ies) for regulation of managed care should create and update at least annually a “standard product description” in a format to facilitate direct comparison of plans by consumers, designed with input from stakeholders, in as non-political a process as possible. The DOC should require plans to use the standard format to present information about any product they offer. This standard benefits characteristics document should include a statement on how drug formulary decisions are made; should describe key elements of the plan’s grievance procedure; should include independent “exit polling” information on number disenrolling and primary reasons for disenrollment; and should offer, for each plan or medical group/IPA with which the plan contracts, a brief but specific description of the referral and authorization process, and the process through which medical decision are made. [Consumer Information, Communication, and Involvement recommendation summary]

• Health plans must adopt best grievance practices, including having adequate internal systems and information to provide assistance which may be particularly important for vulnerable populations. Two pilot, independent external assistance or ombudsman programs should be authorized, and state funding should be secured. Such pilot programs should be used to assess how best to serve and educate consumers about external assistance and to complement existing resources. [Improving the Dispute Resolution Process recommendation]

• Plans should establish a governing body which is composed of at least one third member or enrollees and ensure that sufficient resources are made available to educate enrollee board members so that they can participate effectively. This committee(s) shall communicate and advocate for members’ needs and serve as a resource for the governing body and HMO/plan administrators. It shall be responsible for establishing mechanisms and procedures for enrollees to express their views and concerns about the HMO/plan, including the viewpoints of enrollees who are members of vulnerable populations. [Consumer Information, Communication & Involvement recommendation]

7 Throughout this paper, the intention of the Task Force is that stakeholders include consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.
B. Recommendations that are Specific to Vulnerable Populations

In addition to the recommendations made in other sections of this report, the Task Force makes the following recommendations that it considers critical to better understanding and meeting the needs of vulnerable populations in managed care settings.

1. The Task Force encourages purchasers to explore the feasibility of identifying and tracking the vulnerable populations among their membership, and reporting technologically feasible performance outcomes for these populations. Purchasers should work with DHS to determine how to develop most effectively the systems necessary to implement such identification, tracking, and reporting.
   
   (a) Purchasers should explore the feasibility of providing incentives for plans to implement effectively by withholding a percent of the premium and paying plans on a sliding scale based on performance.
   
   (b) Purchasers should explore the feasibility of developing common contract standards for plans to track, identify, and monitor performance outcomes for all vulnerable populations.

2. The Task Force encourages continuing DHS and other entities' efforts to study and pilot initiatives to assess the feasibility of the integration of acute, chronic, and long-term care services, as well as linkages to social services in the community for all plans.

3. The Task Force recommends that purchasers encourage those plans they contract with to work towards credentialing and certifying medical group/IPAs and providers based on their knowledge, sensitivity, skills, and cultural competence to serve vulnerable populations.

C. Application of Recommendations to the Medi-Cal/Medicare Populations

4. Resources should be provided to DHS to prepare annual reports for the Legislature and interested public on the quality of and access to care for Medi-Cal consumers and include the following topics:
   
   (a) A comparison of the performance of plans within each Medi-Cal managed care county as well as among counties
   
   (b) A comparison of networks among plans and between private pay and Medi-Cal commercial plans
   
   (c) A comparison of access, quality, and cost indicators for Medi-Cal managed care patients with privately insured patients in California
   
   (d) An evaluation of Medi-Cal consumers' (1) understanding of (2) use of and (3) access to managed care plans
   
   (e) An analysis of the effectiveness of translated materials and the ability of plans to serve multi-lingual and multi-cultural consumers
   
   (f) An analysis of provider continuity including analysis of impact of changes in Medi-Cal eligibility
   
   (g) An analysis of patterns of default and disenrollment

The Task Force supports DHS' ongoing efforts to assess the impact of Medi-Cal managed care on the public health system.

5. Resources should be provided to DHS to prepare a periodic report for the Legislature and interested public on the impact of Medi-Cal managed care on the capacity of the public health system and
other safety-net entities to provide care for uninsured patients. This should include county-by-county analyses of changes in access and quality for uninsured patients as well as analyses of changes in the institutional capacities of safety-net providers.

6. Resources should be provided to DHS to prepare a periodic report for the Legislature and interested public on the impact of Medi-Cal managed care on the capacity of public health entities to continue their work in population health including their capacity to track epidemiological trends and to do population-based health education.

The Findings Section was adopted 22-0 while the recommendations were individually adopted as follows:

Recommendation No.1 — Adopted 21-0
Recommendation No.2 — Adopted 22-0
Recommendation No.3 — Adopted 23-0
Recommendation No.4 — Adopted 17-2
Recommendation No.5 — Adopted 16-4
Recommendation No.6 — Adopted 16-4
Improvement of Managed Care Through Coordination and Integration: Case Study on Women’s Health Findings and Recommendations

I. Background
Managed care promises not only to contain health care costs, but to improve efficiency and enhance health status and consumer satisfaction through a focus on prevention and better integration and coordination of care. While many managed care organizations have successfully contained costs and have increased availability and coverage of routine care and preventive services, they have gotten mixed reviews from a consumer satisfaction perspective and have largely failed to achieve many promised improvements over traditional unmanaged fee for service (“indemnity”) plans, particularly in the area of coordination of services. Utilization patterns continue to reflect the “fragmentation” that managed care seeks to correct. This paper explores some of the challenges managed care plans face in addressing women’s health care needs, and suggest how coordination and integration in managed care could offer significant promise for improving health care for women.

II. Managed Care - Ideals and Challenges
As envisaged by the pioneering organizations, managed care offers the potential benefit of a coordinated system of health education, preventive care and treatment for illness. The overall premise is more proactive than that of traditional indemnity insurance: managed care plans seek to “optimize member health” rather than to simply treat members when they become sick. Experience to date has been mixed. Proponents of managed care point to success in the areas of cost savings, increased prevention and overall satisfaction levels similar to those of indemnity coverage. Critics point to vocal consumer dissatisfaction with specific elements such as coverage limitations, curtailment of access to specialists, and broader use of non-physician providers (i.e. licensed health professionals, operating within their scope of practice).

Different health care systems, insurers and clinical authorities define and provide coverage for primary care in varying ways. The Institute of Medicine’s definition of primary care, “integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” contrasts with the reality of most primary care provision in our current system.

Attempts to improve coordination and integration of care are appearing throughout the industry. One plan has developed an “adult primary care” model through which to coordinate more proactively the primary prevention and care needs of its adult member population. A similar focus on systematic management of chronic conditions in the member populations has become a common feature of managed care organizations through “disease management” programs which present a focal point within the plan for integration of multi-disciplinary expertise around common chronic disease states.

3 “Disease management, a term invented by the Boston Consulting Group in 1993, refers to a complete, systematic approach to treating chronic diseases to reduce complications, overall utilization and cost.”
III. Women's Health - Challenges for Managed Care

Women's health provides a very powerful example of the failings, some of the successes and most importantly the potential of the managed care system to provide the benefits of integrated care. While most observers agree that managed care plans have been very successful in making preventive care more broadly available, consumers and critics contend that the system remains difficult to access and navigate. Several specific realities of the role of women in the health care system highlight both the challenges and potential for an integrated system of care:

- Women are the primary consumers of health care. They are responsible for coordinating care for most children and elders as well as for themselves. Enhancements to access through initiatives such as expansion of primary care sites, extended hours and telephone nurse advice lines can significantly affect their experience of the health care system.

- Fragmentation in clinical practice between the reproductive and non-reproductive elements of women's primary care is a well-documented problem. This fragmentation poses serious challenges to accessibility and accountability, and results in duplicative visits for many women.

- Women live longer than men and have a higher incidence of chronic diseases such as osteoporosis, arthritis, diabetes, depression, multiple sclerosis, lupus, urinary incontinence, thyroid disease and breast and gynecological cancers, yet women have been the subject of far less clinical investigation. For example, a number of NIH funded studies on the prevention of cardiovascular disease in the 70's and 80's excluded women, despite the fact that approximately the same number of American men and women die of heart disease each year. The potential for improving clinical care for women through increased research, case management and chronic care programs is great.

- Policymakers, researchers and consumers have identified women's health as a significant issue and have delineated a number of areas in which plans could make specific improvements in both organization and practice. The subject of women's health is timely, and many have acknowledged that managed care organizations are well positioned to innovate in this area.

IV. Integration and Coordination in Women's Health

Integration and coordination challenges in women's health can be categorized or characterized in many ways. The following examples will explore challenges in coverage and benefit design, the consumer-provider relationship and access to/utilization of care.

A. Coverage and Coordination of Care

Women's health care services have historically been delivered in a fragmented manner, encouraged by several phenomena. Medical training and specialization has separated reproductive health specialties from primary care for women; public financing for reproductive health for low income women separates reproductive health issues from other primary care; and politicization of reproductive services has promoted organizational segregation of providers and sites of care.

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4 The principles and potential benefits of integrated care may be applied widely, such as to mental and physical health care and to medical, surgical and pharmaceutical treatments.
8 Rédy Kéch D, “The Health of Older Women in California,” California Women’s Health Project, CEWAER, June 1996, p. 15. Note: A woman is twice as likely as a man to die within a few months of a heart attack.
Much of the backlash against the broader managed care system has been directed at plans' use of the primary care "gatekeeper." The majority of managed care plans employing the gatekeeper model have not convinced consumers that the primary care provider is performing a coordinating function – the overwhelming perception is that the gatekeeper is a barrier to choice and access. (See the Task Force's Physician-Patient Relationship paper).

A number of states introduced bills under which managed care consumers would have the right to self-refer to some specialists. This legislation reflects a very real concern on the part of consumers and presents interesting challenges for managed care organizations committed to pursuing coordinated and integrated care and controlling costs. The most prominent example highlights the fragmentation between reproductive and other health services for women. In the case of direct access to obstetrician/gynecologists, certified nurse midwives and women's health nurse practitioners, the legislation represents consumer demands for comprehensive primary care from organizations ostensibly organized to provide this care through coordination and integration of appropriate resources.

Managed care has proven confusing to many consumers because of the broad variation in coverage and benefits. Results from the Commonwealth Fund survey indicated that many women (including between 7% and 15% of insured women depending on the specific service) do not seek basic, preventive care because they do not know whether their plan will pay for the services. One out of three insured women surveyed reported that cost was a barrier to use of preventive services. While HMOs help to reduce the cost barrier by minimizing copayments, lower income women who must cover copayments for multiple family members can face cost barriers even in an HMO setting.

Limitations on coverage for reproductive health services and mental health services represent two of the most significant barriers to improvement of the health status of women, and have been areas in which a great deal of the criticism of managed care has been focused. Demands for broader coverage of preventive services have often been countered, however, by lack of reliable outcomes measures and cost-effectiveness data for specific interventions. Development of a standard benefit package for primary, preventive care for women has been further confounded by leading authorities' variations in guidelines for screenings for services such as the Pap smear and clinical breast exam.

B. Coordinated, Integrated Care – Provider Issues

The relationship between consumers and providers of care remains the primary relationship in the health care system. Integration of providers and the population includes elements as diverse as training of providers, recognition of the qualities and capabilities of a diversity of providers and relationship of providers with the health plans with which they contract. As noted earlier, women's health – particularly women's primary care — presents some particular challenges for effective integration of providers and consumers. Studies show that women are more likely to receive primary care in a fragmented fashion (i.e. from both a generalist and a reproductive health specialist), to be dissatisfied with their provider and to request to switch physicians, usually over problems of communication.

C. Access to and Utilization of Care

1. Time and Cost Constraints

Time demands and constraints result in significant access issues for women: a 1994 study indicated that 29 percent of women 65 and under had not received care they knew they needed in the prior year due to

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time constraints. The availability of services at times and sites convenient to women is clearly an important factor in improving utilization of care. Cost of care is also a strong predictor of utilization. The same study indicated that one out of three insured women surveyed reported that cost (i.e. copays and/or deductibles) was a barrier to use of preventive services. While managed care plans generally have lower premium costs and out of pocket expenses than indemnity plans, cost remains a barrier to treatment for many insured under managed care plans.

2. Authorized Providers/Sites of Care

Because issues of reproductive health and social determinants of health (e.g. poverty and domestic violence) have been central to the development of the women's health movement, community health centers and reproductive health clinics have played an important role in providing services to women, and their important contributions as elements of a comprehensive primary care system have been noted by many. Selective contracting in managed care often overlooks these resources because they are seen as providers of free care or care duplicative of that offered by the plan's “provider panel.” According to a 1994 GHAA/Kaiser Family Foundation survey only 23% of HMOs “had a contract with a family planning or abortion clinic.” Over half of the remaining plans, however, indicated that they “intend to contract with such clinics in the future.” Studies show that women and their families continue to rely on these providers of care even when they are insured, because of their proximity to their homes, cost, availability of services not covered under their insurance, and concerns about confidentiality. Under the current system this often results in cost-shifting to publicly-funded clinics.

V. Conclusion

Effective integration and coordination of health care presents a significant challenge for those working to improve the managed care system. It is clear that the issues of integration and coordination of care commonly discussed in the context of managed care need to be broadened if they are to reflect the comprehensive health needs and health-seeking behavior patterns of women.

The “model” managed care plan would use demographic and encounter information to identify patients in need of specific care or services, conduct proactive outreach, offer preventive services with minimal cost sharing and consider whether and how the primary users of services – women – will access services once they are made available. Managed care organizations have begun to develop innovative approaches to the challenges of integration and coordination of care and should be encouraged to work in partnership with consumers, clinicians and other advocates for women's health to incorporate the diverse and important needs of women into these improvements.

Health care experts note that integration and coordination of care are very important attributes of an ideal health care delivery system, but they are difficult (if not impossible) to define in legislative language. Innovations in the areas of integration and coordination of care, therefore, are most likely to emerge from health care organizations working with member input to improve efficiency, effectiveness and member satisfaction.

VI. Principles and Recommendations

Specific recommendations for improvement of integration and coordination of women's health in the managed care system rest on several guiding principles.

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A. Principles

1. The managed care system will only deliver on its promise of optimizing member health while containing health care costs if it operates upon a foundation of coordinated, integrated care.

2. Comprehensive primary care addresses both biomedical and psychosocial factors in health and wellness.

3. Provision of comprehensive primary care and coordinated care of chronic diseases will improve health status and outcomes.

4. Women's utilization of primary and preventive care is highly dependent on accessibility. As women are responsible for coordinating care for both themselves and most dependents, managed care organizations must not simply offer services, but must consider when, where and by whom services are being offered if they wish to achieve the full benefits of these interventions.

B. Recommendations

The Task Force recommendations on consumer protection, consumer information, quality improvement and provider-patient relationships are particularly relevant to reducing socio-cultural and other barriers to health care for women. The following recommendations address coordination and integration of services as well as the need for more comprehensive health services for women, especially in the area of reproductive health.

1. Managed care organizations (MCOs) should be encouraged to coordinate and integrate care around the needs of members. Purchasers and accrediting organizations should work with advocacy groups to define member survey questions that measure the extent to which MCOs are effectively integrating and coordinating members' care, including services exclusive to women and incorporating measures of under and over-utilization. Because HEDIS measures are used widely by purchasers and consumers to assess health plan performance, the elements included strongly influence health plans' priorities in service delivery and quality improvement, and they serve as important leverage points for influencing both plan and provider behavior. MCOs should involve consumers and advocates in developing improved gender sensitive indicators for HEDIS and other quality improvement tools.

2. Recognizing that members, particularly women and adolescents, are likely to forego care because of issues of scheduling and confidentiality, managed care organizations should address these specifically as issues of access and should survey members to determine whether they feel that services are accessible and confidential.

3. When managed care organizations refer members to community-based clinics for services not available elsewhere within the plan (or recognize that many of their members are self-refering to these facilities), they should be encouraged to provide an option that allows reimbursement for necessary primary and preventive care delivered at these sites.

4. (a) Health plans should be required by the state entity responsible for regulating managed care to provide information on coverage and benefits to all plan enrollees (not only to the primary plan subscriber), upon request, to ensure that those plan members covered as dependents are aware of the services available to them.

   (b) This coverage and benefits information should include full disclosure of limitations on reproductive health services and referrals.

5. The division between primary care and routine reproductive care for women results in underutilization of necessary preventive services, fragmentation of services, unnecessary duplication
of services, inconvenience and cost for members and increased costs for insurers. To alleviate these problems:

(a) Primary care training programs should incorporate the full range of primary health needs of men and women, and should prepare practitioners or design practitioner teams to provide for the totality of these needs.

(b) Managed care organizations should ensure that primary care practitioners or teams made available to members are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. Managed Care Organizations should be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in the basic aspects of gynecological care such as breast and pelvic exam, contraceptive management, and initial management of common gynecological problems, as well as sensitivity to the unique needs and concerns of women.

(c) Plans shall be required to allow women direct access to their reproductive health care providers, be they physicians, nurse practitioners, certified nurse midwives, or other appropriately credentialed advanced practice professionals. The Task Force strongly urges plans to construct direct access arrangements in a manner that permits and encourages coordination and integration of services among an individual’s health care providers (e.g. provisions should be made to ensure that providers agree upon division of tasks/treatment areas, communicate their findings and treatment advice with one another, and update and share patient records) while maintaining patient confidentiality.

6. The Task Force encourages collaboration between the public and private sectors on development of consistent standards and evidence-based, gender-specific practice guidelines.

The Findings Section was adopted 19-0 while the recommendations were individually adopted as follows:

Recommendations No.s 1 through 5(b) — Adopted 18-0
Recommendation No. 5c) — Adopted 18-0
Recommendation No. 6 — Adopted 18-0
Academic Medical Centers
Findings

I. Introduction
The purpose of this paper is to document the trends and changes in health care delivery and managed care plans and how they have affected Academic Medical Centers (AMCs) and health professions education. While this paper focuses on the issues of physician education, the Task Force recognizes that managed care has had profound affects on how all health professionals deliver services and are, or should be, trained. The Task Force encourages the monitoring of the impacts of the changing health care system on the staffing needs, initial training, and ongoing professional development of the full spectrum of health professionals.

A. Role of Academic Medical Centers in the Health Community
California has eight allopathic medical schools and one osteopathic medical school. Five of the eight allopathic schools are part of the University of California (UC) system (UC-Davis, UC-Irvine, UC-Los Angeles, UC-San Diego, UC-San Francisco). The other three allopathic schools (Loma Linda, Stanford, and University of Southern California) and the osteopathic school (Western University of Health Sciences) are private. In the 1995-1996 academic year, the eight allopathic medical schools enrolled 4,366 medical students, and the osteopathic school enrolled 681 students. The five UC schools accounted for approximately 50% of first-year enrollees. In 1995, there were 645 allopathic residency programs in California, which enrolled a total of 8,678 residents, and slightly over half of these residents were enrolled in programs affiliated with the UC system. Although a great deal of training occurs in public hospitals, due to the complexity of obtaining financial data for the various teaching institutions, the Task Force narrowed its scope to focus primarily on the AMC-owned, university teaching hospitals. These centers include: UCLA Medical Center, USC Medical Center, University of California at Irvine Medical Center, University of California at Davis Medical Center, Loma Linda University Medical Center, UCSD/San Diego University Medical Center, UCSD/Lajolla Thorton Hospital, Medical Center at UCSF, and Stanford University Medical Center.

1. Education
One of the core missions of all AMCs is medical education and training. AMCs provide undergraduate and graduate medical training in a unique environment that brings together education with research and patient care. Although AMCs educate and train many types of health professionals, the focus of this report is on those activities that prepare individuals to practice medicine and/or conduct health-related research.

2. Research
The United States has been the world’s biomedical research leader over the past half-century and is home to the world’s leading experts in nearly all fields of biomedical research. The preeminence attracts scientists from around the globe to study and work at AMCs throughout the country. California’s AMCs have been both world and national leaders in ground-breaking research. In addition to the improvements realized in medical care, this investment has also fueled the growth of the biotechnology, pharmaceutical, and medical equipment industries. These are exceptionally high-value-added industries, which, for that reason, make a great contribution to the growth of the California economy.

3. Clinical Care
AMCs apply leading edge technology in the treatment of disease and serve as sources of clinical innovation for the rest of the industry. They operate as “centers of excellence” providing tertiary care to a more acute...
patient population, as well as providing a great deal of routine care. These centers provide a disproportionate amount of care to vulnerable populations and serve as part of the societal safety net.

B. Transition of Health Delivery System
AMCs are based in the most complex and specialized part of the delivery system. They make use of and develop the latest in medical technology, have traditionally valued the specialist over the primary care provider (PCP), and in the past their approach to the delivery of health care has been the least cost conscious. This orientation, if not addressed, sets them squarely on a collision course with the major transformation that is occurring in the broader health care system.

C. Concerns AMCs Have Related to Managed Care
1. AMCs fear loss of payment for public goods: Managed care, as the agent of major payors, is not willing to pay for certain public goods produced by AMCs. Concern exists that managed care organizations (MCOs) will not pay a premium to support education or clinical research.

2. Loss of payment for services: Managed care, the more competitive environment, and reduced payments by Medicare and Medicaid, have resulted in a decrease in the prices for services paid to AMCs.

3. AMCs fear loss of volumes: AMCs fear that lower referral rates from MCOs to AMCs for specialty care could lead to loss of revenues and patient volumes necessary to conduct training and research, although this has not been the experience in California so far.

4. Adverse selection: Patients most likely to stay with AMCs are those most dependent on their services; this group includes the indigent and those with highly unusual or costly tertiary care needs.

5. Loss of Disproportionate Share Hospital (DSH) funds: Medi-Cal recipients are being enrolled in managed care, and AMCs are often unable to compete for members who, for the first time, have a choice of health plan and delivery system. Enrollees may prefer to establish a relationship with a non-AMC provider, or they may choose to receive care at a facility more easily accessible. The voluntary and involuntary movement of Medi-Cal recipients from AMCs that receive Medi-Cal DSH funds and other traditional safety-net providers to non-safety-net providers reduces the financial resources of AMCs and other traditional safety-net providers. AMCs are concerned that the private providers may enroll the healthiest populations, leaving the sickest and most costly for the safety-net providers. Also, although recently reversed under the new Balanced Budget Act, AMCs experienced a loss of Medicare Graduate Medical Education (GME) funds when health plans received Medicare capitation payments based on a formula that included allowances for teaching hospitals, and failed to pass them through to the AMCs.

II. Findings
A. Health Profession Education
According to several leading authorities, too many specialists are being trained in California, as well as in other parts of the country. Under new legislation, the Health Care Financing Administration (HCFA) is now offering incentives to AMCs to reduce their residency programs, and this appears to be desirable public policy. Although some progress has been made in California towards shifting the primary care-specialist mix, overall the change has not been substantial. Stanford maintains a 71% specialist to 29% primary care ratio with no plans to adjust in the future. UC entered a voluntary agreement with the state to adjust the mix, but other California AMCs are not bound by this agreement. It would be beneficial if

4 Interview with Ann Dohn, Director, Office of Graduate Medical Education, Stanford School of Medicine, September 1997.
the leaders of California's AMCs would work together to develop an authoritative projection of physician personnel (and other health professionals) needs and a plan for adjusting educational programs to meet them.

Clinical education has traditionally taken place in the inpatient setting and clinics of affiliated hospitals. However, this no longer provides adequate preparation for practice as advances in medical knowledge and improved technologies have lowered hospitalization rates, reduced lengths of stay, and shifted care to ambulatory settings (outpatient departments and physicians' offices). Also, society's need to contain the cost of medical care and to produce more primary care physicians, with a focus on population-based medicine, requires greater student exposure to physician and public health practice in community and ambulatory sites, including managed care practice settings.

Although this section focuses on graduate medical education of physicians, many analogous observations would apply to the training of other health professional personnel. As the composition of non-physician health care personnel changes to reflect managed care's effort to cut costs while continuing to meet patients' medical needs, various professions will share some of the tasks that have historically been reserved for the physician. Training programs and demand for certain groups of health care providers, including advanced practice nurses and physician assistants have been increasing. Health care employers in California have indicated that they will significantly increase the number of advanced practice nurses they employ over the next several years. It will be important that educational programs, where possible, be integrated across professional communities to prepare PCPs, nurse practitioners, and physician assistants to work together collaboratively in primary care settings. This should occur through increased sharing of clinical training resources, more cross-teaching, more exploration of the various roles played by professionals, and the active modeling of effective team integration in the delivery of efficient, high-quality care.

B. Financing and Data
An appraisal of the financial impact of managed care is made difficult by the fact that the financial data of AMCs are incomplete and uncertain, and by the fact that change has been very rapid in the recent years, and that published data in recent years are not yet available. Mission-based accounting systems are not in place, identifying and tracking revenues and expenses related to education, research, and clinical care is not possible. Accounting systems are not centralized, so a complete assessment of the financial performance of the medical school, hospitals, and faculty practice plans proves difficult. Data do not exist that combines information from these various entities in a useful manner. Currently there are separate surveys of medical schools, faculty practice plans, and hospitals, and it is not possible to balance the accounts between these surveys. No California AMC publishes a consolidated statement of total revenues and expenses. Even within the different entities the data are often hard to understand. For example, faculty practice plan revenues have historically been unaudited and underreported, and billing systems have been maintained by individual departments.

In the past, AMCs used clinical revenues generated from hospital and faculty practice plans to cross-subsidize their teaching and research missions. A reasonable and probable inference from the available data is that the actions of managed care, in parallel with similar actions by Medicare and Medicaid, are reducing contract rates and squeezing the net income margins of AMCs, challenging their ability to continue to finance teaching and clinical research. AMCs recognize the need to make major changes to adapt to this new environment, and are working hard to make them. In recent years, they have taken many millions of dollars out of their cost structures. So far there have not been significant reductions of medical education, residency training, or clinical research in California.

5 UCSF Center for the Health Professions.
6 California Strategic Planning Committee for Nursing, Planning for California's Nursing Workforce, 1996.
7 Reuter, J, “The Financing of Academic Health Centers,” Georgetown University Medical Center’s Institute for Health Care Research and Policy, April 1996.
The education and appropriate training of medical providers is a public good. The financial support for medical education has never been clearly defined. To a substantial degree, the cost of medical education has been supported by clinical revenues through cost shifting. As pressure on reimbursement intensifies and clinical revenues are threatened, more discrete funding streams need to be identified. It is in the interest of the public to define the cost of medical education and to develop stable funding mechanisms for the continued excellence of medical education.

A major problem for managed care in California results from the fact that patients want access to costly therapies whose efficacy has not been substantiated by controlled clinical trials or other convincing evidence. New treatment modalities need to be evaluated rigorously, under carefully designed and controlled clinical trials, to establish whether they should be included in a standard of care. AMCs, in particular, have the capability to conduct such studies. When appropriate, managed care organizations and other payors should support such studies in order to identify which technologies do and do not contribute to patients' health. (Refer to Improving the Delivery of Care and Accountability in the practice of Medicine paper regarding coverage of clinical trials.)

Adopted by the Task Force 24 to 0.
Health Industry Profile

Findings

I. Introduction
California has led the profound and rapid national transformation of health care financing and delivery systems since the 1970’s. Although federal and state regulatory statutes facilitated some of the shift from traditional, unmanaged fee-for-service (“indemnity”) insurance to pre-paid managed care coverage, economic conditions and private market forces have driven the movement toward more cost-conscious, rationalized care. This paper presents the historical context of managed care and highlights key indicators of its tremendous and varied growth; provides a brief overview of the regulatory context; defines major industry terms, structures, and players; presents the primary challenges and objectives of the industry; and discusses current industry trends.

II. Historical Context of Managed Care
Health insurance became a large-scale enterprise during World War II. When wages were frozen and employers sought ways to attract employees, the government permitted employer-paid health insurance to be excluded from the wage limits and the taxable incomes of employees, effectively subsidizing insurance. Union activity also encouraged the growth of employer-provided health insurance. As coverage by private sector employers proliferated, the government also became a purchaser for its employees. From 1940 to 1970, the number of Americans covered for at least hospital expenses rose from approximately 9% to over 75% of the population.

Though widespread health insurance was welcomed by individuals, insurance companies, and providers, it added complexity to the marketplace by distorting the fundamental laws of supply and demand. Prior to the 1970’s, virtually all health insurance was based on the fee for service, indemnity approach, which basically operated as a “cost-reimbursement” model under which providers determined the cost of services. Physicians and other appropriately credentialed health professionals operating within the scope of their practice (“providers”) were not trained or encouraged to consider cost as a factor in treatment decisions, and the health care system did not encourage coordination of care among providers. Providers determined treatment levels and standards of care free from economic constraints, as fee-for-service enabled them to pass additional costs and “marginal” procedures and tests to price insensitive purchasers.

By 1970 expanding health care costs had become a national concern for employers, the government, and health care economists. Experts worried that if trends continued unabated, the national economy would suffer. In 1970, Dr. Paul Ellwood coined the term health maintenance organization, or “HMO” as part of his vision of a national strategy to solve America’s problems of uncontrolled health care expenditure growth, fragmentation and lack of accountability. Congress passed the HMO Act in 1973. The Act provided grant funding and a regulatory structure for the development of HMOs and required that companies with more than 25 employees that offered health benefits also offer the HMO as an option. Although HMOs grew in number and power after 1973, traditional indemnity coverage still dominated the landscape and health care costs continued to dramatically outpace inflation. Seeking to bring soaring health care costs under control, some employers proposed to continue to offer employees indemnity coverage but to do so with selective provider contracting and discounted fees. These arrangements ultimately resulted in legislation authorizing preferred provider insurance (PPI); the other main form of managed care. It was not until the late 1980’s that the cost pressures on employers and government really forced a proliferation of managed care across the nation. As managed care has expanded and become a fact of life for a large percentage of the population, regulatory interest and activity have intensified.
III. The Regulatory Context of Managed Care

The California Legislature has instituted government regulation of health care coverage through two major bodies of law, which are enforced by two governmental Departments. The Insurance Code provides a regulatory framework for indemnity insurers and “preferred provider organizations,” and is enforced by the Department of Insurance (DOI). The Knox-Keene Act, a portion of the Health and Safety Code, governs health care service plans and is enforced by the Department of Corporations (DOC).

These and other government agencies also regulate health professionals, facilities, and other health insurance arrangements. Under the present regulatory structure, however, there is no direct regulation of many medical groups/IPAs by a government agency. Rather, most medical groups/IPAs are regulated indirectly by the Knox-Keene plans with which they contract as a requirement of the health care service plans’ licensure. Medical group/IPAs wishing to accept fully capitated contracts must receive “limited licensure” from the DOC, which requires meeting Knox-Keene standards. Hospitals in California are regulated at the federal, state, county and city level by multiple entities and organizations.1

The private sector supplements these state and federal regulatory functions through a variety of quality measurement and accreditation organizations that assist employers and consumers to evaluate their purchases by providing information. Their efforts, as well as those of their counterparts that are internal to managed care organizations, are intended to be used by providers, provider groups and plans to improve quality of care and service. In addition, large purchasers, including government, can use their substantial negotiating power to positively influence the health care system, in particular by providing consumers with the ability to choose the best value plan for their needs, through appropriate information, incentives and choices. Please see the Task Force Report “Government Regulation and Oversight of Managed Health Care” for a comprehensive discussion the regulatory environment of health care in California.

IV. Major Industry Terms and Structures

Regardless of where they fall on the health care financing and delivery continuum, all managed care organizations employ techniques to control costs and quality, including but not limited to: selective provider utilization management/review, contracting, negotiated fees, quality management and enrollee incentives. Managed care spans a broad range of coverage types and employs varied techniques to encourage cost-effectiveness.

A four-tiered structure characterizes the general financial, service and information flow through the health care delivery system: the “purchasers” control the market share of the various delivery systems and contract for coverage of their enrollees, or “consumers”, who ultimately receive care. The “payer” type determines how restrictive use of “providers” will be: indemnity insurance restrictions are limited to malpractice issues, community medical standards and technological developments; PPI uses very limited contractual constraints in addition to those identified in indemnity insurance; Point of Service (POS) encourages strong loyalty to an HMO panel of providers while retaining the option for choice; HMOs restrict consumers’ covered care to a specified network of providers.

A. Purchasers

Traditionally, there have been three main purchasers of health care: the government, employers and individuals. More recently, purchasing groups have become a significant force in the market. The past two decades have been characterized by rapidly escalating health care costs, an aging population and expansion of the number of people covered under federally subsidized programs. These developments have resulted in government assuming the responsibility for an increasing portion of the nation’s total health care costs. In 1994 government-sponsored programs such as Medicare and Medi-Cal accounted for about

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1 For example, one California hospital provided a list of 17 federal and 27 state agencies and organizations that had some regulatory or oversight authority over it in 1997.

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41% of California's total health care expenditures of $105.3 billion.² (During this same year the total health care expenditures by California employers were $35.3 billion, or 34% of the total).³ These figures include coverage for public employees, who constitute another major sector of government-sponsored health care spending. In California, an increasing portion of government health care dollars are going to managed care organizations. For example, as of October, 1997, 40% of Medicare beneficiaries in CA were enrolled in managed care plans.⁴ The Medi-Cal program has also exhibited a notable trend toward managed care coverage. From January, 1995 to January 1997, total Medi-Cal enrollment decreased from 5.46 million to 5.30 million. During the same time period, the percent of Medi-Cal enrollees covered by managed care plans increased from 17.1% (93 million) to 28.5% (1.51 million).⁵ This trend continued through the most recent data collection period, with 1.86 million, or 36.3% of Medi-Cal enrollees in managed care plans in July of 1997.⁶

Although the majority of health insurance coverage in the United States has historically been linked to employment, increases in health care costs have helped prompt both a change in the type of employer coverage — changing eligibility rules for employees or shifting a higher percentage of costs to employees — and a decrease in the overall percent of citizens receiving coverage through private sector work. The percent of the national employment pool offered health care coverage dropped from 81% in 1995 to 78% in 1996.⁷ Private employers provide health coverage under three primary arrangements: through a third party payer, through “self-funding” coupled with the services of a third party administrator, and through pooling of buying power by joining a purchasing coalition. The smallest proportion of purchasers are those individuals who purchase individual insurance directly from a health plan because either they do not have access to, or do not use, public or employment-based coverage. Issues of economies of scale, differential negotiating power, adverse selection and tax policy have thus far limited the growth of individual purchase of coverage.

The percentage of Californians without health insurance of any kind has increased steadily over the past several years. California’s employer-sponsored insurance levels are below national levels, and its Medicaid and uninsured rates are significantly higher. From 1988 to 1994, the percentage of Californians with no health insurance increased from 17% to 20% and the percent receiving coverage through Medi-Cal rose from 7.1% to 11.3%.⁸ An increasing number of working Californians are without insurance, mirroring national trends. The cost implications of increased voluntary participation in health insurance reveal a situation that is unlikely to be easily remedied. Premium costs for a comprehensive health plan represent 15% of income for an individual at 200% of the poverty level, and over 60% of uninsured Californians have incomes below this level.⁹

B. Payers and Providers
Payers are the traditional indemnity insurers and newer managed care plans, and providers include physicians, other appropriately credentialed health professionals operating under the scope of their practice, hospitals, acute care centers, community health centers, clinics and ancillary service suppliers. Reimbursement mechanisms between payer and provider represent one of the key distinguishing features both among health plans and among the different types of HMOs. Reimbursement can be tied to many factors, including volume and quality, and occurs on two levels, from the payer to the provider group and from the provider group to the individual provider level. Among other factors, the five commonly recognized

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³Ibid.
⁴Interview, HCFA Office of Managed Care.
⁵Interview with CA Department of Health Services, Medi-Cal Managed Care Division.
⁶Ibid.
⁷Factors seen as contributing to this trend include a shift in the employment base toward service rather than production jobs, a shift to smaller companies and more work by independent contractors. The percentage of US workers offered health insurance increased from 74% in 1993 to 81% in 1995 before dropping in 1996.
⁹Ibid.
HMO models — staff, group, IPA, network, and hybrid — generally differ in their provider level reimbursement arrangements.

Medical group/IPAs have become an increasingly important force in managed care in California. The prevalence of groups has increased and group sizes have grown; some groups now bear a considerable amount of risk and retain increasing authority over utilization and treatment decision-making. Medical group/IPAs represent a broad and constantly changing range of financial and organizational models; elements of which have implications for such activities as access to capital, physician incentives and relationships with other entities in the health care delivery system. Groups have increasingly invested in the information systems and quality programs that could prove prohibitively time consuming and expensive for individual physicians.

Since the advent of competitive managed care, the hospital industry has responded with consolidation and closure of hospital beds. Some hospitals have gone out of business and a substantial number of beds have been closed. While excess bed capacity remains in some areas, others face bed shortages, particularly in intensive care and emergency units.

C. Consumers

Consumers represent the third tier of the system. Historically, consumers have had very limited direct influence on health plan or provider service structure, and very little voice in plan decision-making. Nationwide legislation designed to strengthen the position of the consumer in the health care system and to improve consumer access to health care system information introduced across the country over the past several legislative sessions, however, points to the increasing concern over and interest in the rights of consumers in the managed care system. Consumer feedback mechanisms in plans and provider groups are in their formative stages; their strength varies and is often limited. (Refer to the Task Force Report on Consumer Information, Communication and Involvement.)

V. Primary Challenges and Objectives/Performance Measurement

The primary challenge the health system faces is in meeting the health needs and improving the health status of the population. Proponents of managed care believe that this challenge can be met by integrating a broad range of previously independent entities to provide high quality, affordable and accessible care. Although indemnity plans are integrating various components of health care financing and delivery, at the HMO end of the delivery continuum, plans are organized to address the various forms of integration more systematically. Many are attempting to integrate institutions, purchasers, providers and members, with the goal of aligning incentives and operating systems.

The issue of cost and quality measures for California health plans is addressed specifically in several Task Force papers, including: Impact of Managed Care on Quality, Access and Cost; New Quality Information; Consumer Information, Communication and Involvement; and Regulatory Organizations.

One issue of interest in California and across the country is the use of the “medical loss ratio” (MLR) in health plan expenditure comparisons and reporting. The medical loss ratio theoretically describes the fraction of total premium revenue that health plans or financial intermediaries devote to clinical services, as distinct from administrative services and profit. This measure is of obvious interest to insurers, providers, payers and consumers, but it has come under significant criticism. While standardized accounting procedures for hospitals have been developed and mandated by the federal and state governments, there is no established standard categorization of expenses or accounting practices under which plans must report medical loss ratios. Observers note that in practice purchasers, providers, consumers, investors and regulators interpret and respond to the MLR in very different ways. The MLR measures the distribution of

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11 Ibid., p. 176.
revenues among administrative and clinical functions. As organizations define and account for these functions very differently, the resulting MLR can vary significantly according to the plan’s provider arrangements, diversity of product offerings, range of buyers to which it markets and number of locations in which it operates.12

VI. Industry Trends

A. The Delivery System

Managed care organizations’ efforts to drive excess cost out of health care have affected, among many other things, the utilization of hospital beds and the overall volume and composition of the physician supply. The reduction of hospital bed utilization in California has mirrored the national trend, but well surpassed the national average. As managed care organizations have emphasized prevention and health promotion and have sought to match contracted physician supply to the needs of their enrolled populations, the HMO industry’s demand for primary care providers (PCPs) has increased and specialists have faced a tighter market for their services. The composition of non-physician health care personnel has also changed as organizations have attempted to cut costs while continuing to meet patients’ medical needs. While many support the use of non-physician providers in roles for which they are licensed and credentialed, some consumers and industry observers have voiced concern that use of lower skilled personnel may result in inferior care.

Training programs and demand for certain groups of health care providers, including advanced practice nurses and physician assistants have been increasing. Health care employers in California have indicated that they will significantly increase the number of advanced practice nurses they employ over the next several years. Recent legislation, however, has created regulatory impediments to full participation of non-physician providers in primary care activities for which they are licensed and credentialed.13

It is generally acknowledged that while managed care organizations have broadened access to services (i.e. have included coverage for some mental health and substance abuse services in standard benefit packages), they have placed stricter limits than are customary under indemnity plans on provider choice and on the volume of reimbursable services. Recent studies have indicated several general trends in mental health coverage under managed care in both the public and private sectors: a decrease in the total cost of mental health care coverage; a decrease in the amount of inpatient utilization and a substantial increase in outpatient utilization; and an increase in access as measured by total number of users.14,15 Many organizations treat these services as “carve outs” and subcontract with specialty groups to develop networks and administer benefits. While some believe that specialized providers are better able to address mental health issues and offer a broader range of settings and providers, others feel that the “carve out” model makes it difficult to treat the consumer’s health care needs in a holistic fashion. Behavioral health and health promotion activities have become “mainstream” managed care features and are being incorporated into standard medical training and practice. Clinical practice in these areas relies on multi-disciplinary teams, requiring physicians to work collaboratively with allied health professionals. While there is general recognition of the need to integrate acute and long term health services, the difficulties in coming to agreement on financing have prevented the integration of long term care services into the standard package of benefits, leaving long term care primarily as a government responsibility once an individual’s assets have been spent down.

12 Ibid., p.179.
13 Knox-Keene language refers to primary care “physicians,” rather than providers, creating barriers for qualified advanced practice nurses to serve as primary care providers in managed care plans.
15 Institute for Mental Health Services Research, 1997, presentation to California Mental Health Directors Association.
B. Industry Structure/Mergers

The managed care industry was characterized by expansion until the late 1980’s and early 1990’s when widespread merger activity and industry consolidation among the larger players began. While the payer/HMO and hospital consolidations have been attracting the most attention, mergers are occurring in all tiers of the health care industry. In the late 1980’s, managed care coverage was fairly extensive and HMOs were concerned that growing competition would erode their profit margins. Large, publicly traded HMOs sought to assure earnings growth through cost-cutting and entering less developed markets. Most industry observers agree, however, that despite significant merger activity, there is still a great deal of competition among health plans in all but a few rural areas where competition has always been a problem. There has been concern, however, that in certain instances unequal negotiating power and the dominance of large entities in particular market segments may be anti-competitive.

As HMOs’ buying and selling power increased, hospitals, medical groups, IPAs and purchasers began to consolidate as a defensive measure to protect their margins and premiums. Provider consolidations, including both hospital and medical group/IPAs, have largely followed the “horizontal merger” pattern. These horizontal mergers may cause antitrust concern in the industry. Vertical mergers combining hospital and medical group/IPAs have become more prevalent. The figure on the following page provides an illustration of consolidation in the California HMO marketplace during the 1990s. (Similar illustrations of merger activity in the medical group/IPA and hospital markets are included as attachments to the Health Industry Profile background paper.)

CA HMO Consolidation – 1990-1996
(For Illustrative Purposes: Not Comprehensive)

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Source: Interstudy Competitive Edge Survey, 2.2 and 7.1. Membership figures are for all products, statewide. Note: Data from July 1996; changes since then not reflected. Foundation and HSI have merged to become HSI; PacifiCare acquired FHP in 1997; and Blue Shield acquired CareAmerica Health Plans.

C. Tax Status

Historically, insurance plans and delivery system HMOs were non-profit for several reasons. Physician-driven organizations did not need access to private capital markets and preferred an organization dedicated to “public benefits” rather than to “shareholder benefits.” US hospitals have historically been not for profit as well, a fact that has been seen as appropriate to their charitable purpose. The majority have been.

By the 1980's and early 1990's when widespread merger activity and industry consolidation among the larger players began.
government-owned or owned and operated by religious organizations, and the remaining private hospitals were largely built with government funds through the Hill-Burton program. The government continues to subsidize hospital construction through tax-exempt bond financing.

Although a few large non-profits may have enough internally generated revenues or market power to compete effectively while staying non-profit, most do not. For these smaller organizations, nonprofit status has become increasingly difficult to maintain because they lack access to capital critical for growth.\(^{17}\) For-profit status is becoming increasingly more common in CA and across the nation.

One facet of the increasing media backlash against managed care in recent years has been the perceived negative effects of consolidation, especially as for-profit HMOs merge with non-profits. Critics of for-profit medical organizations are concerned that they will not care for vulnerable populations or the poor or uninsured as well as non-profits. As a matter of tax law, not-for-profit health care organizations must, in return for their tax benefits, dedicate themselves to some form of “public benefit” or “social welfare” goals, which are sometimes referred to as “community benefits.” There is no such obligation imposed on for-profit health plans (which pay corporate taxes). Advocates of for-profit control assert that non-profits enjoy a “halo” effect that is not justified by their commitment to community benefit services.\(^{18}\)

A number of studies comparing performance of for-profit and not-for-profit organizations in health care have been conducted. Studies of private quality and satisfaction surveys of plans have found that non-profit plans have been disproportionately represented at the top of HEDIS and independent publications’ rankings.\(^{19}\) A Kaiser Family Foundation study examined public opinion on several factors in for-profit and non-profit health plans and hospitals using two surveys conducted in March and August of 1997. The March results indicated that Americans thought that for-profit providers offered higher quality care and were more responsive and efficient than non-profits. By August, public opinion on quality and responsiveness had leveled off, while the majority still perceived for-profit organizations as more efficient than non-profits. Non-profits were ranked more favorably than for-profits on being “more helpful to the community” and “costing consumers less.”\(^{20}\) A HCFA review of disenrollment rates from Medicare risk contracts found that the five HMOs with the highest disenrollment rates were for-profit HMOs and the five with the lowest rates were nonprofit HMOs.\(^{21}\)

As non-profit to for-profit “conversions” through merger or organizations’ decisions to change tax status continue, both the body of literature discussing the relative merits of the two types of health care organizations and studies comparing for-profits and non-profits have become more prevalent.\(^{22}\)

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Adopted by the Task Force with 23 affirmative votes.

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\(^{17}\) HMOs need capital to finance their past and future growth and assure that they are able to maintain broad, attractive networks. Some scholars have recommended providing non-profit HMOs with access to alternatives to equity capital to limit the pressure to convert to for-profit status.


\(^{18}\) Hasan M in Gray, BH, “Conversion of HMOs and Hospitals: What’s At Stake?,” Health Affairs, March/April 1997, p. 34.


\(^{20}\) Kaiser Family Foundation Survey, March and August 1997 as reported in Harvard Health News Index.


\(^{22}\) See Health Affairs 16:2, March/April, 1997 for several articles on hospital and health plan tax status conversations.
Impact of Managed Care on Quality,
Access and Cost

Findings

I. Introduction
Early signs of managed care have existed in California for decades. However, managed care has grown faster and farther in recent years, causing rapid change in the areas of quality, access, and cost.

II. Impact of Managed Care on Quality
Quality has been defined variously by different individuals and organizations.1 Some define quality in terms of the outcomes that quality care should efficiently and effectively provide. Others have simply defined quality as “doing the right thing right.” Though not current and not entirely specific to California and therefore difficult to draw conclusions from with certainty, the best scientifically valid and available evidence suggests that health maintenance organizations (HMOs) have improved quality in several areas, but that there are also some areas of concern. Patients and providers (e.g., physicians and other appropriately licensed health professionals operating within their scope of practice) alike are concerned that certain aspects of quality have suffered as a result of managed care.

According to available research, there is no “winner” between HMOs and traditional, unmanaged, fee-for-service “indemnity” plans. Certain empirical studies have demonstrated that quality of care under HMOs is often found to be the same or better; others suggest that care has been worse.2 In addition, managed care and indemnity are not monoliths. Each consists of high, medium, and low quality organizations and individual providers. Nor should the results of studies related to HMOs be generalized to all forms of managed care, which include preferred provider organizations that often have much in common with indemnity plans. Several studies point to specific areas of quality concerns in HMOs including the chronically ill elderly and chronically ill poor,3 shorter lengths of stay,4 and detection and treatment of mental health.5,6 Most studies of customer satisfaction of the insured adult population conclude that Americans are generally satisfied with their health care coverage and the quality of their care, regardless of type of plan.7,8,9,10 However, there is variation in satisfaction among plans within plan model types, and for some populations and some measures satisfaction is lower (See also Task Force paper on Public Perception and Experiences with Managed Care).

Several quality-enhancing activities are associated with the best practices of managed care. They include quality measurement, quality improvement, process improvement, provider profiling and publishing provider outcomes measures, continuity and coordination of care, disease management, prevention and

2 Miller R and Luft H, “Does Managed Care Lead to Better or Worse Quality of Care?” Health Affairs, 16:5, September/October 1997, 7-25.
3 Ware J, et al., “Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results From the Medical Outcomes Study.” JAMA, 276:13, October 2, 1996, 1039-47.
6 Wells K, Hays R, Burnam M, Rogers W, Greenfield S, Ware J, “Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-for-Service Care: Results From the Medical Outcomes Study.” JAMA, 262:23, December 15, 1989, 3298-3302.
health promotion, early diagnosis, reduction in treatment variation, concentration of volume sensitive procedures in high volume centers, and rewarding quality. Many of these activities have been driven by purchasers and not the organizations themselves. Not all managed care organizations have embraced them or embraced them all. None of these activities are sufficient in and of themselves, but must work together with other elements to improve quality.

III. Impact of Managed Care on Access

Access is a multi-faceted issue, and the story of access under managed care is one of trade-offs. HMOs have generally improved financial access to insurance and care. Lower HMO premiums keep coverage more affordable for more people. Modest copayments and no deductibles make care at the point-of-service for those covered generally more affordable. In addition, HMOs provide access to certain benefits, such as prevention and health promotion, which were not typically covered benefits in unmanaged products.

Despite lower overall costs generally, the number of uninsured continues to be high. Despite the lower proportion of total health care costs born by consumers, some consumers perceive their costs going up because their employers have shifted responsibility for additional costs to them directly. In fact, employer-paid benefits come out of employees' total compensation, at least in the long-run, but this is an economic principle that consumers do not generally recognize. While employee out-of-pocket costs have increased, these cost increases would likely have been greater in the absence of managed care.

The flip-side of greater financial access is tighter restrictions on access to providers and services. Because HMOs require lower cost-sharing in general than non-HMOs, demand for services increases, requiring HMOs to restrict services based on need in order to control costs. Closed-end HMOs restrict choice of providers to those within their networks. At-risk HMOs and their contracted medical groups and IPAs also apply greater restrictions on access to providers and services as they attempt to manage utilization and prevent unnecessary care. According to some, additional access concerns under managed care include formulary restrictions, mental health services restrictions, and lack of insurance coverage in rural areas. Enrollees of managed care plans, especially vulnerable populations, also report greater unmet medical needs than in unmanaged plans.

IV. Impact of Managed Care on Cost

Driven by purchasers, competition, and threat of legislation, managed care has slowed the rise in health insurance costs. Nationally, costs of employer-sponsored premiums increased by 11.5% overall in 1991. Increases fell steadily to a 0.5% increase in 1996, with a slight upturn in 1997 to a 2.1% increase, about

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25 Boyle P and Callahan D, “Managed Care and Mental Health: The Ethical Issues,” Health Affairs, 14:3, Fall 1995, 7-22.
the rate of inflation. Recent reports suggest that premium prices are expected to increase more in 1998, though less so in California than elsewhere.23

According to HMO self-reported data, average premiums in California increased for families by 17.3% and 6.6% for individuals in 1992 (See Background Paper, Figure 1).24 Since then, premiums have increased at a much lower rate or decreased through 1996. Since 1992, year-to-year changes in average premiums have been better than the national average (See Background Paper, Figure 1). In addition, with increased managed care enrollment, all sectors in California for which data is available also show reductions in the rate of premium growth (See Background Paper, Figures 2-5).

A 1997 study by The Lewin Group estimated the amount of savings resulting from managed care.25 Based on their own and more conservative Congressional Budget Office assumptions, the Lewin Group found that total national savings attributable to managed care in 1996 was between $23.8 and $37.4 billion. Total savings over the 1990 to 1996 period were between $116 and $181 billion. For California, savings in 1996 were between $5.5 and $8.6 billion or between 15% and 23% of total premiums. Total savings over the 1990 to 1996 period were between $28.4 and $44.3 billion.

Information about the cost structure underlying insurance premiums suggests that California generally has a lower cost structure than the nation on average (See Background Paper, Figure 6). Variations in utilization of hospital days and visits among California medical groups may suggest continued room for improvement. According to medical group data, the least efficient medical group typically uses twice the resources of the most efficient medical group (See Background Paper, Figure 6).26 Improvement in the least efficient groups could reduce costs considerably. Further improvement, however, may not be easy. Efforts such as fall prevention and disease management require sophisticated team-based care management that is not well-developed in all HMOs or model types.

Managed care may also impact important non-economic factors such as uncompensated care and emerging clinical research which should also be considered in an evaluation of impact on costs. However, no empirical evidence is available in these areas.

Adopted by the Task Force with 25 affirmative votes.
Letters Submitted by Task Force Members Pertaining to the Task Force and its Findings and Recommendations

Pursuant to Standing Rule No. 4.5 [adopted November 21, 1997], these letters will be included in the Main Report Volume of the Task Force report mandated by AB 2343 [Chapter 815, Statutes of 1996].
December 19, 1997

Alain Enthoven, Chairman
Managed Health Care Improvement Task Force
1400 Tenth Street, Room 206
Sacramento, CA 95814

Dear Chairman Enthoven and Task Force Members:

This letter will focus on government regulation -- but this focus should not be interpreted as an unqualified endorsement of the remaining report. I would be remiss if I suggested that we have done enough -- that the Task Force recommendations should be the final word to guide us on managed care reform.

Although the Task Force took the important step of publicly acknowledging the need for a new entity to regulate health plans in California, I believe we missed a tremendous opportunity by not making a decision as to what type of leadership should be in charge of that new entity. I argued for a board structure -- five or more individuals, appointed by the Governor and Legislature. My proposal is grounded in the belief that a board would provide the necessary stronger oversight, greater accountability, diversity, and stability to the regulation of managed care. I believe it is critical to have a strong board to oversee this complicated industry in order to protect the interests of health care consumers in California.

While I reiterate that the report does not go far enough, I hope that by expressing my views at this time they will get consideration in future debates.

Sincerely,

[Signature]

Martin Gallegos, D.C.
Chair, Assembly Health Committee
December 19, 1997

Alain Enthoven, Chairman
Managed Health Care Improvement Task Force
1400 Tenth Street, Room 206
Sacramento, CA 95814

Dear Chairman Enthoven and Task Force Members:

This letter will focus on binding arbitration -- but this focus should not be interpreted as an unqualified endorsement of the remaining report. I would be remiss if I suggested that we have done enough -- that the Task Force recommendations should be the final word to guide us on managed care reform.

Many health plans utilize binding arbitration to settle disputes with enrollees. These health plans generally require enrollees, as a condition of enrollment, to waive their right to go to court if a dispute arises. While there is some disagreement as to whether health plans should be allowed to force enrollees into arbitration in the first place, I think that once a dispute is in arbitration, there is (and should be) an expectation of a fair, speedy, and less costly (compared to litigation) resolution.

With these goals in mind, I submitted specific recommendations to the Task Force. Several of these recommendations were adopted, but I think the Task Force should have gone further to require that arbitrations be independent of health plans and to prohibit health plans from forcing enrollees to utilize a costly and time-consuming three-arbitrator panel to settle disputes over $200,000.

1) Require that arbitrations be independent of health plans.
This recommendation seems simple enough. How can an arbitration be fair if one of the parties (the HMO) controls the process? There are only a few health plans that do not use independent arbitrations. It is difficult for me to understand why some members felt they did not have enough time to study this issue. There was some suggestion that independent arbitrations would limit the choice of arbitrators, but I disagree and see this argument as a smokescreen clouding the real issue of fairness.
Chairman Alain Enthoven and Task Force Members
Managed Health Care Improvement Task Force
December 19, 1997
Page 2

2) Prohibit health plans from forcing enrollees to utilize a costly and time-consuming three-arbitrator panel.

Again, a seemingly simple recommendation. Current law provides for a single neutral arbitrator in disputes of $200,000 or less. If the parties agree (e.g., if the case is particularly complex), a tripartite (three-arbitrator) panel, or other multiple arbitrator system, may be used. I argued for eliminating the $200,000 threshold because requiring more than one arbitrator unfairly disadvantages enrollees. If there is a single arbitrator, both parties split the cost of that person’s time. In a typical tripartite panel, both parties split the cost of the one neutral arbitrator, while each party must pay the full cost of an additional arbitrator. Tripartite panels also increase the likelihood of delays. It’s simply more time-consuming to arrange for the appointment of, and coordinate the schedules of, three individuals versus one individual. There are certainly going to be times when the complexity of a case would benefit from a tripartite panel, and my proposal factors this in by allowing for the single arbitrator requirement to be waived by agreement of both parties.

While I reiterate that the report does not go far enough, I hope that by expressing my views at this time they will get consideration in future debates.

Sincerely,

[Signature]

Martin Gallegos, D.C.
Chair, Assembly Health Committee
MINORITY REPORT
ON THE
STANDARDIZATION OF BENEFITS

As part of its majority report, the Managed Health Care Improvement Task Force has adopted recommendations pertaining to the standardization of health plan benefits and contracts. While the background paper suggests that the primary purpose of standardized benefits packages is to allow employees of a particular employer to select from among competing plans in a way that allows for value comparisons, the recommendations do not reflect that intent. Instead, the recommendations call for the creation of standardized benefits and contracts for use in the individual market, where no single plan sponsor exists, and in the small group market, where existing law would make use of these standard packages difficult and where employers are less likely to offer multiple options of the same plan type.

The majority’s recommendations would lead toward standardization of benefits in the marketplace, curtailing innovation and choice, and would burden plans with the unnecessary administrative mandate to provide written comparisons of the plans they offer with one of the standard packages. Consequently, the undersigned members of the Managed Health Care Improvement Task Force respectively disagree with the most of recommendations in the paper titled, “Standardization of Benefits.”

ISSUES
The majority paper recommends creation of up to 20 standard “reference packages,” or standardized benefits and contracts for optional use in the small group and individual markets. Because health care service plans must, by law, provide very comprehensive coverage with modest copayments, these standard reference packages are likely to vary only with regard to ancillary benefits such as durable medical equipment, prescription drugs, chiropractic, acupuncture and mental health coverage. For many individuals and small employers, coverage above the statutorily mandated package is a luxury.

Large Employers
Standardization is most common among large employers that offer multiple plans. When a large employer offers several different health plans to its employees, offering a standard set of benefits—with the same benefits, copayments and exclusions—allows employees to
make clearer price and quality comparisons of the various health plans. Without standardization of the benefit package, for example, employees would have to try to determine whether a plan with a $5 copayment and a limit of 30 physical therapy sessions is a better value than a plan with a $3 copayment and a limit of 40 physical therapy sessions. Thus, standardization within an employer group is appropriate.

Small Employers
The majority’s recommendation is not likely to have impact in the small group market because the laws pertaining to the small group market discourage health plans from offering a large number of benefit packages to small employers. Under the small group law, a health plan must fairly and affirmatively offer, market and sell all of the plans offered in the small group market to all employers in the small group market. Offering many small group plans is administratively costly. Plans would be unlikely to adopt these new standardized package if existing packages were successful in the marketplace and purchasers did not want those existing packages withdrawn or changed.

Individual Purchasers
The majority paper cites the standardization of Medicare supplement products as an example of successful standardization of benefits in an individual market. This comparison is not relevant to the under-65 market. Medicare offers a standardized set of benefits. Medicare supplement policies are designed to fill in the coverage gaps left by Medicare and, given Medicare’s broad range of coverage, are relatively narrow in terms of their areas of coverage. The standardization of Medicare supplement policies occurred because some sellers of Medicare supplement products sold overlapping products to vulnerable, uninformed senior citizens. The standardization of Medicare supplement policies corrected these abuses. No such abuses have occurred in the individual market because individuals tend to purchase one policy that includes all the coverage they want. In addition, individuals are not faced with a government-sponsored program that does not adequately cover certain forms of care.

The majority paper also recommends that plans be required to publish, presumably in a plan document, and provide upon request statements that explain how a plan’s benefit package differed from one of the standard reference packages. Currently, plans offer multiple benefit packages, which they may further customize for particular employers. The Task Force’s proposed requirement would result in health plans having to produce hundreds of comparison statements for disclosure to employees of employers who specifically requested the customized benefit package that varies from one of the standardized package—even though the package was specially requested and the
employees do not have access to any of the standardized packages. We fail to see how this burdensome administrative requirement would benefit consumers.

The standard reference packages are to be created by a working group that will, out of necessity, have to make political compromises to satisfy provider demands, interest group requests, consumer preferences and employer cost constraints. These packages are not likely to have any more validity in the marketplace than the packages currently offered in the marketplace today.

CONCLUSION

Given the regulatory nature of the recommendations, particularly the comparison statement, the creation of up to 20 standard reference packages for optional use in the marketplace is likely to lead to standardization throughout the market. Standardizing benefit packages in the market would simply curtail innovation and limit the variety of products now available. For example, 10 years ago few if any health insurers or HMOs offered health plan benefits that included chiropractic care or acupuncture. Today, several do and more are expanding their benefits in this area soon. Had benefit packages been standardized at that point, innovation would have been much slower, and competition less likely to respond as quickly with newer, more varied products.

Even if the reference packages were intended for use only by larger employers and purchasing pools, which have the resources to create such packages themselves, we seriously question whether this facilitation of purchaser activity is the appropriate role of government and the appropriate use of public resources, especially in light of other government priorities in this area.

We agree with the majority’s recommendation that a working group be convened to review existing regulations pertaining to the format for plan Evidence of Coverage and Disclosure Forms. There may be improvements that can be made to increase enrollee use of these materials. But we must oppose the remainder of the majority paper.

Rodney Armstead, M.D.  William Hauck
Rebecca Bowne  Ron Williams
Terry Hartshorn  Allan Zaremberg
MINORITY STATEMENT
ON
THE TASK FORCE RECOMMENDATIONS
REGARDING ARBITRATION

California’s Managed Health Care Improvement Task Force has made several recommendations pertaining to arbitration in its paper on Dispute Resolution. We, the undersigned minority of the Task Force, oppose the recommendation that the regulator of managed care plans be empowered to prohibit a plan from requiring an enrollee to continue to participate in arbitration if the regulator finds that the plan has engaged in willful misconduct.

This recommendation fails to acknowledge existing law that provides appropriate remedies to protect enrollees when misconduct occurs. The remedy proposed in the recommendation is inappropriate because it would create additional delays and legal proceedings that would not hasten the proceedings nor benefit the enrollee in terms of resolving the dispute that is the subject of the arbitration.

Existing law, Section 1373.20 of the Health and Safety Code, requires that when a plan does not use a professional dispute resolution organization, the enrollee may take the plan to court if a neutral arbitrator is not selected within 30 days of service of a written demand for that selection. If the court finds that either party to the arbitration has engaged in deliberate, dilatory conduct, the court may award the other part costs and fees associated with the filing of the court petition. Thus, the courts are empowered to step in and correct abuses in the pre-arbitration process. This statutory provision was codified by SB 1660 (Rosenthal) of 1996 in response to the allegations in the Engalla case.

Once the neutral arbitrator has been selected, that neutral arbitrator has all of the powers of a judge to sanction the two parties to the arbitration if they fail to comply with the law or the deadlines set by the arbitrator, or if they engage in any inappropriate behavior. The neutral arbitrator polices the process in this regard to ensure that the arbitration is conducted appropriately and fairly for both parties.

If the state regulator were empowered to intervene in an arbitration at the request of one of the parties, the regulator would have to conduct a fact-finding proceeding, possibly in court or before an administrative law judge, in order to credibly “find” that misconduct has occurred. This proceeding would take considerable time, and any action by the regulator or administrative law judge could be appealed by the health plan or enrollee, creating further delay.
The neutral arbitrator, who is privy to the agreements made regarding the arbitration and to the behavior of the two parties, is the appropriate official to sanction any party that is acting inappropriately. To empower the state regulator to intervene in a legal proceeding would not be conducive to timely resolution of the dispute.

Thus, the undersigned minority opposes this recommendation in the Task Force paper on dispute resolution and urges that it be rejected in favor of existing remedies.

Rodney Armstead, M.D.  Bruce Spurlock, M.D.
Rebecca Bowne        Ron Williams
William Hauck         Steve Zatkin

Allan Zaremberg
A STATEMENT ON THE “PUBLIC PERCEPTIONS” SURVEY RESULTS

California’s Managed Health Care Improvement Task Force commissioned a survey of public perceptions of managed care in this state. The purpose of this statement is to focus on the general results of the survey rather than certain parts of the report.

The results of the survey indicated that most Californians are satisfied with their health plan. These results, indicating that only 10 percent are dissatisfied, are consistent with many other consumer satisfaction surveys that have been conducted over the years. As examples:

- A study of 167,000 households conducted by the National Research Corporation found that 79 percent of HMO members were satisfied or very satisfied with their health plans. Of HMO members in good health, 85 percent of those under 65 report being satisfied with their care, and 92 percent of those over 65 report being satisfied with their care.
- A 1997 survey by ABC News found that 87 percent of those in HMOs rated their coverage as good or excellent, and 88 percent were satisfied with the quality of the care they received.
- A 1995 *Los Angeles Times* Poll found that 92 percent of HMO members are satisfied with their health plan.
- A 1996 national survey by Sachs/Scarborough of 90,000 consumers under 65 found that 76 percent of HMO members in poor to fair health were satisfied with their health care.
- Two annual surveys of 54,000 enrollees in the Federal Employees Health Benefits Program reported that 85 to 86 percent of beneficiaries in HMOs are satisfied with their health plan.
- A March 1994 Towers Perrin survey found that satisfaction among HMO members increases from 72 to 85 percent after three to five years in the plan, and exceeded 91 percent after 15 years in the plan.
- Researchers at the New England Medical Center found that 86 percent of group/staff model HMO members and 85 percent of IPA model HMO members were satisfied with their health plans.
- A 1993 survey of 1,000 adults conducted by the *Boston Globe* and the Harvard School of Public Health found that nearly 75 percent of Americans enrolled in network-based plans would recommend their plan to friends.
A 1993 survey conducted by the Commonwealth Fund and the Kaiser Family Foundation found that 83 percent of HMO members were satisfied or very satisfied with their health plan.

As this long list of results indicates, the satisfaction results found in the Task Force survey were consistent with those found in study after study of HMOs and managed care. Unfortunately, the Task Force survey does not explain the statistic indicating that 42 percent of managed care enrollees experienced problems with their plans during the previous year. (A similar survey--conducted at the same time, but confined to the Sacramento area--found that only 27 percent experienced problems in the previous year.) We, the undersigned members of Task Force members, can only conclude that these problems were not serious or not problems that individual consumers perceived as directly the fault of the plan.

We also must point out that while “denial of care” receives significant attention in the news media as a major issue with managed care, only 2 percent of those who reported experiencing a problem with their plan indicated that denial of care was the problem.

The Task Force survey should be considered in context with other surveys of this nature. And it appears, from the available results, that the one conclusion that can be drawn from all of this data is that consumers are largely satisfied with their health plans. This point should not be lost on policy makers as they review the Task Force report.

Rebecca Bowne
Terry Hartshorn
William Hauck
John Ramey

Bruce Spurlock, M.D.
Ron Williams
Steve Zatkin
Allan Zaremberg
As part of its deliberations on consumer choice, the Managed Health Care Improvement Task Force has recommended that the small group reforms enacted by AB 1672 should be extended to groups of 51 to 100. We, the undersigned members, believe that this recommendation is likely to have unintended consequences resulting in more Californians losing health care coverage. We oppose this recommendation.

In 1992, California enacted AB 1672—landmark reforms improving accessibility and affordability of health care in the small group market. Those reforms included guaranteed issue and renewability, limitations on pre-existing condition exclusions and rate bands for premiums in the small group market. The reforms applied to employer groups of 5 to 50 effective July 1, 1993, and gradually lowered the threshold to employer groups of two. The majority of Task Force members have called for the extension of coverage to groups of 51 to 100 to improve choice in the marketplace. We believe that the opposite will occur.

Extending AB 1672 to groups of 100 is offering a solution to an alleged but undocumented problem. There is no compelling empirical evidence that this segment of the market is having difficulty getting or keeping coverage. Extending the AB 1672 reforms is likely to disrupt the entire market of smaller employers and could undermine the advances of the current law.

Extending AB 1672 Could Reduce Choice in the Marketplace

Extending California's small group reforms to groups of 100 is not likely to provide additional choice for these larger groups. Given the experience in the small group market following the implementation of AB 1672, the opposite may occur. As a result of AB 1672's guaranteed issue requirements, many carriers selling in the small group market reduced the number of products offered and the diversity of product design in order to remain financially viable in the under-50 market others just chose to leave the market altogether. Extending guaranteed issue and imposing rate bands to groups of 100 is likely to have the same effect—fewer products with less flexibility. The richer benefit packages now available to groups of 51 to 100 would become unavailable. For example larger employers have offered extended mental health or chiropractic benefits. It would be difficult for health plans to offer such benefits if they had to be available to very small employers as well. In short, rather than expanding choice, it may well be reduced.

Larger Employers With Good Risk Will Have A Greater Incentive To Self-Fund

Both large and small employers may find an expansion of AB 1672 unacceptable. Specifically, the guaranteed issue and rate band provisions of AB 1672 will create an incentive to self-fund under the federal Employee Retirement Income Security Act of 1974 (ERISA) that could result in higher prices for all in the AB 1672 pool. Limited by legislated rate bands and lack of product diversity, employers with good risk characteristics will be encouraged to self-fund.

Rates In The 2 To 100 Pool Will Probably Increase

If those companies with good risk self-fund, those with poorer risk characteristics will have no choice but to seek coverage in the AB 1672 pool. Because of the mechanics of pooling, their adverse risk will be spread to others in the pool, generally increasing pool premiums. Unfortunately, that risk will be
spread not only to other larger employers but to the 2 to 50 group, who will find it more difficult to seek protections by self-funding.

**Recommendation**

While a majority of Task Force members have endorsed the expansion of AB 1672 to groups of 51 to 100, we cannot support this proposal and recommend that it be rejected both by the Governor and Legislature.

Respectfully Submitted,

Rodney C. Armstead, M.D., UHP Health Care
Rebecca L. Bowne, CNA Insurance
William Hauk, California Business Roundtable
Ronald A. Williams, Blue Cross of California
Allan Zaremberg, California Chamber of Commerce
MEMO

TO: Members of the Managed Health Care Improvement Task Force

FROM: J. D. Northway, M.D., President & CEO

DATE: August 26, 1997

RE: CHILDREN: A VULNERABLE POPULATION

ISSUES

Children are the most important and vulnerable population living in America today. Important because they represent tomorrow: our future leaders, workers, and parents. Vulnerable because they do not vote and they are not able to independently support and care for themselves. They are totally dependent upon others. Vulnerable because, as a group, they are the poorest segment of American society. Much poorer than the elderly.

In 1997, there are 68 million children living in the U.S. It is how they live that must concern us:

- 15.3 million – nearly one in 5 - live in poverty
- 10 million have no health insurance
- 25 percent of all 2-year olds are not immunized

The life a child in California knows is filled with even greater challenges:
Children comprise about 30 percent of the State’s population and 47 percent of those living in poverty.

Only six states have a higher percentage of their children living below the Federal poverty level.

Health-wise, California’s children also face challenges:

Twenty-seven percent of the State’s 2-year-olds are not immunized

1.6 million children are uninsured in California – 17 percent of all children under 17

Recent studies name California as having the highest number of uninsured children for all or part of 1995/1996

These challenges, coupled with their innate vulnerability, make children a population that is easily overlooked in healthcare. And this ultimately forces the in the industry and many providers to regard children as small adults. They are not.

Children have a different set of health needs in part because their illnesses are different from those of adults. The skills a provider needs, both technically and emotionally, are different from those used to care for adults. The drugs, instruments and technologies are often different from those used for adults, or they need substantial modification to work for children. These skills, drugs and materials may need to be altered several times just to meet the changes children experience as they grow from infancy to adolescence.

There is no question that one size does not fit all. Unfortunately, many health care providers, health plans and insurance companies do not recognize this vital fact.

SOLUTIONS

I hope you are beginning to see just how vulnerable children are. We can and must assure our children of easy access to timely, appropriate, and affordable quality health care delivered by providers knowledgeable of and experienced in
pediatric health care. How? By requiring that each health plan contain three key components.

First, each health plan must offer a standardized benefit package for children. It is important that all health care policies include this package to help ensure that plans compete for children’s lives on the only factor that really matters: quality.

Secondly, the pediatric standard benefit must be comprehensive. Ideally, the package will begin with adequate prenatal coverage for the mother. The child’s plan must include preventative care, acute episodic care, and most important, care for children with chronic illness. Most children are healthy, but the small number of children with chronic illnesses can, individually, bankrupt their family. Preventative care would include timely “well” infant and child assessments that include height, weight, vision and hearing screens as well as developmental observations. In addition, nutrition assessments, anticipatory guidance, immunizations, blood and urine screens, and TBC testing must also be included.

The third and final component is appropriateness. The plan must provide easy access to appropriate, well-trained and experienced local pediatric providers (hospitals as well as medical personnel). Hospital capabilities and medical personnel credentials must be carefully reviewed to insure that the child is seeing a truly qualified pediatric provider. Access to such qualified providers, when not present within the child’s health plan, must be available without additional costs or constraints placed on the parents. When possible, this pediatric subspecialty care should be available within the local service area.

Even if we assured the availability of this kind of healthcare coverage, affordability may prove to a barrier for children of low income families. Twenty-seven percent of these families have no health insurance for their children, and the numbers are rising. Some working poor families often forgo health insurance entirely for their children because many small employers are unable to insure dependents. Families, then, are forced to choose between food, clothing, housing or health insurance for their children.

But there is a bright side. Children account for 30 percent of the general population but consume only 14 percent of the health care dollars. They comprise 50 percent of the Medi-Cal population, but use just 20 percent of the dollars. The average annual Medicaid expenditures for a child under 21 is about $1,100 as
compared to $9,000 for an elderly adult. Children, then are a relatively inexpensive population to insure.

One possible way to remove the affordability barrier would be to cover these children by expanding the eligibility criteria for Medi-Cal. The out-of-pocket premium costs could be income adjusted so that only a small percentage of the family’s income need be spent for dependent health care. Children from families below a certain income could have their premiums totally paid by the State, just as if they were on AFDC. There may be more equitable means of assuring affordability, but if the issue is not addressed, children from low income families will continue to remain uninsured!

FOLLOW-UP

After providing our children with good health insurance, we must develop and monitor appropriate pediatric health care indicators to assure that coverage is expanded and that health status is improved. We must develop an annual pediatric health care report card for each plan as well as the State. Following is a list of potential indicators, some reported by the State, others by the plan and others by both.

1. Number of children without health insurance, reported both in absolute numbers as well as a percentage of population

2. Number of children without health insurance who live in families with full-time working parent(s)

3. Number of families who have access to pediatric health insurance but who choose not to take the dependent option

4. Incidence of teenage pregnancies

5. Incidence of premature infants

6. Age and marital status of mother

7. Number of uninsured pregnant women
8. Percentage of pregnant women receiving adequate prenatal care in all three trimesters

9. Percentage of pregnant women receiving prenatal care in the last trimester only

10. Percentage of pregnant women receiving no prenatal care

11. Percentage of enrolled children appropriately immunized

12. Percentage of enrolled children completing the American Academy of Pediatrics recommended “well” infant and child visits

13. Percentage of children assessed developmentally, including height, weight, as well as, vision and hearing tests

14. Percentage of children with recorded dental assessments

15. Incidence of children hospitalized for asthma

16. Incidence of children hospitalized for diabetic ketoacidosis

SUMMARY

The children of our State are a very vulnerable but important segment of our population. Many of them live in poverty and without health insurance. Yet, as a group, they are relatively inexpensive to insure. But they are not small adults and should not be considered as such, especially relative to health care. Every health plan in the State of California should include a children’s health package which covers at least three major components. In addition, an annual pediatric health care report card will be developed by each plan as well as by the State. The State may have to assume some of the premium costs for children from low income families. Our goal should be to assure that all of California’s children have quality, comprehensive health care coverage.
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Letters Submitted by Task Force Members Referencing General Issues Pertaining to Managed Care

Pursuant to Standing Rule No. 4.5 [adopted November 21, 1997], these letters will be included in the Main Report Volume of the Task Force report mandated by AB 2343 [Chapter 815, Statutes of 1996].
December 18, 1997

Alain Enthoven, Ph.D., Chairman
Managed Health Care Improvement Task Force
1400 Tenth Street, Room 206
Sacramento, CA 95814

Dear Dr. Enthoven:

I am writing to comment on the recommendations of the Managed Care Task Force and its role in the ongoing debate over quality and accountability in our health care system. While I support efforts to examine the adequacy and appropriateness of health system standards and oversight, I am concerned that the Task Force recommendations — in part or in whole — could adversely impact the affordability and accessibility of health care for Californians.

As minority statements to the Task Force have indicated, certain provisions included in our recommendations threaten to raise health insurance premium costs and cost sharing without offering any comparable benefit to the consumer. Any such increase could price health coverage out of reach for many. Small employers could be forced to reduce or drop coverage altogether, leaving working families, larger employers and public programs to bear the cost. As a result, all Californians could be left with fewer options for affordable, high quality medical care.

I also remain concerned with the issue of health plan liability as a means to improving or ensuring quality medical care. While our final report was silent on this issue, it is certain to reemerge during legislative debate next year. Extending tort liability to health plans ignores the reality that health plans are not engaged in the actual practice of medicine. Health plans instead work with treating physicians and medical groups to monitor quality outcomes and accountability, develop and share best practices, and determine the best outcome for the patient.

Further, extending tort liability to health plans would expand an already flawed malpractice system clearly linked to increased health care costs with little quality improvement. The health plan liability provision was rejected by a majority of the Task Force for these reasons and should not warrant further consideration.

California has long been the nation’s leader in health care and managed care. Health plans have continually worked with payors and providers to respond to market and consumer demands for affordable, high quality health care. Indeed, certain health plan mandates that have been the subject of significant debate in several states are considered industry standard here. As policymakers consider our recommendations and the appropriate role of government in overseeing the health care system, I hope that health plans will be allowed the flexibility to continue developing the innovative delivery systems and practices that are truly responsive to patient needs.

Sincerely yours,

Terry Hartman
Chairman of the Board
Improving Managed Health Care In California Volume Two 157

6 January 1998

Governor Pete Wilson
Honorable Bill Lockyer, Senate President pro Tempore
Honorable Cruz Bustamante, Speaker of the State Assembly
Honorable Members of the California Legislature
Sacramento, CA 95814

Dear Governor, President pro Tempore, Speaker, and Members:

This is not a "minority report." I fully support the findings and recommendations of the Task Force and I believe that, if implemented, they would lead to a greatly improved managed health care system in California. This is a substantial reform program. The Task Force did not resolve every issue the way I would have preferred, but I believe the important thing is the substantial and positive contribution we have made. Moreover, the members worked with great diligence and at considerable personal sacrifice of their time.

In this letter, I offer some insights that I believe are needed to put our findings in proper context.

Historical Context

Managed care as we see it in California today got its start in the late 1920s and in the 1930s, primarily for workers employed in specific enterprises such as those of Henry J. Kaiser. After World War II, the Kaiser Permanente partnership was formed and its services offered to the general community. The focus in Kaiser Permanente was not cost containment as such, although cost containment was a welcome byproduct. The main focus was that the physicians considered this a better way to organize and practice medicine with its collegiality, peer review, shared medical records, emphasis on integration of comprehensive services and preventive services, and continuing education. Kaiser Permanente grew very rapidly, particularly in the 1970s, and this success, plus the enacting of the federal HMO Act of 1973, encouraged others to enter the field and compete with Kaiser. By 1978, there were 34 HMOs serving about 3.5 million enrolled.

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1 This is a revised version of a letter I submitted on 19 December 1997. A member of the Task Force objected to a sentence in that letter, and I agreed to change it. In addition, I have taken advantage of the opportunity to make a few other changes and corrections.
members in California. By 1985, there were 6.2 million HMO members served by 40 HMOs, the
great majority of whom were "volunteers", i.e., in HMOs by choice.

In the latter part of the 1980s, the health expenditure spiral accelerated. Health insurance
premiums in California generally doubled between 1987 and 1992. Purchasers responded by
demanding freezes and premium rollbacks (CalPERS being the most prominent of them) and by
making employees fully responsible for premium differences (e.g. the University of California
and Stanford). Some employers responded by drastically curtailing employees' choices of health
plans, even adopting "single plan replacement" strategies. Employees with choices responded
by migrating to managed care. For example, traditional indemnity insurance lost its viability in
the CalPERS population, and 80% of those beneficiaries have chosen HMOs in preference to two
or more preferred provider plan options. From 1992 to 1997, premiums for the major purchasers,
including the Health Insurance Plan of California (HIPC) that serves small employers, have not
increased. However, CalPERS premiums for 1998 are up 3.2%, and analysts generally are
forecasting more increases based, in part, on the fact that so many HMOs are now reporting
losses or narrowed profit margins. There is no assurance that premiums will not resume their
growth. In fact, I see a resumption of an inflationary spiral as a real danger. A key determinant
will be the regulatory environment and the climate of public opinion. To the extent that
limitations on providers and therapies are considered unacceptable, managed care will be unable
to contain costs. A resumption of an inflationary spiral like the one we saw in the late 1980s
would cause great economic damage, especially for people who depend on government and
others with low incomes. But this should not be necessary. At 13.6% of GDP spent on health
care, we spend about 1.5 times as much as the countries with the next highest percentages.

California's HMO membership accelerated, from 8.7 million in 1990 to 13.7 million in
1996. Membership in full service Knox Keene health plans increased from just over 10 million
in 1990 to about 17 million in 1996. This was an extraordinarily rapid rate of change, one that
was bound to cause great friction. With this change came some qualitative differences. Many
providers and patients were new to managed care and had little or no idea how to deliver or
receive it. In their enthusiasm to sell the new product, few if any employers fully explained to
employees the limitations on their choice of provider and the need for them. Many people –
doctors and patients – lost freedoms they valued but, for the most part, freedoms whose cost they
were not willing to pay.

After years of growth at a much faster pace, bringing the rate of growth of health
expenditures down to the growth rate of GDP was bound to cause wrenching change. However
done – through price-competitive managed care, price controls on HMOs, a Canadian-style
single payer, or any other model – such a change would have reduced the incomes and autonomy
of health professionals and deprived patients of some of the access and freedom they previously
enjoyed. Wise political leaders should not be surprised by the backlash against managed care
and should not support damaging legislation. Instead, our leaders should use their bully-pulpits
to call for patient responsibility for their health and the cost of care and to acknowledge the
appropriateness of some limitations, should counsel patience, and should give HMOs, doctors
and patients time to sort out the problems.
Types of Managed Care

Conceptually and for the most part, "managed care" in California can be divided into three types: Prepaid Group Practice (predominantly Kaiser Permanente), Network/IPA models, and Preferred Provider Insurance (often referred to as preferred provider organizations (PPOs) or "discount fee-for-service, but I prefer to use PPI because there is no "O" there). Prepaid Group Practice models are conceptually the simplest. The physicians work with one health insurance plan that is their partner or marketing arm. These physicians are all there by choice and the great majority of enrolled members are also. Because they all work with one health plan, they have a much better chance of learning the rules and processes and being able to navigate the system successfully. The physicians have a decisive voice in what will be covered. Essentially, a service provided by a Permanente physician is thereby covered without further negotiation. Moreover, the physicians are carefully selected and thoroughly inculcated in the values of the group, so prior authorizations are rarely, if ever, required.

IPA/Network models, the largest of which are Foundation Health Systems and PacifiCare, are largely made up of physicians who were recently mostly in traditional fee-for-service practice (either in multi-specialty groups or in individual practice or small single-specialty groups) and would prefer to be so. These physicians generally serve patients who were recently in traditional indemnity coverage and would prefer its freedom, but they or their employers decided that the difference was not worth the extra cost. This is a population that includes many reluctant participants. Managed care offers them restraint, and not much of the positive benefits seen in the organizational form experienced by the Permanente physicians. Physicians in other than multi-specialty groups participate by forming Independent Practice Associations or IPAs that contract with the IPA/Network models. Physicians in IPA/Network plans typically contract with 15 different managed care plans, each with its own rules, utilization management and formularies. This presents physicians with a degree of complexity that would drive anyone to great frustration, if not despair. It is likely to be impossible for them and their allied health professionals to master all the rules and procedures of, on average, 15 different health plans. Moreover, physicians deal with these insurers at arms-length, if not as adversaries. Thus it should not be very surprising that physicians and patients are having problems with this model. One must hope that time, technology, learning or market forces will ameliorate these problems. They are but a few of the many problems in the health care system that are unlikely to be solved by legislation.

PPI offers patients a complete free choice of doctors who are paid on a fee-for-service basis, some of whom have agreed to accept the insurer's fees as payment in full and accept some utilization management processes. Patients can go to PPI providers at a lower out-of-pocket cost than they would face going to non-contracting providers. Traditional indemnity insurance, which offers complete freedom of choice of doctor at the point of service, is nearly extinct. Its fatal defect is that it cannot influence the fees, charges or resource use of providers. PPI is the closest living descendant of traditional indemnity insurance. A major part of its cost containment strategy is to offer a narrower scope of coverage than HMOs (e.g., little or no preventive services) and a much greater reliance on deductibles and coinsurance. In general, the experience with PPI is that it is less effective than HMOs in controlling costs, as in CalPERS, Stanford and the University of California. At least in theory, its premiums could be contained by raising
deductibles and coinsurance (that is the share of each service that the patient pays), but that could raise considerable financial barriers to care for some.

In my judgment, if an unfavorable regulatory climate makes HMOs too costly, most employers will fall back to self-funded, unregulated, PPI with high employee cost-sharing. That is the most plausible alternative to full service Knox Keene plans. This would be a regrettable outcome because it would decrease the pressure on providers to organize care processes more efficiently and likely remove coverage for a great deal of primary care and prevention.

Public Perceptions

With the help of the California HealthCare Foundation and the Institute for Healthcare Advancement, the Task Force commissioned a survey of Californians' perceptions and experiences with their health insurance, including managed care. In a sample chosen to represent the general population, 76% of Californians reported they were satisfied with their health insurance plan (including 33% who were very satisfied), 10% were dissatisfied (including 3% who were very dissatisfied). This applied to all kinds of health insurance and not just to managed care or HMOs. For all the publicity, there was nothing surprising in this survey. Numerous surveys have been done, all showing that a high percentage of Californians are satisfied with their HMOs. For example, the California Cooperative Healthcare Reporting Initiative of 1996, sponsored by the Pacific Business Group on Health (PBGH), surveyed members of PBGH HMOs and found that on average, 77% were satisfied with their health plan, and 80% were satisfied with the quality of care and services. On average, 5% were very dissatisfied. This information was presented to the Task Force last summer. A 1995 survey by the Los Angeles Times found that 92% of HMO members surveyed rated the quality of their coverage as excellent or good.

In judging these findings, I believe it is important for policy makers to understand that all health insurance, public or private, for-profit or not-for-profit, managed or unmanaged, has features that antagonize some people: inherent complexity of the subject and the contracts, limits and exclusions (such as of experimental or investigational procedures), ambiguity, and the important fact that people do not read their insurance contracts until they need them, i.e. when they are sick and likely to be in an unhappy frame of mind. My parents were on fee-for-service Medicare, and some of the worst moments of my life were having to cope with the avalanche of bills, explanations of benefits (EOBs), secondary carrier billings (each with its own unique story about doctors balance billing), denials, etc. while they were dying.

A UCLA survey found that about 63% of Californians who obtain their coverage through employment are enrolled in HMOs, another 7% in "Point of Service" plans, which are HMOs with PPI tacked on so members can go "out of network" if they so desire and take a substantial amount of their insurance with them, 23% are in PPI, and about 7% in traditional indemnity coverage. While I deplore the fact that about 25% of insureds do not have choices of plan, 75% do and are in their plan by choice. About 30% of California Medicare beneficiaries have chosen to enroll in HMOs contracting with the Health Care Financing Administration. Our survey found that 83% of Kaiser members were satisfied (including 44% very satisfied), less than 8%
dissatisfied (including less than 1% very dissatisfied); 75% of IPA/Network members were satisfied (including 29% very satisfied), 11% dissatisfied (including 4% very dissatisfied); while of PPI members, 74% were satisfied (including 39% very satisfied) and 8% dissatisfied (including 1% very dissatisfied). On 5 January 1998, Dr. Helen Schaufler of UC, who led the survey, reported to the Task Force that, of those people who both had serious chronic conditions and were hospitalized in the past year, 90% of Kaiser patients, 77% of IPA/Network and 84% of PPI patients were satisfied. This and similar data from CalPERS refute the notion that HMOs satisfy the healthy and dissatisfy the sick. Apparently, the sick are more satisfied than the general insured population.

Perhaps most important here is that Kaiser HMO members reported a higher level of satisfaction than did people covered under PPI which is the closest surviving approximation to the traditional fee-for-service indemnity model. So, there is no evidence in this survey that people would be more satisfied if the system were rolled back to the traditional model.

Our survey found that 42% of Californians had a “problem” with their health insurance last year. The media were quick to distort this. For example, one newspaper headlined “UC, Field Researchers Find 42% Dissatisfied with HMOs.” I participated in the design of the survey, and I have no criticisms of the competence with which it was performed. However, I believe that this survey is particularly susceptible to misinterpretation (and has been unfairly represented) by those who wish to attack managed care, and by the media who wish to create sensational headlines. This belief is based on several facts.

- First, the survey was designed and intended to elicit problems to help us diagnose the backlash. Many of the respondents might not have had a problem on their minds until encouraged to think of one. They were not asked, “did you have a good experience?” If someone asked me if I had a problem with a bank, airline or other service organization last year, I would probably be able to think of one in each case, but I would not consider that as an indictment of the whole industry. “Problems” occur every day.

- Second, no standard of comparison was offered other than, implicitly, zero problems. We did not have comparative data from other service industries. I wonder, for example, what percentage of UC undergraduates would have reported a “problem” with access to courses, housing, class size, teaching, etc. or how many people had a “problem” with the IRS, the Franchise Tax Board, or the DMV, and how the proportion of people with problems in these organizations would compare with the proportion of people with “problems” with health insurance.

- Third, health plans link health insurance to specific providers of medical care. As I will explain in more detail under the heading of “tort liability” below, medicine is an art, practiced under uncertainty. What can be seen as errors with hindsight occur frequently. If the HMO chose its doctors with reasonable care and has not contributed to a medical decision, we should not condemn it for errors made by its contracting doctors. The survey mixes medical problems and insurance problems, and who to blame, if anyone, is not clear.
• Fourth, the survey did not assess the merits of the complaints. The implicit assumption was that the patient, not the doctor or HMO, was correct. The survey reported that 11% of the general insured population said they did not receive the most appropriate care or what was needed, 10% reported difficulties with referrals to specialists. But these were problems as seen by patients (who probably had to pay little or nothing out-of-pocket for additional care) but not necessarily as would be judged by independent medical experts. In interpreting these percentages, people should remember that a very widespread criticism of the traditional fee-for-service free-choice model made by medical experts was that people were over-using specialists, which can be bad for both cost and quality. (Presumably this is what the California Legislature must have had in mind when it voted to require the University of California to raise the proportion of primary care physicians and lower the proportion of specialists in its training programs.) The fact that a patient wanted to see a specialist but was turned down by the primary care physician may mean no more than that the doctor was doing her or his job properly. The survey reported people’s perceptions; it did not attempt to verify the accuracy or merits of their complaints.

For example, we heard testimony from a doctor in Fresno who said he did not like managed care because it put him in an adversarial relationship with his patients. A pregnant woman asked for an ultrasound test. He replied that he saw no medical indication for such a test at the time and would not order one. She went away angry. If she had responded to our survey, she would have said that she had a “problem”. But in managed care, we ask doctors to use their best judgment about the need for diagnostic tests. If we cannot tolerate doctors making such judgments, there is no way we will be able to limit costs on the basis of eliminating unnecessary or inappropriate care.

• Finally, experience with news reports on the Task Force survey and commentaries on the findings confirms my belief that the survey is very susceptible to anti-managed care interpretation. As far as I could tell from news coverage, none of the journalists or politicians who commented asked themselves (1) were the “problems” serious, (2) what is a reasonable standard of comparison, (3) was the problem created by the health plan or the doctor, or (4) would the patient’s complaint have been judged meritorious by an impartial panel of medical experts.

Of the 33% who reported they were “very satisfied” with their health plan, a full 24% said they had a problem last year; of the 43% who said they were “satisfied”, 40% said they had a problem, so the “problems” could not all be too serious. Only 8% of Californians both had problems and were dissatisfied. Many, but far from all, of the problems people reported with their health insurance were generic to health insurance. Thirteen percent of the general insured population said, “plan not covering important benefits needed” was their most important problem. Benefits coverage decisions are made by the employers that purchase the insurance. HMOs are the wrong address for these complaints.
Hundreds of pages will be written interpreting these data, but in my judgment, one important key to satisfaction and dissatisfaction relates to the proportion of people that are in the plans they want to be in. And a very important part of the path to amelioration will be in consumers having a wider range of choice of plan, including point-of-service or preferred provider plan options, as is the case for those fortunate enough to be covered through CalPERS.

Another very important part of the path toward amelioration will be to realign the relationships between health plans and medical groups. The system needs to move to “Kaiser-like” relationships. Provider organizations like Catholic Healthcare West, Scripps, Sharp and Sutter could either create their own health plans or partner with existing health plans to offer “private label products” whose medical decisions are entirely controlled by the provider organization. If a medical group is making all the decisions about care processes or working exclusively with one health plan, its life, and that of its patients, will be a whole lot simpler, less frustrating and less problem prone.

**Tort Liability**

One of the most contentious votes we had to face was on whether to expand tort liability for HMOs. *I voted against it.* To paraphrase Jefferson, “a decent respect to the opinions of [Californians] requires that [I] should declare the causes which impelled me to that vote.”

I do agree with the proposition that people’s procedural rights ought to be the same whether they work for private sector employers (under ERISA) or not, and whether they have been injured by negligent actions caused by any of the variety of entities that contribute to medical decisions. And I agree that there must be some form of accountability. The reason for my vote is that I oppose any extension of the tort system to the field of medical injuries; on the contrary, it ought to be rolled back and replaced by some form of arbitration and a reasonable schedule of compensatory awards or limits on damages.

The tort system is a costly and counterproductive way of dealing with medical injuries. First, medical injuries with tragic consequences are common. They occur with frequency even in the most prestigious academic medical centers, and they occur with or without managed care. To illustrate, I refer to *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, the report of the Harvard Medical Malpractice Study to the State of New York, done by a multidisciplinary team of some of the most distinguished scholars in their fields. They examined hospital care in New York in 1984 and estimated that in that year there were 98,609 cases of unintended injuries caused by medical management. Of these, 27,179 cases were due to negligence. Fourteen percent of the injured patients or 13,805 died at least in part as a result of their adverse event, and about 2,500 cases of permanent total disability resulted from medical injury. Managed care was minimal in New York that year, so managed care had virtually nothing to do with these events one way or the other. Very well qualified people with the best of intentions make tragic errors in any system of medical care. The errors come from the uncertainty and complexity inherent in medical care and the stressful “real time” atmosphere in which health professionals must work, as well as from deficient care processes that might be improved.
The work of distinguished authorities such as Harvard’s Dr. Donald Berwick has shown that care processes are amenable to Continuous Quality Improvement, a management philosophy and process developed by W.E. Deming and adopted by successful world-class industrial companies noted for high quality such as Hewlett Packard, Motorola and Honda. One of Deming’s principles is “drive out fear.” Fear of reprisals for admitting mistakes leads to concealment, cover-ups and failures to report errors. Fear destroys the honest open search for improvement that must be based on a frank admission of errors and research into the reasons why they could have happened. Fear of tort liability is the major cause of fear and a major impediment to quality improvement in medicine.

Fear of lawsuits is a destructive force attacking the doctor-patient relationship, which must be based on trust. A revealing article in The New York Times of 9 December 1997 reports that doctors often keep mistakes to themselves. It reports a great reluctance in the medical profession to admit mistakes for fear of lawsuits. In commenting on a recommendation that when doctors make mistakes, they should tell the patient what happened, apologize and do whatever it takes to repair the damage, Dr. Nancy Dickey, President-elect of the American Medical Association was quoted as saying, “The problem is that the climate of blame in this country, fueled by the litigation process, where we have to identify someone at fault who will then pay exorbitantly, makes it difficult to walk out and finger yourself.” The people of California would be better served by a system that encouraged the frank admission of errors and by focusing resources on improving clinical processes. Everyone would benefit if injuries did not occur in the first place.

I agree with my physician friends who say that the tort system is random and unfair and often attacks excellent doctors who did the right thing, but got a bad outcome. Moreover, I agree that the threat of malpractice induces “defensive medicine” that raises costs without benefiting patients. Two of my Stanford colleagues have recently published a path-breaking piece of research that actually quantifies defensive medicine. Daniel Kessler, J.D., Ph.D. and Mark McClellan, M.D., Ph.D., analyzed “the effects of malpractice liability reforms using data on all elderly Medicare beneficiaries treated for serious heart disease in 1984, 1987, and 1990. [They found] that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications.” Five to nine percent of a trillion-dollar health care bill for no discernable health benefit is a huge waste.

My concern about unlimited tort liability for HMOs is not about “frivolous law suits.” It is about “defensive utilization management.” HMOs could make everybody happy and avoid any suits for denying or curtailing benefits by backing off from utilization management and approving everything. If they did – and this is not an unlikely consequence of the battering they are taking today – health expenditures would soar again with very destructive consequences, including pricing coverage out of reach for even more families of moderate means.

I am also sensitive to the fact that many who have been harmed by negligent acts are never compensated. However, the tort system is a very poor method for compensating the
injured. Most of the malpractice premium dollar goes to lawyers and insurance companies to pay the cost of litigation (I understand about 30% each), and only about 40% goes to patients.

Many people hold an illusion that the tort system “makes HMOs pay for their mistakes”. They don’t pay; workers and retirees pay in higher premiums. The costs of litigation, judgments, defensive medicine and defensive utilization management all get folded into higher premiums which ultimately come out of the pockets of workers and retirees. So-called “employer paid” health benefits really come out of wages. I think of the tort system applied to medical care as a costly conduit of money from workers and retirees to lawyers. Californians would be served better by a system that focused on improvement rather than punishment.

Hard Choices

Let me offer a final observation. In the HMO format, patients pay very little out of pocket for the care they receive, usually copayments of a dollar, five or ten. This was a well-intentioned idea, pioneered by the Permanente physicians, which I fully supported. It meant no financial barriers to care (so that illness might be detected early and treated more effectively) and more preventive services. It also recognized that most people have little choice but to accept their doctor’s advice about the tests and treatments they need, so it put the incentive on the medical group to use resources wisely. But this has had an unintended consequence. I referred earlier to the doctor in Fresno who testified that he did not like managed care because it made him and his patients adversaries. A pregnant patient came in and demanded an ultrasound examination. He told us he replied that he found no medical indication to order an ultrasound, and therefore he would not do so. The patient went away angry. My unspoken reaction was that the doctor did the right thing, i.e., avoided unnecessary medical expenditure. But he was punished for it. I believe that it is quite likely that if the woman had had to pay even $50 for the ultrasound, a fraction of its cost, that she would have been grateful to the doctor for saving her money.

To continue on this theme, last year we heard a great deal about “drive through babies” even though millions of women and infants had been delivered and returned home safely in 24 hours. Politicians who previously decried excessive medical costs when that was perceived as the national crisis (about two years before) did a 180 degree turn and insisted that women couldn’t be sent home in less than 48 hours unless they wanted to be. I believe that if families had had to pay $100 per night in the hospital, a fraction of the cost, most would have been very happy to save the money and go home in 24 hours. I grant that the HMOs could have done a much better job by making sure that there were appropriate home follow up visits by nurses where indicated.

The experience of the Task Force has changed my opinion on the issue of consumer cost sharing. The managed care backlash will not be solved until all patients see themselves as having a personal stake in economical medical care. (This must be balanced carefully with considerations of access to care.)
The Task Force had neither the time nor the resources to estimate the costs of its recommendations. Most members were sensitive to the importance of making health care affordable. Many of the recommendations will help to make the market work better. But the costs of our recommendations, both short and long-term, should be evaluated and weighed against the benefits before being implemented.

In conclusion, I consider it a great honor to have been chosen to serve as Chairman of the Task Force. It was trying and stressful at times, but it was also a great educational experience. And as I said at the outset, I am proud of the product. If implemented, it will lead to a greatly improved managed health care system in California.

Yours truly,

[Signature]

Alain C. Enthoven, Ph.D.
Chairman
A STATEMENT
ON THE
POTENTIAL COSTS
OF
THE TASK FORCE RECOMMENDATIONS
AND THEIR IMPACTS ON
ACCESS AND QUALITY

California’s Managed Health Care Improvement Task Force has worked long and hard to produce a set of recommendations regarding managed care in this state. While every member of the Task Force dedicated considerable time to this effort, we, the undersigned members of the Task Force, feel that the failure to estimate the costs and benefits of the proposed recommendations is a serious weakness in the final report.

The Task Force executive director had initially proposed to develop cost estimates for certain recommendations using economic modeling, but that proposal was voted down in a straw poll at the November 25 meeting. We believe that this is unfortunate. As a consequence, it is impossible to evaluate the impacts of the recommendations on access to health care as well as quality. For example, the cost of certain recommendations—such as several data collection initiatives—may ultimately be so excessive that small employers will either drop coverage, impose higher cost sharing or reduce benefits, to the detriment of their employees. The relative benefits of the recommendation, then, may not exceed the costs. In other cases, the Task Force recommendations may reduce costs, or significantly benefit patients at little expense, and the Task Force is unaware of this. Therefore, it is impossible to prioritize these recommendations in terms of their greatest benefit to consumers.

Having cost estimates for the various recommendations in the Task Force report may well have produced a very different report, or at least one with clearer priorities. In one case, for example, a reasonably modest cost estimate provided by one Task Force member resulted in the elimination of a proposed recommendation to print booklets on managed care for all managed care enrollees. Task Force members realized that the estimated $10 million cost of this recommendation was not worth the uncertain benefit, and that this $10 million would be better spent on medical care.

The inability of the Task Force to assess the costs of its proposed recommendations against the intended benefits, and the consequential inability of the Task Force to prioritize its recommendations, leaves the report lacking. We recommend that the
Governor and Legislature ensure that the costs and benefits of the recommendations are measured and evaluated before any action is taken them.

Rodney Armstead, M.D.  Leslie R. Schlaegel
Rebecca Bowne         Bruce Spurlock, M.D.
Terry Hartshorn        David Tirapelle
Bradley Gilbert, M.D.  Ron Williams
William Hauck          Allan Zarembek
John Ramey             Steve Zatkin
Anthony Rodgers        Barbara L. Decker
December 20, 1997

Alain Enthoven, Ph.D., Chair
Managed Health Care Improvement Task Force
1400 Tenth St. Room 206
Sacramento, CA 95814

Dear Dr. Enthoven:

As a member of the Managed Care Task Force appointed to represent enrollees, I express my disappointment at the omission of many significant enrollees protections.

As the survey commissioned by the Task Force discovered and as the members of my union and other enrollees complain, millions of Californians have very serious problems with their managed care plans. If almost 10% of adult Californians missed a day or more of work due to problems with their health plan, as indicated by the survey commissioned by the task force, that results in millions of lost work days and lost productivity for the California economy.

Given the magnitude of this problem, the recommendations approved by the Task Force seem modest at best. In virtually every case, the recommendations have been watered down. As best we can tell from the actions taken, which remains is worth implementing but it is not enough to address the problems enrollees have.

Enrollees can never be certain that their doctor (or nurse) is advocating on their behalf so long as doctors and other health professionals face termination without cause and without notice. Health professionals need the protection of just cause and due process so that they can advocate on behalf of patients without fear of being terminated from employment and without fear of contract non-renewal or termination. How can health plans and medical groups guarantee quality of care so long as the health professionals who lay their hands on the patients fear that they are laying their livelihood on the line when they speak up for a patient? This omission alone undermines most of the other recommendations in the report.

I am particularly troubled by the reliance on private working groups of industry associations. If this industry were able to regulate itself adequately, this task force would not have been created and enrollees would not have problems with quality of care. Industry self-regulation is inherently suspect: The history of managed care proves its inadequacy in terms of consumer protection.
Many individual consumers are already paying a greater share of costs while having little or no choice of health plans and while finding problems with the quality of care.

The recommendation to restructure regulation of managed care plans by moving it out of the Department of Corporations and consolidating it with the regulation of other health insurers would be an improvement, especially if the new agency is given strong direction to protect the quality of care as well as the financial solvency of health plans.

Sincerely,

[Signature]

John A. Perez
Executive Director

/gm
Statement on the Report of the California Managed Health Care Improvement Task Force

The Managed Health Care Improvement Task Force was formed to address the transformation that has taken place in health care delivery in California over the past twenty years. That transformation has had tremendous impacts on health care providers, employers, and purchasers, but most of all it has dramatically changed how individual patients receive their care. As one of the few Task Force members who represents a consumer group, I would like to highlight the consumer perspective on the Task Force's report, the strengths of our recommendations, where we have fallen short and the critical next steps that must be taken by the public and private sectors.

I am a member of the Task Force as an individual, but my efforts are informed by my role as the Director of Consumer Protection Programs for the Center for Health Care Rights. The Center for Health Care Rights provides individual assistance to the over one million Medicare beneficiaries in Los Angeles County – the Center is the Health Insurance Counseling and Advocacy Program for the county – and we do a range of other individual and policy advocacy for all health care consumers. One of our programs is the Health Rights Hotline, a pilot program providing independent assistance to all health care consumers in the four-county Sacramento metropolitan area. From the Center's work, I hear daily from consumers for whom the health care system is not working.

California's Consumers Have Real Needs the Task Force Sought to Address

The Task Force considered often conflicting data comparing the quality of care provided through managed care to that delivered by "traditional" fee-for-service delivery systems. While the focus on quality is appropriate, the comparisons are often irrelevant because most Californians do not have a choice between managed care and fee-for-service – managed care is how the vast majority receive their health care. We need to look beyond comparisons to develop systems to ensure that the all health care consumers have access to quality care.

Frequently, the debate over what works and what doesn't work in health care is framed by "proponents" of managed care pointing to high rates of enrollees reporting they are satisfied, while "opponents" give examples of individuals for whom the system has not worked (often characterized as "HMO horror stories"). The Task Force had the benefit of two surveys that help answer why we were convened: consumers are having problems getting the health care they need. The Task Force commissioned a statewide survey that found 42% of respondents had experienced a problem in the past year and a survey conducted by the Lewin Group of Sacramento-area consumers found 27% had problems. The actual "rate" of problems, however, is far less important than is the fact that both of these surveys provide a quantitative window on why consumers are having problems, the severity of those problems and how their difficulties are being resolved. This information can and should inform everyone's efforts to improve health care delivery.
Both surveys found that many consumers reported they experienced problems getting needed care, had disputes over coverage, could not get the doctor they wanted and believed the care they had received was inappropriate. Furthermore, many of these problems were neither minor nor short-lived. Based on the Lewin Group survey, 40 percent of those with difficulties had major problems (e.g., costing the consumer more than $200, the consumer losing more than 10 days from work or their health condition worsening because of the problem) and many problems were unresolved after two months. The surveys also highlighted some “good news”: many consumers were satisfied with how their problem was resolved and with how their health plan handled their problem. However, the surveys also indicated that consumers frequently do not know where to turn and do not think they can make a difference when they have a problem. The results of these surveys underscore that the Task Force was convened because of real problems facing consumers.

**Important Task Force Recommendations**

The Task Force recognized that health care is complex and it made recommendations to both private groups (such as employers, purchasing groups, accrediting organizations), as well as to the public sector (particularly to the Governor, the Legislature, state agencies and the federal government). Some of central recommendations and themes that are reflected in the Task Force Report are:

- The Task Force recognized the important role played by private organizations, while affirming the special obligation on government to ensure all individual providers or groups provide quality care, ensure all consumers have sufficient information to make informed choices and that valid quality information is available on all providers.
- The Task Force recommended that the oversight of managed care be dramatically improved. That oversight needs to cover both health plans and medical groups and needs to have the resources, leadership and focus to significantly bolster consumer protections. At the same time, the Task Force also recommended that this oversight be streamlined to minimize the burdens on health plans and providers.
- The Task Force made a series of recommendations to expand the information available to consumers. Consumers must have better information to make informed choices and to navigate an often-confusing health care system.
- The Task Force acknowledged that while consumers’ problems cannot be eliminated entirely, the systems to resolve those problems can and should be bolstered. To this end, the Task Force recommended the state establish an independent third-party review process for denials, delays or curtailments of care.
- The Task Force affirmed that any future efforts building on its work must include all of the stakeholders. The Task Force recommended that consumers, consumer groups, advocates of the disabled and representatives of other vulnerable populations must have a seat at the table.

**Where the Task Force Fell Short**

While the Task Force report includes an array of important recommendations, in a number of key areas the report falls short. The Task Force simply did not have time to address all of the important issues and was sometimes unable to reach agreement among its membership. The areas that the Task Force did not sufficiently address include:

- The impacts of the changing health care system on vulnerable populations. Unfortunately, the Task Force’s failing in this area is not surprising since the composition of the Task Force itself...
fell short of including representatives of those who are most impacted by the changes to the health care system: people with chronic illnesses and disabilities, children and other vulnerable populations. Similarly, the Task Force fell short by not reflecting impacts of the changing health care system on the array of health professionals. The only provider representation on the Task Force was of physicians.

- Organizational liability and equal treatment. The Task Force did not make a clear statement that all organizations should be liable for their actions and that all Californians should have the same rights and remedies available to them. Currently, the actions of health plans and groups that may impact health decisions can be unfairly protected behind the façade that only individual doctors “practice medicine.” In addition, many Californians who receive their health coverage through employer-sponsored plans have far fewer rights, because they are not entitled to state law protections, than those who are not in such plans because of the federal ERISA standards.

- The limits on consumer choice. Task Force also did not fully address the limits on consumers choice – either their choice of health plan or their choice of provider. Consumers should be able to choose at both levels and the Task Force makes only passing reference to these important issues.

Critical Next Steps

The Task Force had a large mandate, but only a short time in which to meet. Because of the limited time, the Task Force did not fully investigate and make recommendations in a number of important areas. In particular, the Task Force did not fully consider the potential costs of some recommendations or their relative benefits. In addition, the Task Force recommends that a number of studies be commissioned and that a series of “blue-ribbon” groups be convened. The ultimate impact of our recommendations is now in the hands of the Governor, the Legislature, state agencies and private groups. Each of the individuals and groups to whom this report is directed has the responsibility to consider and act upon its Findings and Recommendations. We all have the responsibility of working to ensure that these Recommendations serve as a road map that is built upon to ensure that all of California’s consumers have access to quality cost-effective health care.

While we did not always agree, I am appreciative for the constructive dialogue, dedication and different perspectives brought to our deliberations by each of the Task Force members, Chairman Enthoven and the staff. Finally, I want to thank the many Californians who took the time to testify before the Task Force, send us letters and share their personal experiences. Health care is a very personal thing, and the Task Force benefited greatly by the patients and health professionals who again and again kept us anchored in why our Task Force was formed.

Sincerely,

Peter V. Lee
Director of Consumer Protection Programs
December 18, 1997

To those who will work to implement the Managed Care Improvement Task Force's recommendations:

The Managed Care Improvement Task Force in its scores of recommendations addresses many issues critical to reestablishing consumer safety and trust with regard to the health care system. Unfortunately, the Task Force left many issues unaddressed or the subject of weak and potentially ineffectual recommendations. Those with the power to make policy changes will have to reach far beyond the Task Force's often inappropriately modest approaches if consumers are to feel protected when they use managed health care.

Often, when issues were too controversial, the Task Force ducked its responsibility to directly address consumer concerns. Thus, some of the recommendations that would have most directly benefited consumers were diluted from recommendations for decisive action to recommendations for studies or, worse, were eliminated altogether. Many other critical and often controversial issues were never debated at all.

This Task Force report clearly states that lack of action on an issue by the Task Force should not be construed to mean the Task Force did not believe the issue to be of importance. With only eight months in which to do its work, this diverse and often divided Task Force was unable to speak to all of the critical issues raised by the health industry's recently rapidly changing nature. Many of this Task Force's omissions are dealt with in a consumer-friendly manner by Health Access California's Patient Bill of Rights which addresses many key issues the Task Force left behind.

The eighteen well-thought-out bills that comprise the Patient Bill of Rights are based on needs prioritized by California consumers and have been considered by legislative committees and in floor debates. Unfortunately, few of the issues covered by these bills were addressed by the Task Force. The Governor vetoed seven of these bills this fall saying he was awaiting a framework for reform from the Task Force. This Task Force's work provides an incomplete framework and must be taken together with other important reform efforts if consumers are to hope for a sense of safety and security in their dealings with managed care.

While some of the Task Force's recommendations do not go far enough and some important issues were not acted upon, the recommendations in this report and the Health Access California Patient Bill of Rights, if taken together and
acted on energetically and in a timely manner have the potential to begin rebuilding consumer confidence and better assuring quality health care. We encourage all of the entities that have the authority to act on these important policy matters to do so with rigor and due speed.

Sincerely,

Maryann O'Sullivan
Task Force Member
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: IMPLICATIONS FOR CALIFORNIA REFORM ACTIVITIES

STATEMENT

The majority of the Managed Health Care Improvement Task Force has considered and produced a set of recommendations that, if implemented, will result in significant change to the provision of managed health care services to Californians and may have adverse consequences in the marketplace. We, the undersigned members, believe that the Task Force failed to consider adequately the implications of provisions of the federal Employee Retirement Income Security Act (ERISA), which pre-empt aspects of state regulatory authority and which greatly limits the utility of the Task Force recommendations.

Background

ERISA was passed by Congress and enacted into federal law in 1974 in response to severe problems with pension fraud, pension theft and poor investment practices. The provisions of Section 514 of the Act prohibited states from passing laws that relate to “employee benefit plans.” Since enactment, there has been considerable debate about the application of Section 514, and a series of judicial decisions, including notable Supreme Court cases, have resulted in a new class of group health coverage. These group health plans—referred to as ERISA, self-insured or self-funded plans—are now a mainstay of the U.S. health care system. Self-funded plans are now fairly common. Approximately 33 million Americans have coverage under these plans. Self-funded plans are attractive because they are not regulated by state insurance law.

While self-funded plans are exempt from state insurance regulation, the breadth of that exemption has yet to be determined. Unequivocally, states are prohibited from requiring employers to offer health benefits. States may not regulate the terms or conditions of self-funded plans except through the regulation of traditional insurance carriers. While not tested directly in the courts, it is believed that states may not impose the following on self-funded plans: consumer grievance procedures, uniform utilization and cost data systems, uniform claims procedures, participation in purchasing cooperatives, or arbitration of plan malpractice disputes. ERISA implications remain an area of judicial activity by both plans and individuals.

The implications of ERISA for state health care reform are widely known. The efforts of states to establish comprehensive state health reform initiatives in the late 1980s and early 1990s had to be abandoned or diminished in scope because of ERISA. In fact, because ERISA pertains only to group health plans, state individual market reforms are the only state reform activities that have remained unaffected by the federal statute. Congress is fully aware of the ERISA implications for health reform. In 1996, Congress assured the uniform applicability of the health reforms included in the Health Insurance Portability and Accountability Act by making modifications to the ERISA statutes. In fact, two other 1996 federal changes—maternity hospital length of stay and mental health parity requirements—were also made applicable to self-funded plans. Because of the ERISA preemption, uniform applicability of health insurance reform is a predominant theme in discussion of possible federal legislation today.

Regulating a Dwindling State Market

The Task Force failed to fully appreciate the extensive implications of ERISA in its deliberations. This

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failure is significant in two respects. First, several recommendations call for Congress to modify ERISA. The Task Force had no discussions of nor do the recommendations consider the political feasibility of the recommendations or the impact if Congress fails to make the suggested modifications. Second, because of the breadth of the ERISA preemption, most if not all of the Task Force recommendations apply only to state regulated health plans. If these recommendations are enacted, they could result in significant financial and administrative burdens for state-regulated plans, creating an incentive for employers to move to self-funded coverage. Any movement toward self-funded coverage will reduce the effects of the recommendations included in this report. Recent data suggest that the number of individuals covered under self-funded plans is declining. That speaks well for state reforms. However, enactment of the recommendations of this Task Force could well change the incentive structure for employers. The incentive to move to self-funded coverage remains real and should not be underestimated. As such, we recommend the following.

- While we neither support nor oppose changes to ERISA, we recommend that the Governor and the Legislature review all Task Force recommendations calling for change in federal ERISA statutes to assess their political feasibility. If it is unlikely that ERISA statutes will be changed, the implications of the recommendations should be assessed and considered before any state legislation that would impose new burdens on state regulated plans is proposed.

- The Governor and the Legislature should evaluate the cost impacts of the proposed recommendations on plans in the state-regulated market, and assess the likelihood of the movement of group plans from the state-regulated to the self-funded market. That assessment should be considered before any new legislation is proposed, and recommendations that would result in significant destabilization of the market as a result of the exit of large employers should not be pursued.

Respectfully Submitted,

Anthony Rogers, L.A. Care Health Plan
Leslie R. Schlaegel, Bank of America
Terry Hartshorn, PacifiCare Health Systems
Ronald A. Williams, Blue Cross of California

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December 19, 1997

Alain C. Enthoven, PhD., Chairman
Managed Health Care Improvement Task Force
1400 Tenth Street, Room 206
Sacramento, CA 95814

Dear Dr. Enthoven & Members of the Commission:

As previously established by the Chairman, no provision has been made for the
development of a minority report. The Chairman has been aware for some months that I
and possibly other members of the Commission might have interest in providing a minority
report. Having been advised at our last meeting on December 13, 1997 that all comments
must be submitted by noon on December 19, 1997 in order to be included in the final
document, I submit the following remarks, acknowledging that six calendar days does not
constitute a fair or reasonable period of time in which to adequately develop a minority
report.

It has been a privilege to serve on this Commission. Over the months, I have gained great
respect for many of my fellow Task Force members, and have learned much from their
expertise whether or not I have always agreed with them. After months of written and
oral testimony, intense discussions and the inevitable conflict of points of view about the
managed care industry, it is only natural to reflect on what has transpired and imagine how
the report that has been prepared will be received. I believe we may well be remembered
most for what we did not do.

In several of the papers and recommendations approved by this Task Force, the text
invokes the moral authority of Cardinal Joseph Bernardin. By inference and by omission,
the impression may well have been created that somehow Cardinal Bernardin was
comfortable with the precepts of managed care, at ease with the manifestations of a
"market driven reform" of the health care industry. It would be a grievous injustice to this
man and what he stood for to permit staff to select convenient excerpts from his writings
for the ostensible purpose of cloaking the managed care industry with his moral authority.
Therefore, I have attached to this memorandum the full text of his speech of January 12,
1995 before the Harvard Business School Club of Chicago, so that it can be included in
the body of this report that will go to the Governor's Office. In this speech, Cardinal
Bernardin asserted that there is a fundamental difference between the provision of medical
care and the production and distribution of commodities, that the not-for-profit structure
is better aligned with the essential mission of health care delivery than is the investor-
owned model, and that the leaders in both the private and public sector have a
responsibility to find ways to preserve and strengthen the not-for-profit hospital and health
care delivery system. The Managed Care Improvement Task Force simply never addressed the issue of Wall Street's impact on the health care delivery system of this State, the commoditization of health care.

From the outset, the Chairman and staff members preparing our work have clearly demonstrated that they are of a "school of thought." Nowhere has this been more pronouncedly evident than in the original drafts of papers. Having been confronted with a nearly mindless adherence to the belief that all managed care is good, and everything that came before has been bad, one is compelled to raise the issue of balance. This point is important not just because balance has been sorely lacking, but also because the final papers constitute compromise? When compromise is purchased in an unbalanced environment, who can attest to the value or virtue of this compromise? My case in point is the travesty of our Academic Medicine Paper, which began with a 50 page virulent assault on our university teaching hospitals, which over time, and through impassioned negotiations, became a weak five page document which is largely unresponsive to the mandate of the legislation that gave us our commission. After all these months it is sad, indeed, that we will offer the Governor and the Legislature no more than this. The reality of the matter is that neither fee for service nor managed care are an evil industry. Both approaches are fraught with problems, and the health plans are just as much in need of restraints, monitoring and regulation to protect the public from excesses as any other component of the health care industry.

Our legislative mandate compelled us to hold public hearings. Although public hearings were scheduled, a vast majority of the time was instrumentally allocated, and by that I mean scheduled, for managed care industry proponents. In reality, the public had very little time to come before the Task Force. The Chair repeatedly expressed his aversion for and impatience with "horror stories," which is his reference to members of the public bringing forward anecdotal information about their experiences with managed care companies. Yet our charge was to do exactly that, listen to the public and formulate recommendations based at least in part on that testimony. The people who tell these "hard luck" stories are citizens who earned their medical benefits through employment, or Medicare entitlement. Their stories reflect pervasive concerns and should not be treated as isolated instances or bizarre occurrences unworthy of note. A second means of deriving public input has been the Public Perception Survey. At our meeting on December 13, the Task Force was advised by the Chair that only the first two parts of the survey would be available, and perhaps the third segment which targeted the opinion of the sick, i.e., people who are trying to use their health plan benefits, may not be available at all because of "statistical problems." Having so deliberately limited testimony from the public during hearings, failure to produce the third and perhaps most important part of the Public
Perception study may have the unintended consequence of squelching independent public input.

It is difficult to believe that our Task Force would complete its work without consideration of the erosion of the safety net, the burden of which was once shared by hospitals, insurance companies and physicians. Whether you agree with the propriety of cost shifting or not, it was a means by which the medically indigent found access to health care. With the advent of managed care, this burden has been entirely shed by the health plans, leaving hospitals and physicians bound by the provisions of COBRA and their not-for-profit ethos, where applicable, to handle the situation alone. State and federal governments have not stepped into the breech. One wonders where all this will lead us, since none of us are so naive as to believe that hospitals can solve this problem alone, especially in the face of dwindling patient revenues associated with the advent of managed care contracting. Our discussions of the managed care industry never touched on the well publicized compensation of health plan executives, some in the tens of millions and at least one in the billions. The public benefit rationale for looking at this phenomena is extremely compelling when taken in the context of the "medical loss ratio" concept. In 1993, the largest publicly traded HMOs had medical loss ratios of 78% of premiums. In 1994, the medical loss ratio for these HMOs fell to 76.6%. Oxford Health Plan's medical loss ratio in the early 1990s was consistently below 75%. U.S. Healthcare got its ratio as low as 68% in the fourth quarter of 1994. Should the Commission have tackled the weighty but socially significant question of how much premium should be spent on patient care? Should any of us be worried about where this is all taking us? The essence of medicine is to spend money to fight illness and the currently applied operative logic of medical loss ratios is antithetical to this.

As Task Force members charged with assessing the impact of managed care on California's population, there was no balanced investigation of what some call the dark side of managed care, the incentive to under treat or provide "insufficient care." In our December meetings, I referenced a 1995 study of 7,000 heart surgeries performed in 1992. Kathy Jenkins, a Boston cardiologist found, after adjusting for the risk of the surgery, patients with regular commercial insurance were less likely to die than those with HMO coverage. The difference was noted to be especially pronounced in the largest HMO market, California.1 A mid-1995 survey by Robert Blendon, a professor at the Harvard School of Public Health found that 21% of HMO members in poor health said they had not been able to see a specialist when they needed to in the past year.2 Studies such as these have not been presented by staff to the Task Force for consideration. It is

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perhaps understandable that the Commission support staff, being managed care enthusiasts, selected only those studies that advanced their point of view. This makes the missing portion of the Public Perception Survey, the section where sick people are asked about their health plans, all the more important, so important perhaps that the report to the Governor and the Legislature should not be deemed complete without it.

Managed care may have eliminated the incentive to over treat patients that is touted as the critical flaw of fee-for-service medicine. However, it has spawned its own perverse incentives among which are: clinically dangerous restriction of access to specialists, early discharge of patients, dodging adverse populations, carve-out contracts for specialty services based on price as opposed to demonstrated quality and experience, shifting the burden of care to families at precisely the same time two parent incomes are becoming a social norm and perhaps a necessity, and dangerous emergency care restrictions. The consulting firm Mathematica, studying Medicare HMOs found that Medicare HMO members were discharged from hospitals quicker and sicker than a control group in fee-for-service Medicare. The HMO patients went home two days earlier, and were less likely to be sent to rehabilitation hospitals. This finding of the report issued in 1993 raised concern about the quality of care provided in HMOs. While HMOs started out to end wasteful practices, and are deserving of recognition for progress in this area, clearly the Mathematica study and others like it establish the need to be mindful that cost saving behavior is a double edged sword. A 1993 survey by the Medicare Advocacy Project in Los Angeles found that 68% of hospital social workers had trouble getting home health care, durable medical equipment or physical therapy approved for HMO members.

The paper that has been adopted on the practice of medicine is fatally flawed without the explicit recognition of the role that health plans play in medical decision making. In failing to recommend that health plans be held accountable for their actions, the Task Force displayed an absolute bias to protect the industry, an industry where profiteering Wall Street style has become the norm. We have paid extended lip service to the sanctity of the physician-patient relationship, yet we would not go the distance to afford it the protections it deserves and requires. Physicians and hospitals have long been held to a standard of disclosure to patients called informed consent. This standard requires disclosure to the patient in terms that the patient can understand of all the risks, benefits and alternatives to the proposed treatment. When health plans limit treatment, advance treatment algorithms or protocols for disease management, deny care or channel patients to treatment alternatives, they are practicing medicine, they are making medical judgments that can and do affect patient care. They should meet the same duty of care in disclosure. A further, grievous failing in our recommendations relates to utilization decisions and pretreatment

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authorization. When physicians request permission to treat a patient, and the patient's condition is urgent, the physician should be talking to a peer, with the same medical expertise. We voted on that matter on December 13th. Today I reviewed the language furnished by staff, which does not accurately reflect what the Task Force members voted on. Instead the paper states "where prior authorization review is required, denials of care must include a review by appropriately qualified, credentialed individuals." There can be no mistake of what my intent was when I introduced my motion. Very simply stated, staff has once again undercut the intent of the Task Force. I include this in these remarks for fear that there will not be any further opportunity to correct this serious mistake. I would appreciate your cooperation in rectifying this error.

It is curiously anomalous that this Task Force demonstrates such strong feelings about generating data permitting comparisons among health plans, yet failed to make any recommendation to the Department of Corporations that would give a consumer information to choose among medical groups within a health plan.

The Task Force recommendations on dispute resolution are seriously flawed to the extent that there is no stipulation as to a reasonable standard for time frame. An outside time frame standard for health plan resolution of urgent complaints is essential for consumer protection. Patients are unlike any other consumer, to the extent that time may well be their enemy in a serious disease process. The courts have already seen litigation of cases in which extended deliberations and appeals have worked to the detriment of a critically ill health plan member. In some instances, by the time a decision was rendered to offer the requested but initially denied service, it was too late to be medically efficacious. While one would hope that most health plans would not abuse their program beneficiaries in this manner, when there are no compulsory standards the unscrupulous are free to create their own.

The Task Force did not make a definite recommendation with respect to clinical trials and experimental treatment. Health plans are free to define what is experimental and what is standard of practice, frequently to the detriment of patients seeking care for extreme forms of illness. Without a uniform definition of what is experimental, and therefore not a covered benefit, there is substantial variability across plans. Both patients and academic medical centers deserve clarity and uniformity. Health plans have taken the position that they should have no financial responsibility for clinical research and academic medicine, yet without question they benefit downstream from the activities of both. Like indigent care, medical education and training was a matter of cost shifting and outright subsidization in days gone by. It was once everyone's responsibility, in a time when our social agenda was driven by notions of the common good. Health plans have been
allowed, in the absence of regulation and government oversight, to present themselves as infallible judges of what is medically necessary and what is not.

Before concluding, I would like to take this opportunity to express deep concern over what appears to be a prevailing bias about hospitals that has been an underlying but pervasive attitude in our reports and deliberations. It would seem that hospitals are incidental to the extent that this State is perceived to be over bedded. "Let the market take care of it" reflects a generalized belief that our State's bed inventory can be corrected by a market driven revolution. The problem with this approach is that bed closures do not always occur where they should. What makes good economic theory sometimes makes poor social policy. I fully recognize that I am more preoccupied than most with the hospital segment of the healthcare industry. I do not nor have I ever expected that this Task Force would be focused on the issues of hospitals in the managed care environment. However, I am concerned that the absence of interest in these problems parallels the same apparent absence of interest in the opinions of sick health plan members, the people who are using hospitals. The question of over bedding is indeed just that, a question. Yet we speak of it as though it were fact. As I have pointed out previously, the popular press has reported low occupancy rates based on licensed bed capacity. This purported bed glut is a mirage. I have been a practicing hospital administrator for over 20 years. I have worked in university settings, private community hospitals, district hospitals and Kaiser Foundation Hospitals. In my experience, the only hospitals that routinely operate all of their licensed beds are Kaiser Hospitals. True bed capacity is measured by calculating occupancy based on operating beds. The gap between licensed beds and operating beds in not inconsequential. I have also submitted to Task Force staff documentation regarding seasonality of admissions. Between the overstatement of bed availability and the seasonality of disease incidence lies a problem of access during peak months, typically during winter. When coupled with the phenomenon of baby boomers marching inexorably toward their most resource consumptive years, there well may be trouble down the road. We cannot plan our health resources moment by moment; some advanced planning is warranted. All of this comes at a time when hospitals are experiencing a very real depredation of revenue as a consequence of managed care. Precisely at the same time when hospitals will be spending down substantial reserves to meet State mandated seismic safety standards by 2008, they must still have sufficient reserves on hand to create and operate the management information systems of the future that will document all aspects of care and produce outcome measurements. California hospitals also maintain the emergency rooms where we treat first and ask financial coverage questions later, where retroactive denial of payment for service is a way of life.

In conclusion, I would be remiss if I did not document my belief that managed care is a system with enormous potential that requires and deserves the benefit of our efforts to
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make it a good system. There are excellent examples of health plans that have ethical practices, wisely administered programs, and outstanding quality. Most of us on the Task Force know who they are. Our Task Force has been given a remarkable opportunity to shape the future. I would be remiss in my duty to my fellow Task Force members if I did not fully express my professional opinion, and I would be remiss in my duty to the residents of the Hospital District for whom I work if I did not carry their issues and concerns to Sacramento.

I offer these remarks in the spirit in which I first accepted this important appointment with the promise to discharge my duties with honesty and diligence.

Respectfully submitted,

[Signature]

NANCY FARBER
Chief Executive Officer

NF/jlm

enclosures
Good afternoon. It is a privilege to address the Harvard Business School Club of Chicago on the critical, but often conflicted issue of healthcare. Because of its central importance to human dignity, to the quality of our community life, and to the Church's mission in the world, I have felt a special responsibility to devote a considerable amount of attention to healthcare at both the local and national levels.

In the last year, I have spoken at the National Press Club on the need to assure access to adequate healthcare for all; I have issued a Protocol to help ensure the future presence of a strong, institutional healthcare ministry in the Archdiocese of Chicago; and in order to be more in touch with ongoing developments in the field, I have joined the Board of Trustees of the Catholic Health Association of the United States — the national organization that represents more than 900 Catholic acute and long-term care facilities.

In the interest of full disclosure, I must warn you that this considerable activity does not qualify me as a healthcare expert. Healthcare policy is challenging and extraordinarily complicated, and in this area I am every bit the layman. But because of its central importance in our lives — socially, economically, ethically and personally — we "non-experts" avoid the healthcare challenge at our peril.

I come before you today in several capacities. First, as the Catholic Archbishop of Chicago who has pastoral responsibility for numerous Catholic healthcare institutions in the Archdiocese — though each is legally and financially independent. Second, as a community leader who cares deeply about the quality and availability of healthcare services throughout metropolitan Chicago and the United States. And third, as an individual who, like you, will undoubtedly one day become sick and vulnerable and require the services of competent and caring medical professionals and hospitals.

The Growing Threat to Not-for-Profit Healthcare

In each role I am becoming increasingly concerned that our healthcare delivery system is rapidly commercializing itself, and in the process is abandoning core values that should always be at the heart of healthcare. These developments have potentially deleterious consequences for patients and society as a whole. This afternoon, I will focus on one important aspect of this problem: the future vitality and integrity of not-for-profit hospitals.

Not-for-profit hospitals constitute the overwhelming majority of Chicagoland hospitals. They represent more than three quarters of the non-public acute-care general hospitals in the country. Not-for-profit hospitals are the core of this nation's private, voluntary healthcare delivery system, but are in jeopardy of becoming for-profit enterprises.

Not-for-profit hospitals began as philanthropic social institutions, with the primary purpose of serving the healthcare needs of their communities. In recent decades, they have become important non-governmental "safety net" institutions, taking care of the growing numbers of uninsured and underinsured persons. Indeed, most not-for-profit hospitals regard the provision of community-benefit as their principal mission. Unfortunately, this historic and still necessary role is being compromised by changing economic circumstances in healthcare, and by an ideological challenge to the very notion of not-for-profit healthcare.

Both an excess supply of hospital beds and cost-conscious choices by employers, insurers, and government have forced not-for-profits into new levels of competition for paying patients. They are competing with one another, with investor-owned hospitals, and
with for-profit ambulatory facilities. In their struggle for economic survival, a growing number of not-for-profits are sacrificing altruistic concerns for the bottomline.

The not-for-profit presence in healthcare delivery is also threatened by a body of opinion that contends there is no fundamental distinction between medical care and a commodity exchanged for profit. It is argued that healthcare delivery is like other necessary economic goods such as food, clothing, and shelter and should be subject to unbridled market competition.

According to this view, economic competition in healthcare delivery is proposed as a welcome development with claims that it is the surest way to eliminate excess hospital and physician capacity, reduce healthcare prices, and assure the "industry's" long-term efficiency. Many proponents of this view question the need for not-for-profit hospitals since they believe investor-owned institutions operate more efficiently than their not-for-profit counterparts and can better attract needed capital. Thus, they attack the not-for-profit hospital tax exemption as an archaic and unwarranted subsidy that distorts the healthcare market by providing exempt institutions an unfair competitive advantage.

This afternoon, I will make three arguments: first, that there is a fundamental difference between the provision of medical care and the production and distribution of commodities; second, that the not-for-profit structure is better aligned with the essential mission of healthcare delivery than is the investor-owned model; and third, that leaders in both the private and public sector have a responsibility to find ways to preserve and strengthen the not-for-profit hospital and healthcare delivery system in the United States. Before making these arguments I need to clarify an important point.

The Advantages of Capitalism and Free Enterprise

In drawing the distinction between medical care and other commodities on the one hand, and not-for-profit and investor-owned institutions on the other, I am not expressing any general bias against capitalism or the American free enterprise system. We are all beneficiaries of the genius of that system. To paraphrase Pope John Paul II: if by capitalism is meant an economic system which recognizes the fundamental and positive role of business, the market, private property, and the resulting responsibility for the means of production — as well as free human creativity in the economic sector — then its contribution to American society has been most beneficial.

As a key element of the free enterprise system, the American business corporation has proved itself to be an efficient mechanism for encouraging and minimizing commercial risk. It has enabled individuals to engage in commercial activities which none of them could manage alone. In this regard, the purpose of the business corporation is specific: to earn a growing profit and a reasonable rate of return for the individuals who have created it. The essential element here is a reasonable rate of return, for without it the commercial corporation cannot exist.

Society’s Non-Economic Goods

That being said, it is important to recognize that not all of society’s institutions have as their essential purpose earning a reasonable rate of return on capital. For example, the purpose of the family is to provide a protective and nurturing environment in which to raise children. The purpose of education at all levels is to produce knowledgeable and productive citizens. And the primary purpose of social services is to produce shelter, counseling, food, and other programs for people and communities in need.

Generally speaking, each of these organizations has as its essential purpose a non-economic goal: the advancement of human dignity.

And this is as it should be. While economics is indeed important, most of us would agree that the value of human life and the quality of the human condition are seriously diminished when reduced to purely economic considerations. Again, to quote Pope John Paul II, the idea that the entirety of social life is to be determined by market exchanges is to run "the risk of an ‘idolatry’ of the market, an idolatry which ignores the existence of goods which by their nature are not and cannot be mere commodities.” (Emphasis supplied.)

This understanding is consistent with the American experience. In the belief that the non-economic ends of the family, social services and education are essential to the advancement of human dignity and to the quality of our social and economic life, we have treated them quite differently from most other goods and services. Specifically, we have not made their allocation dependent solely on a person’s ability to afford them. For example, we recognize that individual human dignity is enhanced through a good education, and that we all benefit by having an educated society; so we make an elementary and secondary education available to everyone, and heavily subsidize it thereafter. By contrast, we think it quite appropriate that hair spray, compact disks, and automobiles be allocated entirely by their affordability.

Healthcare: Not Simply a Commodity

Now it is my contention that healthcare delivery is one of those “goods which by their nature are not and cannot be mere commodities.” I say this because healthcare involves one of the most intimate aspects of our lives — our bod-
ies and, in many ways, our minds and spirits as well. The quality of our life, our capacity to participate in social and economic activities, and very often life itself are at stake in each serious encounter with the medical care system. This is why we expect healthcare delivery to be a competent and a caring response to the broken human condition—to human vulnerability.

To be sure, we expect our physician to earn a good living and our hospital to be economically viable, but when it comes to our case we do not expect them to be motivated mainly by economic self-interest. When it comes to our coronary by-pass or our hip replacement or our child’s cancer treatment, we expect them to be professional in the original sense of that term—motivated primarily by patient need, not economic self-interest. We have no comparable expectation—nor should we—of General Motors or Wal-Mart. When we are sick, vulnerable, and preoccupied with worry we depend on our physician to be our confidant, our advocate, our guide and agent in an environment that is bewildering for most of us, and where matters of great importance are at stake.

The availability of good healthcare is also vital to the character of community life. We would not think well of ourselves if we permitted healthcare institutions to let the uninsured sick and injured go untreated. We endeavor to take care of the poor and the sick as much for our benefit as for theirs. Accordingly, most Americans believe society should provide everyone access to adequate healthcare services just as it ensures everyone an education through grade twelve. There is a practical aspect to this aspiration as well, because like education, healthcare entails community-wide needs which it impacts in various ways: We all benefit from a healthy community; and we all suffer from a lack of health, especially with respect to communicable disease.

Finally, healthcare is particularly subject to what economists call market failure. Most healthcare “purchases” are not predictable, nor do medical services come in standardized packages and different grades suitable to comparison shopping and selection—most are specific to individual need. Moreover, it would be wrong to suggest that seriously ill patients defer their healthcare purchases while they shop around for the best price. Nor do we expect people to pay the full cost of catastrophic, financially devastating illnesses. This is why most developed nations spread the risk of these high-cost episodes through public and/or private health insurance. And due to the prevalence of health insurance, or third-party payment, most of us do not pay for our healthcare at the time it is delivered. Thus, we are inclined to demand an infinite amount of the very best care available. In short, healthcare does not lend itself to market discipline in the same way as most other goods and services.

So healthcare—like the family, education, and social services—is special. It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities. It is, to repeat, one of those “goods which by their nature are not and cannot be mere commodities.” Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier community, not to earn a profit or a return on capital for shareholders. This understanding has long been a central ethical tenet of medicine. The International Code of the World Health Organization, for example, states that doctors must practice their profession “uninfluenced by motives of profit.”

The Advantages of Not-for-Profit Institutions

This leads me to my second point, that the primary non-economic ends of healthcare delivery are best advanced in a predominantly not-for-profit delivery system.

Before making this argument, however, I need to be very clear about what I am not saying. I am not saying that not-for-profit healthcare organizations and systems should be shielded from all competition. I believe properly structured competition is good for most not-for-profits. For example, I have long contended that the quality of elementary and secondary education would benefit greatly from the use of vouchers and expanded parental choice in the selection of schools, similarly, the Catholic Health Association’s proposal for healthcare reform envision organized, economically disciplined healthcare systems competing with one another for enrollees.

Second, I am not saying that all not-for-profit hospitals and healthcare systems act appropriately: some do not. But the answer to this problem is greater accountability in their governance and operation, not the extreme measure of abandoning the not-for-profit structure in healthcare.

What I am saying is that the not-for-profit structure is the preferred model for delivering healthcare services. This is so because the not-for-profit institution is uniquely designed to provide essential human services. Management expert, Peter Drucker, reminds us that the distinguishing feature of not-for-profit organizations is not that they are non-profit, but that they do something very different from either business or government. He notes that a business has “discharged its task when the customer buys the product, pays for it, and is satisfied with it,” and that government has done so when its “policies are effective.” On the other hand, he writes:

“The ‘non-profit’ institution neither supplies goods or services nor controls (through regulation). Its ‘product’ is neither a pair of shoes nor an effective...
regulation. Its product is a changed human being. The non-profit institutions are human change agents. Their 'product' is a cured patient, a child that learns, a young man or woman grown into a self-respecting adult; a changed human life altogether."

In other words, the purpose of not-for-profit organizations is to improve the human condition, that is, to advance important non-economic, non-regulatory functions that cannot be as well served by either the business corporation or government. Business corporations describe success as consistently providing shareholders with a reasonable return on equity. Not-for-profit organizations never properly define their success in terms of profit; those that do have lost their sense of purpose.

This difference between not-for-profits and businesses is most clearly seen in the organizations' different approaches to decision making. The primary question in an investor-owned organization is: "How do we ensure a reasonable return to our shareholders?" Other questions may be asked about quality and the impact on the community, but always in the context of their effect on profit. A properly focused not-for-profit always begins with a different set of questions:

- What is best for the person who is served?
- What is best for the community?
- How can the organization ensure a prudent use of resources for the whole community, as well as for its immediate customers?

Healthcare's Essential Characteristics

I believe there are four essential characteristics of healthcare delivery that are especially compatible with the not-for-profit structure, but much less likely to occur when healthcare decision making is driven predominantly by the need to provide a return on equity. These four essential characteristics are:

- access
- medicine's patient-first ethic
- attention to community-wide needs, and
- volunteerism.

Let me discuss each.

First, there is the need for access. Given healthcare's essential relationship to human dignity, society should ensure everyone access to an adequate level of healthcare services. This is why the United States Catholic Conference and I argued strongly last year for universal insurance coverage. This element of healthcare reform remains a moral imperative.

But even if this nation had universal insurance, I would maintain that a strong not-for-profit sector is still critical to access. With primary accountability to shareholders, investor-owned organizations have a powerful incentive to avoid not only the uninsured and underinsured, but also vulnerable and hard-to-serve populations, high-cost populations, undesirable geographic areas, and many low-density rural areas. To be sure, not-for-profits also face pressure to avoid these groups, but not with the added requirement of generating a return on equity.

Second, not-for-profit healthcare organizations are better suited than their investor-owned counterparts to support the patient-first ethic in medicine. This is all the more important as society moves away from fee-for-service medicine and cost-based reimbursement toward capitation. (By "capitation" I mean paying providers in advance a fixed amount per person regardless of the services required by any specific individual.)

Whatever their economic disadvantages, fee-for-service medicine and cost-based reimbursement shielded the physician and the hospital from the economic consequences of patient treatment decisions and, thereby, provided strong economic support for a patient-first ethic in American medicine. Few insured patients were ever undertreated, though some were inevitably overtreated. Now we face a movement to a fully capitated healthcare system which shifts the financial risk in healthcare from the "payers of care to the providers."

This development raises a critically important question: "When the provider is at financial risk for treatment decisions who is the patient's advocate?" How can we continue to put the patient first in this new arrangement? This challenge will become especially daunting as we move into an intensely price competitive market where provider economic survival is on the line everyday. In such an environment the temptation to undertreat could be significant. Again, not-for-profits will face similar economic pressure but not with the added requirement of producing a reasonable return on shareholder equity. Part of the answer here, I believe, is to ensure that the nation not convert to a predominantly investor-owned delivery system.

Third, in healthcare there are a host of community-wide needs that are generally unprofitable, and therefore unlikely to be addressed by investor-owned organizations. In some cases, this entails particular services needed by the community but unlikely to earn a return on investment, such as expensive burn units, neonatal intensive care, or immunization programs for economically deprived populations. Also important are the teaching and research functions needed to renew and advance healthcare.

The community also has a need for continuity and stability of health ser-
vices. Because the primary purpose of non-profits is to serve patients and communities, they tend to be deeply rooted in the fabric of the community and are more likely to remain—if they are needed—during periods of economic stagnation and loss. Investor-owned organizations must, on the other hand, either leave the community or change their product line when return-on-equity becomes inadequate.

Fourth, volunteerism and philanthropy are important components of healthcare that thrives best in a not-for-profit setting. As Peter Drucker has noted, volunteerism in not-for-profit organizations is capable of generating a powerful countercurrent to the contemporary dissolution of families and loss of community values. At a time in our history when it is absolutely necessary to strengthen our sense of civic responsibility, volunteerism in healthcare is more important than ever. From the boards of trustees of our premier healthcare organizations to the hands-on delivery of services, volunteers in healthcare can make a difference in peoples’ lives and “forge new bonds to community, a new commitment to active citizenship, to social responsibility, to values.”

Role of Mediating Institutions
In addition to my belief that the not-for-profit structure is especially well aligned with the central purpose of healthcare, let me suggest one more reason why each of us should be concerned that not-for-profits remain a vibrant part of the nation’s healthcare delivery system: They are important mediating institutions.

The notion of mediating structures is deeply rooted in the American experience. On the one hand, these institutions stand between the individual and the state; on the other, they mediate against the rougher edges of individualism’s inclination toward excessive competitiveness in healthcare. The need for mediating institutions in healthcare is great. Private sector failure to provide adequately for essential human services such as healthcare invites government intervention. While government has an obligation to ensure the availability of and access to essential services, it generally does a poor job of delivering them. Wherever possible we prefer that government work through and with institutions that are closer and more responsive to the people and communities being served. This role is best played by not-for-profit hospitals. Neither public nor private, they are the heart of the voluntary sector in healthcare.

Earlier, I identified several reasons why I believe investor-owned organizations are not well suited to meeting all of society’s needs and expectations regarding healthcare. Should the investor-owned entity ever become the predominant form of healthcare delivery, I believe that our country will inevitably experience a sizeable and substantial growth in government intervention and control.

Until now, I have made two arguments: first, that healthcare is more than a commodity—it is a service essential to human dignity and to the quality of community life; and second, that the not-for-profit structure is best aligned with this understanding of healthcare’s primary mission. My concluding argument is that private and public sector leaders have an urgent civic responsibility to preserve and strengthen our nation’s predominantly not-for-profit healthcare delivery system.

This is a pressing obligation because the not-for-profit sector in healthcare may already be eroding as a result of today’s extremely turbulent competitive environment in healthcare. The problem, let me be clear, is not competition per se, but the kind of competition that undermines healthcare’s essential mission and violates the very character of the not-for-profit organization by encouraging it—even requiring it—to behave like a commercial enterprise.

Contemporary healthcare markets are characterized by hospital overcapacity and competition for scarce primary care physicians, but also and more ominously by shrinking health insurance coverage, and growing risk selection in private health insurance markets. These latter two features encourage healthcare providers to compete by becoming very efficient at avoiding the uninsured and high risk populations, and by reducing necessary but unprofitable community services—behavior that strikes at the heart of the not-for-profit mission in healthcare. Moreover, the environment leads some healthcare leaders to conclude that the best way to survive is to become for-profit or to create for-profit subsidiaries. The existence of not-for-profits is further threatened by the aggressive efforts of some investor-owned chains to expand their market share by purchasing not-for-profit hospitals and by publicly challenging the continuing need for not-for-profit organizations in healthcare.

Advancing the Not-for-Profit Healthcare Mission
Each of us and our communities have much to lose if we allow unstructured market forces to continue to erode the necessary and valuable presence of not-for-profit healthcare organizations. It is imperative, therefore, that we immediately begin to find ways to protect and strengthen them.

How can we do this? Without going into specifics, I believe it will require a combination of private sector and gov-
ernmental initiatives. Voluntary hospital board members and executives must renew their institutions' commitment to the essential mission of not-for-profit healthcare. Simultaneously, government must reform health insurance markets to prevent "redlining" and assure everyone reasonable access to adequate healthcare services. Finally, government should review its tax policies to ensure that existing laws and regulations are not putting not-for-profits at an inappropriate competitive disadvantage, but are holding them strictly accountable for their tax exempt status.

Let me conclude by simply reiterating the thesis I made at the beginning of this talk. Healthcare is fundamentally different from most other goods and services. It is about the most human and intimate needs of people, their families, and communities. It is because of this critical difference that each of us should work to preserve the predominantly not-for-profit character of our healthcare delivery in Chicago and throughout the country.

Bibliography


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Surgical Repair of Total Anomalous Pulmonary Venous Connection: Thirty-year Trends
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Purpose: The purpose of this study was to examine the factors associated with the improvement in perioperative mortality and to determine the risk factors for death and reoperation due to pulmonary venous obstruction after repair of total anomalous pulmonary venous connection (TAPVC). Method: One hundred patients (47 supracardiac, 25 cardiac, 20 infracardiac, and 8 mixed connection) operated between April 1966 and January 1995 were included in this study. Using univariate and multivariate regression analysis, risk of early and late mortality and need for reoperation was analyzed. Results: In spite of increased frequency of neonatal repair (29% in 1966-85; 62% in 1991-95, p < 0.05) in the most recent time period, operative mortality declined (4/38 = 11% in 1966-85, 5/38 = 14% in 1986-90, 0/26 = 0% in 1991-95). The incidence of post-op pulmonary hypertension crisis (PCH) (p < 0.001), death due to PCH (p = 0.002), and reoperation (p = 0.05) significantly decreased over the study period. By ANOVA, by univariate analysis, pre-op PH (p < 0.001) and pre-op NYHA class (p < 0.01) correlated with early mortality up to 1990 but not in the past 5 years. Multiple logistic regression identified only small pulmonary venous confluence associated with diffuse pulmonary vein stenosis as an independent risk factor for early (p < 0.001) and late death (p < 0.001) as well as need for reoperation (p < 0.003). At a median follow-up of 86 months, late survival was 97% (88/91 operative survivors) and all are NYHA class I. Conclusion: Improvements in surgical technique and perioperative management account for the reduction in both mortality and need for reoperation for most types of TAPVC. However, the presence of a small pulmonary venous confluence associated with diffuse pulmonary vein stenosis remains a consistent risk factor for adverse outcome.

Brain Oxygenation and Cardiopulmonary Bypass Method in Children
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Cerebrovascular hemoglobin-O2 saturation (ScO2) measured by near infrared spectroscopy reflects the O2 supply/demand relationship in the brain. Recent studies in children undergoing cardiac surgery showed that an increase in ScO2 during CPB cooling before circulatory arrest was associated with favorable neurologic outcome. The present study examined the effect of temperature, arterial pressure, and Hct on ScO2 in order to identify CPB factors controlling ScO2. We studied 35 Children <7 years of age during ASD repair. They were assigned to 1 of 4 CPB protocols: normothermic full-flow (150 ml/kg/min), hypothermic full-flow (150 ml/kg/min); hypothermic low-flow (75 ml/kg/min), or hypothermic low-flow, ScO2 during CPB was measured relative to pre-CBP and compared between groups. Groups had similar age (3 ± 1 yr) and pre-CBP nasopharyngeal temperature (35 ± 1°C, MAP 78 ± 2 mmHg, pH 7.48 ± 0.01, POCO2 28 ± 11 torr), POCO2 (460 ± 30 torr), and Hct (35 ± 1%). Of these variables, only Hct, temperature, MAP, and Hct changed significantly during CPB: TP temperature decreased in hypothermic groups versus normothermic group (25 ± 1 ± 33 °C), MAP decreased in hypothermic low-flow versus other groups (32 ± 1 v 50 ± 2 mmHg), and Hct decreased in hypothermic low-Hct versus other groups (16 ± 1 v 23 ± 1%). In hypothermic full-flow group, ScO2 increased 20 ± 1% during CPB (p < 0.01). In contrast, ScO2 during CPB remained unchanged from baseline in all other groups. These data show that increases in ScO2 during CPB cooling result from hypothermia and not hemodilution or other CPB factors. However, arterial pressure/pump flow and Hct must be maintained at certain levels in order for brain hypothermia to increase ScO2. Thus, temperature, arterial pressure, and Hct influence brain oxygenation during CPB cooling and may be important to cerebral protection before inducing circulatory arrest.

Mortality Risk for Surgical Procedures for Congenital Heart Defects in Children: Effect of Type of Insurance
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We previously reported a strong association between large case volume and low mortality rates for congenital heart surgery. To explore whether this effect is related to differences in type of insurance, we used hospital discharge abstract data from children in 8 states (CA, CO, FL, IL, MD, MA, PA, and WA) to determine
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the effect of insurance on in-hospital mortality for surgery for congenital heart defects.

Of 724 pediatric cardiac surgical cases from 107 institutions identified using ICD-9-CM codes, 489 (67%) had 1 of 32 specific cardiac procedures. In procedure-adjusted analyses of this group using generalized estimating equations, we determined that the effect of all insurance type (commercial, medicad, or HMO) on in-hospital mortality was significant. Insurance type had a strong effect on mortality, although the effects differed from state to state. Adjusting for baseline state effects and procedure, in comparison to patients with CA commercial insurance, odds ratios (OR) for in-hospital death for patients with medicad were 3.6 (p < 0.0001) or greater in CA, CO, MA, MD, and PA, and were 0.9 in FL, IL, and WA. In patients insured by HMOs in CA, FL, IL, MA, and MD, ORs for death were 2.9 (p < 0.01) in comparison to patients with CA commercial insurance; however, the risk decreased much lower in patients insured by HMOs in WA (OR 0.2) or PA (OR 0.6), compared to CA commercial insurance.

In a large population-based analysis in 8 states, insurance type had a surprisingly strong effect on mortality for congenital heart surgery. Understanding the relationship between insurance type and mortality will be essential to formulate appropriate policy for care for these children.

Chamber Size and Aorto-Septal Angle Control Septal Shear Stress: A Possible Explanation for the Development and Progression of Subaortic Stenosis

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Previous studies have demonstrated an association between (1) subaortic stenosis (SAS) and (2) associated cardiac defects and morphologic abnormalities (such as septal Aorto-Septal angle [AoAS]). We have demonstrated elevated septal shear stress in the regions of SAS formation which are directly caused by these associated factors. This study addresses the hypothesis that outflow tract size (OTS) interacts withAoAS such that the effect of septal shear stress increases with growth from infancy to childhood. Methods: The Navier-Stokes equations of motion were solved on a Cray C90 supercomputer and validated experimentally. Outflow tract was varied from 0.8 to 2 cm (linearly with gradual convergence and divergence). Results: SAS increased from 0.5-5 m/s as OTS of 120°-150° was based on our clinical studies. Results: Septal shear stress increased with smaller AoAS for all flow conditions studied. Septal shear increased as OTS increased for normalized flow conditions (26.1 to 32.0 dynes/cm² for steepest angle, 1 and 2 cm chamber, outflow velocity = 80 cm/s). The sensitivity of septal shear stress to AoAS was enhanced with growing OTS (35% elevation vs 25% OTS = 1-2 cm). Conclusions: Steepened AoAS causes elevations in septal shear stress to levels which have been associated with cellular changes in previous studies. This effect is enhanced by growing OTS. These findings may help identification of patients at risk for either development or recurrence of SAS, and may illustrate why SAS is rare in infancy and more commonly found later in childhood.

Intermittent Whole Body Perfusion with "Semistoplegia" versus Blood Perfusion to Extend Duration of Circulatory Arrest

Takuya Miura, Toshiharu Shinoka, Peter Laussen, Adre da Plessis, Hart Lidov, Richard A. Jones. Department of Cardiac Surgery, Children's Hospital, Boston, MA

Whole body perfusion with an organ preservation solution "hypothermosol" (HTS) similar to University of Wisconsin solution has been reported to allow more than 3 hrs without blood perfusion. Fifteen piglets underwent 185 minutes cardiopulmonary bypass including 100 minutes of hypothermic circulatory arrest (CA) at 15°C. Control animals had uninterrupted CA (group-C, n = 5), group HTS were perfused with HTS for 5 minutes every 25 minutes during CA (n = 5) and group B were perfused intermittently as for group HTS using the blood perfusate in the circuit (n = 5). Redox state of the brain was assessed by near-infrared spectroscopy (NIRS) during and after CA. Neurological recovery of animals was evaluated daily by neurological deficit score (NDS, 0 = normal, 500 = brain death) and overall performance categories (OPC: 1 = normal, 5 = brain death). Blood samples were taken on the next day to evaluate organ damage. Brain was fixed in situ on postoperative day 4 and examined by histological score (HS; 0 = normal, 5 = necrosis). All animals except one group of HTS survived the procedure. NIRS revealed marked reduction of cytochrome a3 signal in group-HTS during CA. Other results are shown below.

PCO₂ NOS CO₂ Exhume Hb

<table>
<thead>
<tr>
<th>Group</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>IV</th>
<th>III</th>
<th>II</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group-C</td>
<td>216</td>
<td>140</td>
<td>110</td>
<td>92</td>
<td>36</td>
<td>3.4</td>
<td>2.8</td>
<td>2.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Group-HTS</td>
<td>204</td>
<td>108</td>
<td>85</td>
<td>65</td>
<td>36</td>
<td>2.6</td>
<td>2.5</td>
<td>3.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Group-B</td>
<td>114</td>
<td>42</td>
<td>28</td>
<td>24</td>
<td>3.4</td>
<td>3.3</td>
<td>3.1</td>
<td>2.8</td>
<td>2.8</td>
</tr>
</tbody>
</table>

mean value: *p < 0.05 vs. Group-C by ANOVA

Conclusion: Intermittent whole body perfusion with blood perfusate rather than HTS has a beneficial effect on recovery after prolonged CA.

Dexeramine Avidex Reoxygenation Injury in Immature Cyranotic Heart

Kai Bohnke, Kristo Morita, Gerald D. Buckberg, Bernhard Winkelman, Helen Young, Friedhelm Beyerstedt. Albert-Ludwigs-University, Cardiovascular Surgery, Freiburg, Germany

Introduction: Hypoxia-reoxygenation of cyranotic immature hearts on cardiopulmonary bypass (CPB) causes a reoxygenation injury, which is iron-catalyzed, oxygen free radical related and is avoidable by treatment with Dexeramine.

Methods: Sixteen immature piglets (2-3 weeks, 3-5 kg) underwent 1 hour of hypoxemia on CPB (pO₂ 20-30 mm Hg) with flow and hematocrit adjusted to maintain normal CO₂ tissue delivery. Six were not made hypoxic (control). Six were reoxygenated on CPB either with (IV) or without (IVe) Dexeramine (50 mg/kg). We assessed myocardial conjugated diene (CD), and creatine krase (CPK) production, and tissue antioxidant reserve capacity (MDA production, ADRC). Ventricular function was evaluated from endysosscopic elastance (Ees; contractility catheter).

Results:

<table>
<thead>
<tr>
<th></th>
<th>IV delivery (mL/kg/min)</th>
<th>Ees (%) recovery</th>
<th>CO-Prod (ng/100 mg)</th>
<th>CPK-Prot (U/L/100 mg)</th>
<th>ADRC (mg/ml protein)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>14 ± 2</td>
<td>102 ± 9</td>
<td>1.0 ± 0.5</td>
<td>10.0 ± 4.9</td>
<td>760 ± 40</td>
</tr>
<tr>
<td>IVe</td>
<td>14 ± 1</td>
<td>135 ± 8</td>
<td>1.3 ± 0.7</td>
<td>15.5 ± 5.9</td>
<td>110 ± 59</td>
</tr>
<tr>
<td>Rx</td>
<td>13 ± 1</td>
<td>96 ± 11</td>
<td>0.7 ± 0.4</td>
<td>12.0 ± 6.8</td>
<td>810 ± 40</td>
</tr>
</tbody>
</table>

Data are mean ± SE (ANOVA). *p < 0.05 vs. control. **p < 0.05 vs. IVe

Conclusion: These results imply that hypoxia-reoxygenation during surgical correction of cyranotic subjects on CPB causes a reoxygenation injury that results in biochemical and functional myocardial damage. Oxygen free radicals generated through the iron catalyzed Haber-Weiss reaction seem to play an important role. Treatment with the iron-chelating agent Dexeramine avoids this "unintended reoxygenation injury".

Cardiovascular Disease in the Young: General Pediatric Cardiology I

Monday Morning

Convention Center Exhibit Hall

Abstracts 0246-0263

Hemodynamic Effects of Captopril in Children with a Biventricular Glenn Shunt

Satinder K. Sandu, Dennis C. Crowley, Thomas R. Lloyd, Achi Ludmirdsky, Sharon P. Stier, Roger P. Vermillion, Robert H. Beecken. C.S. Mott Children's Hospital, The University of Michigan, Ann Arbor, MI

To assess the acute hemodynamic effects of captopril (C) in children with a biventricular Glenn shunt (BGG), oral captopril (0.5 mg/kg) was administered at catheterization to 16 children 5-20 months after BGG catheterization for univentricular heart. Patient age ranged from 14-98 months (median 19). Pulmonary blood flow (Qp) was calculated using measured oxygen consumption (VO₂), and systemic flow (Qs) was measured by thermodilution (in catheter in right atrium, thermodilutor in aort). Values at baseline, 30 and 60 minutes were compared by repeated measures ANOVA (mean ± SE).

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>30 min</th>
<th>60 min</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQp/CQs ratio</td>
<td>0.63 ± 0.03</td>
<td>0.66 ± 0.04</td>
<td>0.92 ± 0.04</td>
<td>0.009</td>
</tr>
<tr>
<td>CO₂ (mmHg)</td>
<td>3.0 ± 0.3</td>
<td>2.9 ± 0.3</td>
<td>2.7 ± 0.3</td>
<td>0.028</td>
</tr>
<tr>
<td>LVO₂ (mmHg/L)</td>
<td>4.8 ± 0.2</td>
<td>5.2 ± 0.2</td>
<td>5.2 ± 0.2</td>
<td>0.001</td>
</tr>
<tr>
<td>LVO₂ (mL/min)</td>
<td>14 ± 0.7</td>
<td>12 ± 0.5</td>
<td>12 ± 0.5</td>
<td>0.003</td>
</tr>
<tr>
<td>ApO₂ (mmHg)</td>
<td>63 ± 0.9</td>
<td>61 ± 1.6</td>
<td>61 ± 1.2</td>
<td>0.029</td>
</tr>
</tbody>
</table>

Stroke index increased (42 vs 44 cc/min/pa; p = 0.01), with an increase in peak systolic dP/dt (1262 vs 1442 mmHg/sec; p = 0.02), but no change in RV EDP.
Minority Report: Differences between PPOs and HMOs

Many of the recommendations refer to "health plans" without consistently identifying whether the recommendations will apply only for health care service plans (Knox-Keene licensed HMOs) or also for indemnity/managed care plans (PPOs). Some recommendations, such as the ones for tracking outcomes data, identifying vulnerable populations and establishing a "gold standard" to waive prior authorization requirements for providers, will be extremely difficult and, in many cases impossible, for indemnity or PPOs plans to implement. Cumulatively, if all of the recommendations are applied to PPOs, consumers will find fewer and fewer PPO options available, other than with the very largest plans offering both HMO and a version of PPO. This latter alternative is not considered adequate "choice" for many Californians.

Many plan designs within PPOs do not use "gatekeepers" or centralize health care services through a medical group that would be capable of tracking and reporting data. All PPOs do not contract directly with their providers, but instead may rely on a PPO vendor. Few PPOs capitate the providers, relying primarily on negotiated fee schedules or discounted fee-for-service. Finally, PPOs do not restrict their insureds exclusively to a limited provider network, although claims are paid at a higher level for in-network care. In addition, many of these Task Force recommendation requirements will be equally difficult for HMOs to apply to that small portion of their business under point of service using non-network providers. In these situations, the HMO does not have leverage, use of protocols, require provider reporting data or exert financial controls other than reimbursement limitations. For the smaller PPOs, this is the situation for their entire book of business. These differences and capabilities need to be recognized when considering implementation of Task Force recommendations and future regulation.

Focusing further on the regulatory structure, the two year time frame is very short for consideration of many complex regulatory and financial issues prior to folding the regulation of PPOs into the new organization. There are many requirements specific to HMOs that are not applicable to PPOs, as well as the reverse. Where a carrier has the majority of business through its HMO, the remaining PPO business is often regulated through Knox-Keene and the Department of Corporations (DOC), providing a single regulatory authority. However, for other carriers, the major medical indemnity or PPO coverage represents just one product among many lines of business regulated under a general life and disability or other insurance license issued and regulated by the Department of Insurance (DOI). Other insurance products provided by such insurers and regulated by DOI include workers' compensation, group and individual life.
insurance, long term care insurance, short and long term disability insurance, supplemental coverage such as, vision, dental, specific disease, short-term medical and high-deductible catastrophic plans as well as the full range of commercial insurance products. Regulation of all of these products is unlikely to move to the new agency. Forcing all PPO carriers to meet the requirements for HMOs and face dual regulatory authority will financially drive all but the largest PPOs out of California, reducing product innovation as well as consumer choice among types of plans. In addition, it limits innovation for combined coverage products.

Unlike health care service plans, which are regulated under one general section of the Health and Safety Code (the Knox-Keene Act), insurance companies are regulated throughout the Insurance Code. There are only a few sections of the Insurance Code which mirror the Knox-Keene Act, primarily in the areas of small employer health insurance and mandated benefits. There are distinct differences in the way insurers and health care service plans do business:

- Insurers must meet strict Unfair Claims Settlement Practices Act requirements and regulations that do not apply to HMOs that are prepaid. The background paper to the Regulatory Organization Paper is in error in stating that the Insurance Commissioner has no authority to enforce the payment of claims. The law sets out severe penalties, including administrative fines which may be levied by the Commissioner when an unfair claims practice has occurred.
- Most insurers contract with a PPO network vendor, and thus do not directly contract with providers. Many PPOs do not have closed panels or capitated provider networks, therefore they are not required to meet and would not have the capability to meet the medical and quality assurance audits required for HMOs.
- PPOs, as insurers, must meet solvency requirements according to reserve formulas that are completely different than the tangible net equity requirements of HMOs.
- PPOs have a different dispute resolution procedure governed by ERISA and the Unfair Claims Settlement Practices Act and Regulations, while HMOs have an internal grievance procedure. PPO consumers do not have to satisfy a grievance process before going to the DOI with a complaint.
- PPOs have a completely different tax structure and are subject to premium taxes as an indemnity insurance product. The DOI collects those premium taxes, although the regulatory functions of the DOI are funded through fees paid by the insurance industry rather than premium taxes. HMOs are considered to provide health care services rather than insurance and thus are subject to a lower effective tax burden through the Bank and Corporations Tax.

These regulatory distinctions between types of health plans underscore how difficult it would be to transfer the regulatory functions for PPOs to a department that specializes in regulation of health care service plans. Not only would this lead to a natural tendency to regulate PPOs as if they were HMOs, but it would also subject the parent life insurance company to dual regulation. The parent company would have to pay twice for regulation that currently is done more efficiently at the Department of Insurance. Such dual regulation would further disadvantage PPOs and limit their participation in the California market.

Thank you for the opportunity to represent the views of one of the few remaining non-HMO carriers serving the consumers and businesses of the State of California.

Sincerely,

Rebecca Bowes
December 19, 1997

To: Governor Wilson, California legislators, Californians and interested parties

Introduction

I sit on the Managed Care Improvement Task Force as a consumer group representative. I am a Senior Attorney and Policy Analyst for Consumers Union’s West Coast Regional Office, and have been the head of the health group for several years. Consumers Union, the nonprofit publisher of Consumer Reports, is an independent, nonprofit testing and information gathering organization, serving only the consumer. We are a comprehensive source of unbiased advice about products and services, personal finance, health, nutrition, and other consumer concerns. Since 1936, our mission has been to test products, inform the public, and protect consumers. Our income is derived solely from the sale of Consumer Reports with circulation of 4.5 million, and other services, nonrestrictive and noncommercial contributions, grants and fees. The West Coast Regional Office represents consumers on various issues and has focused particularly on managed care in California.

This short statement is the only opportunity for me to briefly express my views on the broad range of topics addressed by the Managed Care Improvement Task Force. I appreciated the opportunity to represent consumers on the task force and deeply respect my colleagues who also served on it.

Significant recommendations

The task force operated in a highly charged political atmosphere and was dominated by supporters of the managed care industry who believe that market forces will adequately address consumer concerns. Despite the politics, the composition, and the predisposition of many of the members and staff, this task force produced numerous recommendations which will benefit managed care consumers in California. Taken as a whole, the package provides a broad range of modest recommendations which, if fully implemented, will forge a positive path towards improving and reforming managed care in the State of California. Consumers Union hopes that the legislature and the governor will promptly enact into law this set of recommendations. It represents minimal reforms necessary to be responsive to the millions of Californians enrolled in managed care plans.

Significant Omissions

As the Chairman’s letter may note, the task force did not address the critical problem of uninsured or underinsured Californians. We have more uninsured than any other state: 6.6
million Californians, or 23% of the population under 65, have no health insurance. Millions more have insufficient insurance to meet their needs. The task force should have, but did not, address the affect of managed care on the uninsured.

Millions of low income Californians are now enrolled in Medi-Cal managed care programs throughout the state. Millions more will be transferred into managed care plans in the next few years. Yet the task force did not study the well-documented problems or issues faced by Medi-Cal beneficiaries in order to make informed recommendations, nor did it make any recommendations to immediately benefit this large group of managed care consumers.

Failure to adequately protect consumers.

In numerous important respects the Task Force stopped short of providing consumers with the adequate protections they currently need. Many consumers are experiencing serious problems with accessing quality health care. Studies and surveys consistently report consumer problems with access to physicians, specialists and treatment, delays or denials of care, and a broad concern that the fiscal interests of the health plan may unduly influence medical recommendations and decisions. The public survey conducted by the Task Force (completed after recommendations were formulated) found that 42% of Californians or 6.72 million people have had at least one problem with their health plan in the last year. Of this group 51% or 3.4 million indicated that they suffered longer or that their condition worsened as a result of the problem, and 5% or 336,000 Californians reported that they are permanently disabled as a result of the problem. These results reveal a crisis in the delivery of managed care in the state.

Given these common complaints and startling statistics, the Task Force should have recommended bolder action to protect consumers immediately, holding plans accountable for their actions or inactions in providing quality health care. We repeatedly encourage the private sector and various task forces or working groups of stakeholders to develop standards or best practices, yet we have done little to bolster public enforcement or to hold plans accountable for their actions today. Unfortunately, consumers cannot afford to wait for these protections; they cannot wait to get sick or injured.

The Task Force recommends that a new agency be created to regulate managed care. Yet we provided little guidance to direct the new agency to immediately beef up its review and enforcement of consumer protections in managed care. Consumers Union urges the Department of Corporations to take immediate steps to implement and enforce current law, providing for consumer information and full review of access to quality health care, prompt and adequate resolution of consumer complaints, and systematic sanctioning of plans or groups that fall short of current standards, to the fullest extent permitted by law. This increase of review and enforcement activity should be possible and appropriate given the Department's recent large increase in funding for health care. Furthermore, Consumers Union recommends that the new health care agency (if and when it is created) take an active pro-consumer stance in enforcing and interpreting the law. Finally, it will be incumbent on the Department of Corporations or the new agency to ensure that consumer groups are adequately represented at the various task forces or working groups as suggested by this Task Force.

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It was particularly disturbing that our Task Force fell short of addressing the needs of certain populations: women, children, adolescents, elderly, poor people, non-English speakers, or people with disabilities or chronic conditions. Each of these populations needs special attention regarding benefits, treatment, dispute resolution, access and quality measurement. Although we made some findings and recommendations for vulnerable populations, we did not devote the time and attention necessary to adequately address the needs of these specific populations and the special needs that they face.

Composition of the Task Force

As indicated above, I am pleased to have had the opportunity to represent consumers on the task force. The consumer voice, however, was not as strongly represented on the task force as it should have been. The legislation that enabled this task force directed that there should be 6 persons on the task force who represent consumer groups, and 6 who represent individual health plan enrollees, totaling 12 members that would represent consumers or consumer groups. In fact very few of the appointees legitimately represented individual consumers (without another interest) or consumer groups. If consumers had been represented at the table as intended, perhaps the recommendations would look very different. Notably, none of the members of the task force was from a consumer group specifically representing children, women, disabled people or other vulnerable populations.

Conclusion

This task force makes serious important recommendations to improve the delivery of managed care in the state. These recommendations provide the Governor and the legislature with policy recommendations to guide them in the coming legislative session. These findings and recommendations are not meant in any way to be exclusive or exhaustive. Rather, they represent a minimal set of improvements necessary now. Consumers Union believes that consumers would be better served by faster implementation of bolder steps to provide for better consumer protections, information and involvement now.

Sincerely yours,

Jeanne Finberg
Senior Attorney/Policy Analyst
Consumers Union of U.S., Inc.
West Coast Regional Office