Improving Managed Health Care in California

Supporting Documentation

Volume Three

January 1998

Managed Health Care Improvement Task Force
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Supporting Documentation

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California State Staff:
Alice M. Singh, Deputy Director for Legislation and Operations; Hattie Rees Skubik, Deputy Director for Policy and Research; Terri Shaw, Jennifer Tachera, Stephanie Kauss, and Enrique Ramirez.

Stanford University Staff:
Sara J. Singer, Director/Editor; Carol Vorhaus, Margaret Laws, Megan Jenks, Aimee Jungman, Vicky Keston, Matt Solomon, Susan Boyle, Brian Haas, Meg Holland, and Tom Lee.

Pete Wilson Governor
Alain C. Enthoven, Ph.D. Chairman
Philip J. Romero, Ph.D. Executive Director

Managed Health Care Improvement Task Force
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: The Main Report

Volume 2 contains the following:

- The Chairman’s Letter [the same letter included 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 [This Volume]

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 in 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.

Managed Health Care Improvement Task Force
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Government Regulation and Oversight of Managed Health Care

Background Paper

I. Introduction

Nationally, over one trillion dollars per year are spent in the United States on health care. As health care has become a larger proportion of the overall economy, more entrepreneurs have become involved in the industry, developing market innovations that often do not fit neatly into the categories of businesses and insurance coverages that have traditionally been regulated. In recent years, as managed care has obtained the dominant market position, health care financial intermediaries have become increasingly involved in managing not just the business end of health delivery, but the clinical end. In the current California health care market place, many different regulators are involved in a fragmented oversight structure.

The state of California utilizes a regulatory structure 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 manyfold. (Figure 1 places the regulatory structure in the context of the current marketplace.) One of the central charges of the Task Force is to review the organizational structure of state regulators and determine whether it needs updating. That is the purpose of this paper: to summarize the key players in state and federal regulation of managed care and their responsibilities; to identify design criteria for evaluating the current structure and (if necessary) redesigning a new one; and to recommend changes in state regulatory organization, if needed.

The authors conclude that the industry has evolved business forms well beyond the definitions that govern existing lines of jurisdiction, and some consolidation of jurisdiction among state regulators is necessary.

How this Paper Is Organized

Section II summarizes the necessary roles for government. Section III summarizes the responsibilities of state and federal regulators. Section IV outlines the quasi-regulatory functions performed by private actors such as NCQA. Section V outlines the options available for reorganizing state regulatory organization, and Section VI presents our conclusions and recommendations.

II. Necessary Role for Government

There are several areas in which government intervention is required, where purchasers, plans, and the industry can not or do not satisfy desired goals. Two of the essential roles of government include consumer protection and helping the market work well.

A. Consumer Protection

One of the most fundamental tasks of government is to create the conditions for markets to serve consumers well. These conditions include the rule of law, including securing property rights and defining liability, licensing facilities and professionals, contract enforcement, anti-trust and a regulatory scheme that fits the needs of each market. Well-conceived rules can help markets work better and increase satisfaction all around. For example, the rule that permits airlines to overbook and then auction vouchers to induce volunteers to take later flights creates a “win-win” situation. Consumers’ health and safety need special government protection because when consumers get sick, they are unable to “shop” for themselves as they would for other goods in other markets. Advocacy groups for the poor and disenfranchised are natural allies in the government’s efforts to protect health care consumers; regulators should view them as such.

Government has been active in defining and securing patients’ rights under health care coverage contracts, such as rights to free expression of medical judgments by doctors, to information about how plans operate, to timely payment for care for emergencies, and to confidentiality of personal medical records. In
Figure 1. Overview of Regulatory Structure

**Federal Health Care Regulatory Structure**

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

**California Health Care Regulatory Structure**

*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.*
several of these areas, there is a need for careful balancing. For example, protection of confidentiality needs to be balanced against the legitimate and important needs for research on the relationship between treatments and outcomes to find out what medical treatments work best.

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 (PPOs), 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). The Medical Practice Act governs individual medical licensure. These three bodies of law, which contain many similar provisions, provide consumer protections through financial standards, contractual requirements, quality assurance programs, required grievance and appeals processes, oversight of soliciting and marketing practices, and mandatory basic benefits.

The Knox-Keene Act, in particular, is an extensive body of law that contains specific requirements in numerous areas. For example, the Act requires health plans to file extensive documentation on their proposed health care delivery systems prior to licensure. Health plans must file copies of their contracts with network providers; maps illustrating where provider facilities and offices are located to ensure that licensed facilities and professionals are within 30 minutes or 15 miles of the enrollee's workplace or residence; documentation regarding the ratio of full-time equivalent physicians to anticipated enrollees; demonstrations that the number of specialists will be adequate to serve the expected population of enrollees; and descriptions of the plan's quality assurance program, grievance and appeals processes, and provisions for continuity of care as a patient moves through the health care delivery system. The licensing application also requires detailed financial information to ensure regulators that the health plan's management has realistic projections about costs and revenues and to ensure that the plan has enough reserves to cover all claims costs.

Once a health plan is licensed, the Knox-Keene Act requires the plan to submit quarterly and annual financial statements and to maintain a reserve, or tangible net equity, sufficient to cover outstanding claims. Plans also undergo regular financial audits, and may be placed under closer examination if their financial reports indicate problems.

The Knox-Keene Act contains more extensive requirements in the areas of consumer protection relating to patient care. The Act requires all health plans to have grievance and appeals processes that allow enrollees to submit disputes to the plan and receive a timely response, including expedited review of grievances involving serious conditions. The Act also allows enrollees to seek assistance from the DOC if they are unsatisfied with the health plan's response. When a plan denies coverage for care, the Act requires that the plan must disclose to patients and providers the criteria or clinical basis for the decision upon request. The Act also contains an outside, independent review process for terminally ill patients who have been denied coverage for experimental treatments. Finally, the Act protects consumers by prohibiting unethical marketing and solicitation practices, such as using statements in advertising that are false, deceptive or misleading. All advertising and marketing materials must be submitted to the DOC for review prior to use.

1. Insurance Contracts
The complexity of health insurance contracts makes necessary special rules to ensure there is a meeting of minds between buyers and sellers — what is being sold is what is being delivered. There must be rules and processes that lead to the reasonable expectations of reasonable persons being met.

The Knox-Keene Act and its underlying regulations, which govern HMOs in California, sets comprehensive standards for the contracts between health plans and consumers. All contracts between plans and enrollees, plans and employers, and plans and providers must be filed with the DOC for review and approval, and must meet the statutory “fair and reasonable” requirement that is imposed. Specific requirements are spelled out. Health plans, for example, must cover all medically necessary basic health care services, which are defined to include physician care, hospital care, emergency care in and out of the network.
with a “prudent layperson” standard), urgent care in and out of the network, home health care, diagnostic
tests, laboratory tests, preventive care, physical therapy, speech therapy, and occupational therapy. In addi-
tion, there are statutory mandates regarding preventive care for children, reconstructive surgery and prosthet-
ics for mastectomy patients, medical transportation, screening and diagnostic tests for cervical cancer and
osteoforosis, and medically necessary surgery for temporal mandibular joint disorder. These benefits are not
subject to negotiation between plans and employers; they must be provided in any benefit package. Plans
are also required to offer employers coverage for services such as diabetes education, acupuncture, special
footwear, substance abuse treatment, infertility coverage, and orthotics and prosthetics.

The Act sets out specific disclosure requirements pertaining to these benefit mandates, as well as other
disclosures regarding exclusions, limitations and copayments, and physician payment arrangements. There
are specific contractual requirements for plan contracts with small employers of fewer than 50 employe-
s so that plans may not refuse them coverage nor refuse to renew existing coverage.

The Knox-Keene Act also protects consumers in ways that help expand access to health care coverage. For
example, the Act prohibits the use of genetic information in underwriting so that individuals with genetic
predispositions to certain diseases cannot be denied coverage simply because of that predisposition. The
Act also prohibits plans from denying coverage or services to individuals who are blind, who are physically
or mentally impaired, who have conditions related to diethylstilbestrol, or for reasons related to the race,
color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of an individual.

Large purchasers such as PBGH, CalPERS, and the University of California have the resources to negoti-
ate contracts that are satisfactory to their beneficiaries, but non-pooled small businesses and individuals do
not. State regulators have stepped in and must step in to protect small purchasers. For example, the state
Legislature passed legislation (AB 1672) creating a purchasing pool for small businesses that set rating
limitations on small group premiums, required guaranteed issue and renewal, and allowed for the cre-
ation of two standardized benefit packages. By standardizing the benefit packages, small employers and
their employees could better compare each plan. This legislation solved some of the difficulties small
employers were facing in obtaining affordable coverage for their employees.

2. Quality Standards

In general, regulators and large purchasers should focus on managed care deliverables rather than the
delivery process in order to preserve maximum opportunity for efficiency-improving innovation. How-
ever, broad standards of operation are appropriate. Such a list would include standards for quality assur-
ance and utilization management systems, rules to assure that medical decisions are made by qualified
physicians, rules to assure no interference with doctor-patient communication about treatment options,
and curbs on schemes that give doctors incentives to deny necessary treatment.

The Knox-Keene Act, for example, requires that every health care service plan have in place a quality
assurance program that is designed to continuously review the quality of care provided, review problems
and complaints, and design corrective action plans that prevent problems health plan-wide. In addition,
health care service plans undergo a medical audit every three years to determine whether they are meeting
the requirements of the law regarding quality assurance as well as access to care, continuity of care, and
provision of benefits. These audits include examinations of patient records and documents from quality
assurance committee meetings to ensure that problems have been corrected in a systematic way.

The Knox-Keene Act also prohibits any contractual requirements that would inhibit a provider from
discussing treatment options with his or her patient and prohibits incentive arrangements that would
induce the delay, denial, or reduction of medically necessary and appropriate care. State law also prohibits
any termination or disciplinary action against a provider for advocating appropriate health care on behalf
of a patient. The Knox-Keene Act and its underlying regulations require that medical decision-making be
separated from fiscal and administrative functions so that these functions do not hinder the medical
decision-making process. When a claim is denied for clinical reasons and appealed, for example, it must
be reviewed by a licensed professional with competency in the clinical area in question. Individuals who are hired to review claims may not be compensated on the basis of the number of claims denied or the dollar amount of the claims involved. These provisions of the Act are designed to ban inappropriate financial incentives that may lead to inappropriate denials.

B. Improving the Market for Health Coverage

1. Pooling of Risks

In a system that is based on voluntary insurance, with a large proportion made up of individuals and small groups, government action is needed to require or encourage the healthy to subsidize the sick. Three main ways this is done in our society are public programs supported by taxes such as Medicare and Medicaid; employment-based health insurance which is motivated by exclusion of employer paid health insurance from taxable incomes of employees; and state laws limiting the variation in small group premiums.

If everyone could obtain coverage through a large employer or purchasing group that organized and managed a choice of health coverage options for group members, the market would be likely to provide a satisfactory result. However, much of the population works for small employers or is self-employed, unemployed, early retirees, part-time workers, etc. and does not have access to purchasing groups. Purchasing groups are not currently growing and forming rapidly enough to provide access for everyone in the foreseeable future. State and private entities have attempted to form purchasing groups, but so far have experienced limited growth. In 1996, the California Legislature passed SB 1559 (Peace), which created a statutory framework for the creation of purchasing pools. At this writing, no entity has received licensure under this statute.

Because individuals and small groups of healthy people prefer not to subsidize the costs of individuals or small groups that include sick or high risk individuals, it is difficult to pool individuals and small groups on a purely voluntary basis. Where large purchasers or purchasing groups are not accessible, government can either encourage purchasing through pooled arrangements and the formation of new purchasing entities, e.g., through subsidies, or can act as purchaser or sponsor itself. To limit adverse selection, purchasing pools for individuals would also require specific public policy interventions to achieve market equilibrium, such as a mandate that individuals who purchase coverage do so for minimum periods or subsidies to encourage the healthy ones to buy it.

2. Creating an Information Infrastructure

Government leadership is likely to be required to create an information infrastructure for medical outcomes research, quality oversight, and utilization management (i.e., electronic records, compatible interfaces so entities can communicate, standard definitions of data elements, and the like.) Government can exercise a convening function as well as exert leverage through its purchasing decisions. Private sector initiatives are already underway. However, due to its significant cost, this project may require government leadership and assistance for successful completion.

3. Enabling Comparative Information

Government action is likely to be needed to secure the timely production of accurate quality-related data and health plan performance data that consumers and purchasers need to make well-informed decisions. Though many California health plans and medical groups have cooperated voluntarily in the collection and reporting of the Health Plan/Employer Data Information Set (HEDIS) without government intervention, data needed for risk-adjusted medical outcomes studies, by hospitals, health plans, and providers in California is lagging behind other states.

Government might help to lead the whole health services industry in the development of uniform data standards for reporting about prices, performance, quality, and service and for comparative evaluation studies. Government should coordinate these efforts with and build on local private, national, and international efforts to set and promote data standards which are a prerequisite to generating adequate information on the basis of which to judge health plans and providers.
4. Facilitating Structural Change
Collective action may be required to enact basic structural reforms to address market failures such as the lack of choice among plans and the lack of competition among delivery systems. For example, in the early 1970s, the federal government saw that HMOs were a potentially desirable alternative to the dominant fee-for-service system, but that their establishment and growth were inhibited by lack of capital, and by state legislative barriers. So the government enacted legislation that defined HMOs, provided access to grants and loans, required most employers to offer them to employees as a choice, and override restrictive state laws. Thus government actions led to the transformation of the industry. Legislative changes have led to similar and fundamental changes in the electric power and telecommunications industries. Collective action in Minnesota by private employers and government as purchaser, have led to a partial replacement of the carrier-based HMO system with a system based on competing medical groups.

5. Considering Antitrust Actions
Where necessary, government must take anti-trust actions to prevent business combinations or actions that block competition. Existing antitrust law is designed to prevent this. When health plans merge, the Federal Trade Commission conducts a review under existing antitrust law and principles. In addition, the state Attorney General typically undertakes a review as well, using national standards and guidelines. There have been several large mergers among California HMOs recently which have received, and passed, anti-trust scrutiny. However, those conducting the analyses and making the decisions face a significant challenge to understand the implications of a market changing so rapidly. The consolidation of medical groups/IPAs and their collective bargaining-type activities also pose challenges for regulators in this area.

6. Not Creating Entry Barriers
It is important to be sure that government does not inadvertently create artificial barriers to market entry by new health plans. For instance, the time and cost for DOC approval of a new Knox-Keene license have been reported to be very substantial, and DOC’s requirement for contiguous expansion makes growth more difficult for new health plans. These requirements lead some to seek less onerous regulation under the DOI. Ultimately, consumers pay for entry barriers through fewer choices and higher costs.

C. Government as Purchaser
Government is California’s largest single health care purchaser. As such, its significant buying power has external effects on other purchasers, and therefore on the entire health system. These effects can be for good (e.g., holding vendor plans and providers to rigorous quality standards) or ill (e.g., cost-shifting public liabilities onto private payers). Pursuing self-interest can conflict with broader policy objectives.

III. State and Federal Regulatory Structures for Managed Health Care
A. State Government
The following bullets lay out the general California oversight framework. We then describe each agency in detail. Refer to Figure 2 (“State Health Care Oversight Related to Managed Care”) for an overview.

- **Health coverage plans**: Indemnity health plans, including their Preferred Provider Organization (PPO) products, are regulated by the Department of Insurance (1). Health maintenance organizations (HMOs) and point of service (POS) plans are under the purview of the Department of Corporations (2). The Department of Health Services regulates managed care organizations through its Medi-Cal managed care contracts (3).

- **Facilities**: The Department of Health Services licenses health care facilities and certifies them for Medi-Cal and Medicare payments (3).

- **Providers**: The Department of Consumer Affairs has numerous boards and commissions that regulate medical practitioners and their continuing medical education requirements (4). The Medical Board of California licenses and investigates complaints against physicians and the Board of Registered Nursing licenses and disciplines registered nurses.
Figure 2. State Health Care Oversight Related to Managed Care
Figure 4. CALIFORNIA'S MANAGED HEALTH INDUSTRY
CURRENT STATE REGULATORY OVERSIGHT JURISDICTION

<table>
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<tr>
<td>A. Licensure</td>
<td>DOI</td>
<td>DOC</td>
<td>DCA Health Boards</td>
<td>DHS Soc. Services</td>
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<tr>
<td>B. Monitoring/ Auditing</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS (Medi-Cal)</td>
<td>-</td>
</tr>
<tr>
<td>C. Operational Modifications</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS</td>
<td>-</td>
</tr>
<tr>
<td>D. Complaints</td>
<td>DOI</td>
<td>DOC</td>
<td>DHS</td>
<td>DCA Health Boards</td>
</tr>
<tr>
<td>E. Enforcement</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>DOC</td>
<td>DOC (if bear risk)</td>
<td>DHS</td>
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<tr>
<td>B. Quality of Care</td>
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<td>DHS (Medi-Cal)</td>
<td>DCA Health Boards</td>
<td>Medical Board (indirectly)</td>
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<td>C. Due Process</td>
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<td>D. Access</td>
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<td>E. Affordability</td>
<td>Market</td>
<td>DHS (Medi-Cal)</td>
<td>Market</td>
<td>Market</td>
</tr>
</tbody>
</table>

KEY:
- **DOI**: Department of Corporations.
- **DOC**: Department of Insurance.
- **DHS**: Department of Health Services.
- **DCA Health Boards**: Boards under the Department of Consumer Affairs that license and regulate health professionals.
- **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.
• **Workers’ compensation:** The Department of Industrial Relations certifies health care organizations that provide managed care to injured workers (5).

• **Programs to expand access:** The Managed Risk Medical Insurance Board operates three specialized programs: the Major Risk Medical Insurance Program, Access for Infants and Mothers Program, the new California Children’s Health Plan, and the Health Insurance Plan of California, which is presently being outsourced to private contractors (6). The Department of Health Services oversees Medi-Cal, California’s Medicaid program (3). The California Medical Assistance Commission negotiates Medi-Cal contracts with medical providers, including hospitals and managed care plans (7). The Department of Aging operates the Health Insurance Counseling and Advocacy Program (HICAP) to assist Medicare beneficiaries with their health care questions (8).

• **Legal issues:** The Office of the Attorney General provides legal assistance to various health care services oversight agencies and monitors antitrust matters such as mergers and acquisitions (9).

• **Data and policy:** The Office of Statewide Health Planning and Development collects and tracks data to support improvement in California’s health care delivery system (10).

• **Employee benefits:** The California Public Employees’ Retirement System provides health benefits to one million people (11).

Figure 4 summarizes current state jurisdiction over different segments of the industry by regulatory function and broad public policy goal.

1. **Department of Insurance**

   The Department of Insurance (DOI) is an independent department headed by an elected Insurance Commissioner. DOI regulates the indemnity insurance industry to protect policyholders. To accomplish this, DOI conducts field examinations, maintains solvency surveillance, reviews policy forms, and investigates consumer complaints.

DOI licenses approximately 1,300 California insurance companies that collect $63 billion in annual premiums. Approximately 600 of these companies specialize in writing life and/or accident and health policies. In addition, DOI collects annual taxes from the indemnity insurance industry.

The Insurance Code empowers the Commissioner to hold hearings and to enjoin an insurer from doing business within the state. However, the Commissioner may not force an insurer to pay a claim; that power is reserved for the courts.

For fiscal year 1996/97, DOI anticipates receiving approximately $129 million from its Insurance Fund to support 1,050 positions. The Department funds its regulatory activities almost exclusively from fees and assessments collected from insurance companies, agents, and brokers.

2. **Department of Corporations**

   The Department of Corporations (DOC) is part of the Business, Transportation, and Housing Agency. The Commissioner of Corporations is appointed by the Governor to oversee and administer the duties of the department.

   The Commissioner of Corporations is the sole administrator and enforcer of the Knox-Keene Health Care Service Plan Act of 1975 (Act), which governs health care service plans and specialized health plan con-
tracts. A health care service plan (plan) is defined as an entity "who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." The Act proscribes an extensive licensing process and a continuing compliance system of periodic examinations, reports, and medical surveys.

The Health Plan Division, with support from the Division of Enforcement and Office of Policy, carries out these responsibilities. Currently the DOC licenses and monitors 53 full-service health care service plans and 62 specialized health plans enrolling approximately 17 million Californians.

The Knox-Keene Act requires DOC to ensure that health plans demonstrate financial solvency, quality of care, accessibility of services, continuity of care, contracting requirements, and consumer grievance processes. The Act grants DOC the authority to issue administrative cease and desist orders, institute civil injunctive actions, seek appointments of receiver, seize businesses, freeze enrollments, and issue civil penalties. Moreover, a willful violation of the Knox-Keene Act is a misdemeanor.

The Health Plan Division is financed by the plans through administrative assessments, annual regulatory fees based on the number of plan enrollees, and penalty assessments. The state’s 1997/98 budget includes a $6.1 million augmentation for DOC’s Health Plan Division, a 74% increase over the previous year. The funds will be generated through increased assessment fees on the plans.

3. Department of Health Services
The Department of Health Services (DHS) is part of the Health & Welfare Agency. The Governor appoints the Director of Health Services.

a. Involvement with Managed Care
In an effort to promote Medi-Cal beneficiaries’ access to high quality care while controlling costs, DHS is transitioning approximately 3.2 million (60%) of its 5.4 million Medi-Cal recipients into managed care plans.

DHS currently oversees three Medi-Cal managed care models: Geographic Managed Care (GMC), County Organized Health Systems (COHS), and the Two-Plan model. The California Medical Assistance Commission within the Health and Welfare Agency negotiates GMC and COHS contracts. Under the Two-Plan model, DHS contracts with one commercial plan and one locally organized plan in each participating county.

DHS's Audits and Investigations Division performs fiscal and medical audits of Medi-Cal managed care organizations. Noncompliance issues are forwarded to DHS's Managed Care Division for action. DHS has the authority to freeze plan enrollments, terminate contracts, and impose civil penalties.

To meet federal requirements, DHS's 1997-98 budget includes $3 million for the External Quality Review Organization (EQRO) program, in which a private contractor conducts independent quality reviews.

The state and federal government jointly fund Medi-Cal. Expenses, including administration and payments, are generally split evenly between the two agencies.

Federal regulations establish standards for the state programs. Variations from these standards require a waiver from the Health Care Financing Administration (HCFA), a division of the federal Department of Health and Human Services.

5 Knox-Keene Health Care Service Plan Act of 1975 Section 1345(f)
6 Welfare & Institutions Code, Section 14000 et seq., Section 14200 et seq., Section 14450 et seq.; 22 Cal. Code of Regs., Section 50000 et seq., Section 53000 et seq., Section 53200 et seq.
b. **Licensing and Certification**

The Licensing and Certification (L&C) program licenses 30 different types of health care facilities and providers under state law. In addition, L&C certifies facilities and providers for Medicare and Medicaid. This program regulates the quality of care in over 6,000 public and private health facilities, clinics, and agencies throughout the state.

DHS enforcement depends on whether state or federal law has been violated and the type of facility involved. Under state law, DHS can impose citations and fines on long term care facilities. For all other types of facilities, the Department is limited to providing “statements of deficiency” or revoking licenses. When enforcing federal standards, DHS can impose civil penalties and appoint facility caretakers.

L&C is funded by the state general fund, licensing fees, penalty assessments, and the federal government.

4. **Department of Industrial Relations**

The Department of Industrial Relations (DIR) is a Cabinet-level agency with a Governor-appointed Director.

DIR oversees all workers’ compensation programs. Existing law establishes employer liability for job-related injuries. To address high costs, managed care was considered in the Workers’ Compensation Reform package. Under this legislation, DIR certifies health care organizations (HCOs) that provide managed care to injured workers and operates a pilot program for providing comprehensive health care services.

a. **Involvement with Managed Care**

DIR’s Division of Workers’ Compensation (DWC) certifies and monitors workers’ compensation Health Care Organizations (HCOs). HCOs offer managed care services for work-related injuries and illnesses. To be certified, these provider organizations must demonstrate financial stability. Three types of organizations are eligible to apply for HCO certification: DOI-licensed disability insurers, DOC-licensed health plans, and DWC-licensed Workers’ Compensation Health Care Provider Organizations (WCHCPOs). As of August 1997, DWC has certified 10 HCOs, covering 35,000 workers. Three of these HCOs are disability insurers, two are HMOs, and the remaining five are WCHCPOs.

DOI- or DOC-licensed HCOs are subject to those licensing authorities. In addition, DWC requires three-year certification, monitoring, and on-site audits for all HCOs.

b. **24 Hour Pilot Program**

DWC also oversees a “24-Hour” pilot project to evaluate “integrated health delivery systems.” These systems provide both workers’ compensation and non-occupational medical care. The 24-Hour pilots and HCO requirements are similar in many respects, although the HCOs are subject to far more complex administrative requirements. Four pilot projects, with approximately 6,000 enrollees, are operating in four counties. A privately-funded evaluation will examine administrative efficiencies, cost control potential, and service capabilities.

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7 Health & Safety Code, Section 1200 et seq. (clinics), Section 1250 et seq. (health facilities); Title 22, Cal. Code of Regs., Section 70001 et seq.
8 Dr. Linda Rudolph, Managed Care in California’s Workers’ Compensation System: A Survey of Current Practices (February 1996), Department of Industrial Relations, Division of Workers’ Compensation.
10 Telephone conversation with Marissa Pereira, DWC.
12 Dr. Linda Rudolph, loc. cit., p. 2.
13 Ibid., p. 2.
5. Department of Consumer Affairs
The Department of Consumer Affairs (DCA) is part of the State and Consumer Services Agency and is the umbrella agency for a number of independent boards and commissions that oversee specific professions. The major health-related boards are the Medical Board of California and the Board of Registered Nursing. Additional boards regulate other medical practitioners, including acupuncturists, dentists, optometrists, pharmacists, physical therapists, physician assistants, podiatrists, psychologists, respiratory therapists, speech pathologists, vocational nurses, and psychiatric technicians. The Governor appoints DCA's Director.

a. Medical Board of California
The Medical Board of California (MBC) consists of twelve physicians and seven public members appointed to four-year terms. The Governor appoints all members except two public members appointed by the Speaker of the Assembly and the Senate Rules Committee. All members are subject to Senate confirmation.

The MBC is financed by annual physician licensing fees and administrative fees on physicians in violation of the Medical Practice Act. The State Auditor has criticized the MBC for their failure to pursue collection of fines.

The Board is divided into two separate Divisions: the Division of Licensing (DOL) and the Division of Medical Quality (DMQ).

i. Physician Licensing and Oversight
The Division of Licensing (DOL), composed of four physicians and three public members, is responsible for ensuring that all California-licensed physicians have adequate medical education and training. DOL issues licenses and certificates, administers the continuous medical education program, and administers examinations for some license applicants. The Board's Committee on Affiliated Healing Arts Professions and the DOL also regulate dispensing opticians, lay midwives, research psychoanalysts, and medical assistants.

The DMQ, composed of eight physicians and four public members, reviews medical practice quality. The DMQ receives, evaluates, and investigates complaints of physician misconduct and negligence and files charges as appropriate. Following an administrative hearing, the DMQ takes final disciplinary action to revoke, suspend, or restrict the physician's license.

ii. Outpatient Clinic Accreditation
The DOL accredits medical offices, including mobile vans, where outpatient surgery is performed. Depending on the type of licensing, DHS might also license the entity. This accreditation is mandatory.

The Medical Board can terminate approval and bring an injunction for violations. Willful violations are a misdemeanor and can be fined $1,000 per day.

b. Board of Registered Nursing
The nine-member Board of Registered Nursing (BRN) consists of three public members, three RNs actively engaged in patient care, one licensed RN administrator, one nurse educator, and one licensed physician. The Governor appoints one public member and all licensed members. The Senate Rules Committee and the Assembly Speaker appoint two public members. All members serve four-year terms.

The BRN licenses RNs, establishes accreditation requirements for California nursing schools, and reviews nursing school curricula. In addition, the BRN certifies nurse-midwives (CNM), nurse practitioners (NP), and nurse anesthetists (CRNA).

The BRN has enforcement powers comparable to the MBC.

16 Nursing Practice Act, Business & Professions Code, Section 2700 et seq.; Title 16, California Code of Regulations, Section 1400 et seq.
6. Managed Risk Medical Insurance Board (MRMIB)  
MRMIB is housed within the Health & Welfare Agency and consists of seven members. Two ex-officio, non-voting members represent the Secretary of the Business, Transportation, and Housing Agency and the Secretary of the Health & Welfare Agency. Of the five voting members, three are appointed by the Governor, one is appointed by the Senate Committee on Rules, and one is appointed by the Speaker of the Assembly.

MRMIB administers programs that extend private health coverage to certain uninsured groups (as described below). In addition, the Board develops policy and recommendations on providing health insurance to over six million uninsured Californians.

MRMIB manages the Major Risk Medical Insurance Program (MRMIP), Access for Infants and Mothers (AIM) Program, and the Health Insurance Plan of California (HIPC).

a. Major Risk Medical Insurance Program (MRMIP)  
This program provides health coverage to Californians who are unable to secure adequate coverage for themselves and their dependents because insurers consider them to be “medically uninsurable,” i.e., at high risk of needing costly medical care. Subscribers can choose among three PPOs and four HMOs. The program has the capacity to enroll 19,500 individuals.

b. Access for Infants and Mothers (AIM) Program  
AIM provides comprehensive subsidized coverage through nine managed care plans to pregnant women and their infants. Women whose family income is between 200 and 300 percent of the Federal Poverty Level (FPL) are eligible for the program. (Those with incomes below 200 percent of FPL are eligible for Medi-Cal.)

c. The Health Insurance Plan of California (HIPC)  
The HIPC program makes health insurance more affordable for small employers (two to 50 employees) by establishing a statewide purchasing pool. Under the HIPC, MRMIB contracts with 25 health plans and seven dental plans.

7. California Medical Assistance Commission (CMAC)  
CMAC is an independent commission within the Health & Welfare Agency. The Governor appoints three voting members, and the Speaker of the Assembly and the Senate Rules Committee each appoint two voting members. The Directors of DHS and the Department of Finance serve as ex-officio members. All members serve staggered four-year terms.

The Commission negotiates contract rates, terms, and conditions with hospitals and the plans participating in the GMC and COHS Medi-Cal managed care programs. CMAC’s objective is to promote efficiency and cost-effectiveness.

8. Department of Aging  
The Department of Aging operates the Health Insurance Counseling and Advocacy Program (HICAP). HICAP’s staff assist Medicare beneficiaries.

HICAP receives a portion of the state Insurance Fund. The Department of Aging can also assess a fee against Medicare HMOs to fund HICAP.

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17 All information from the Governor’s proposed 97/98 budget, p. HW 77 to 78.
18 Insurance Code, Section 12700; Title 10, Cal. Code of Regs., Section 2698 et seq.
19 Insurance Code Section 12695 et seq.; Title 10 Cal. Code of Regs., Section 2699.100 et seq.
20 Insurance Code Section 10730 et seq.; Title 10 Cal. Code of Regs., Section 2699.6000 et seq.
22 Chapter 797, Statutes of 1996 (SB 1482, Mello).
9. Attorney General
The Office of the Attorney General (AG) within the Department of Justice provides legal support and advice to DCA’s professional boards. The Health Quality Enforcement Section provides 50 specialized attorneys statewide to represent the medical board in administrative hearings. The Licensing Division represents the Nursing and Dental Boards.

The AG has general authority over antitrust matters and must give prior approval for acquisitions of non-profit health facilities (e.g., hospital) by for-profit corporations.

10. Office of Statewide Health Planning and Development
The Office of Statewide Health Planning and Development (OSHPD), under the Health & Welfare Agency, provides data that assists health care systems and regulators plan for California’s needs and recognize deficiencies. OSHPD collects financial, utilization, and outcome data from health care providers and facilities, researches health care needs and outcomes, and establishes hospital outcomes measures. OSHPD edits this data, and then produces aggregated reports by region. Much of the data are available on the Internet. OSHPD programs include Health Policy and Analysis, Demonstration Projects, Health Professions Development, Facilities Development, Cal-Mortgage Loan Insurance, and Health Facilities Data.

11. California Public Employees’ Retirement System (CalPERS)
CalPERS provides pension and welfare benefits to over 1,000 public sector employers, including the State of California. CalPERS’ Health Plan Administration Division administers the Health Benefits Program through health plan contracts. The one million-member system is the second largest purchasing pool in the country, after the federal employees’ system.

B. Federal Government
The following bullets lay out the general federal oversight framework. We then describe each agency in detail. Refer to Figure 3 (“Federal Health Care Oversight Related to Managed Care”) for an overview.

- Health plans: The federal government does not directly regulate health insurance indemnity plans. The Health Care Financing Administration qualifies health maintenance organizations and monitors Medicare and Medicaid managed care plans (1). The Department of Labor regulates employee benefit plans (4).
- Facilities: The Health Care Financing Administration sets standards for facilities receiving Medicare and Medicaid reimbursement (1).
- Government purchasing: The Office of Personnel Management oversees plan eligibility standards for federal employees, the largest single purchasing pool in the nation (5). The Department of Veterans Affairs operates one of the largest health care facilities networks in the nation (6). The Department of Defense administers the Civilian Health and Medical Program of the Uniformed Services (7).
- Legal issues: The Office of the Inspector General provides legal assistance to the Department of Health and Human Services (3). The Department of Justice oversees antitrust matters (8).
- Data and policy: The Agency for Health Care Policy and Research conducts and supports research, guideline development, and data collection (2).

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23 Health & Safety Code, § 436.10, 437-443, 446-446.8; Welfare & Institutions Code, § 57551 (Health Policy and Analysis).
Figure 3. **Federal Health Care Oversight Related to Managed Care**

*Employee Retirement Income Security Act (ERISA): 1974 federal law that bans state mandates on employee benefits.*

*Health Insurance Portability and Accountability Act (Kassebaum-Kennedy).*

Note: In addition to these agencies, other hospital regulators include the Dept. 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.
1. Health Care Financing Administration

The Health Care Financing Administration (HCFA) of the Department of Health and Human Services administers Medicare and Medicaid (as well as other federal health insurance expansion efforts), which benefit over 72 million Americans. HCFA regulates health care facilities and HMOs receiving Medicare and Medicaid payments. DHS is its California sister agency responsible for state-level implementation and oversight.

a. Medicare

In fiscal year 1996, Medicare provided coverage for over 38 million beneficiaries at an estimated cost of $196.6 billion. The beneficiaries included approximately 33 million elderly, five million disabled, and 270,000 end-stage kidney disease patients. HCFA’s Center for Health Plans and Providers purchases health care for Medicare. Medicare HMOs must meet the applicable standards of the Federal Health Maintenance Organization Act of 1973.27

HCFA can suspend, modify, terminate, or fine noncomplying plans. Examples of prohibited conduct include failure to provide services, collecting excess premiums, and refusing to enroll eligible individuals. HCFA often refers noncompliance cases to the Office of the Inspector General.

Medicare HMOs operating in California are also subject to regulation by the Department of Corporations. “Medi-Gap” insurance (supplemental insurance for fee-for-service Medicare beneficiaries) is subject to state regulation by the Department of Insurance. Health insurance counseling is available to Medicare recipients through the Department of Aging.

b. Medicaid

HCFA’s Center for Medicaid and State Operations works with states to oversee the Medicaid program and other federal health insurance expansion efforts, such as the Health Insurance Portability and Accountability Act (HIPAA/Kassebaum-Kennedy) and the children’s health insurance expansion project. Unlike Medicare, Medicaid is administered by the states, with matching funds from the federal government. Federal law mandates coverage of basic health care services for categories of low-income people. States have the option of covering other needy people and providing medical services not mandated by federal law. The Medicaid program covered nearly 37 million people in fiscal year 1996 at an estimated cost of $163 billion, including $92 billion in federal funds.

Approximately 13 million Medicaid beneficiaries in 41 states are covered by managed care organizations. States have been required to obtain a waiver from HCFA before implementing Medicaid managed care programs. California has obtained both available waivers: Section 1915(b) “freedom of choice” waivers that allow restrictions on provider networks and Section 1115 research and demonstration waivers.

Medicaid- and Medicare-serving HMOs that fail to meet federal standards can be fined up to $100,000 per determination of noncompliance, plus double the excess amount overpaid, and $15,000 for each recipient not enrolled because of the HMO’s acts. In addition, the federal government can withhold matching payments to the state for individuals enrolled after a determination of HMO noncompliance.29

c. Facilities

Health care facilities—including laboratories, nursing homes, hospitals, home health agencies, ambulatory surgical centers, and hospices—must be certified as a condition of Medicare and Medicaid reimbursement.

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26 Health Insurance for the Aged and Disabled; Social Security Act, Title XVIII; 42 USC § 1395 et seq.; 42 CFR 405 et seq.
27 42 USC § 300e et seq.; 42 CFR § 417 et seq. Any HMO may seek qualification; compliance is mandatory only for Medicare HMOs. Almost half of all HMOs are not federally qualified.
28 Grants to States for Medical Assistance; Social Security Act, Title XIX; 42 USC § 1396 et seq.; 42 CFR 430 et seq.
29 42 USC § 1396(m)(5)(A) and (B).
30 42 CFR § 482 (hospitals); 42 CFR § 483 (long term care facilities); 42 CFR § 484 (home health agencies); 42 CFR § 485 (specialized providers).
This function is typically handled by state agencies through interagency agreements. HCFA trains the state surveyors to enforce the federal quality standards.

Noncompliance can result in nonpayment, disqualification from Medicare and Medicaid, and civil penalties. For long-term nursing homes, the state agency or HCFA can appoint a temporary manager.

The Licensing and Certification Program of the State Department of Health Services enforces federal health facility standards.

2. Agency for Health Care Policy and Research

The Agency for Health Care Policy and Research (AHCPR) is the lead agency for research about the quality of health care, reducing its cost, and broadening access to essential services. AHCPR's programs include the following:

- The Office of the Forum for Quality and Effectiveness in Health Care directs the Evidence-Based Practice Program which develops evidence reports and technology assessments, houses the on-line National Guideline Clearinghouse, and evaluates efforts to translate evidence-based research into clinical practice. They have published science-based guidelines on such high-cost conditions as low back pain, asthma, and pain management.

- The Center for Organization and Delivery Studies conducts studies of the structure, financing, organization, behavior, and performance of the health care system and providers within it.

- The Center for Cost and Financing Studies conducts and supports studies of health care cost and financing.

- The Center for Quality Measurement and Improvement conducts and supports research on measuring and improving the quality of health care.

The Office of Statewide Health Planning and Development and the Department of Health Services carry out similar functions at the state level.

3. Office of the Inspector General

The Office of the Inspector General (OIG) audits, evaluates, and conducts criminal and civil investigations for HCFA. The OIG can impose civil penalties of up to $100,000 per determination of wrongdoing and can terminate providers from Medicare and Medicaid.

4. Department of Labor

The US Department of Labor (DOL), through its Pension and Welfare Benefits Administration (PWBA), oversees the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA sets uniform standards for employee benefits. It applies to any "employee welfare benefit plan which is established or maintained by an employer or by an employee organization (e.g., a labor union) for the purpose of providing ... through the purchase of insurance or otherwise ... medical, surgical or hospital care or benefits." 34

ERISA plans, also known as self-insured plans, are preempted from state regulation. By some estimates, at least 40% of insured Americans, including 70% of managed care recipients, are enrolled in ERISA plans. 35

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31 42 USC § 299 et seq.
32 Titles XVIII and XIX of the Social Security Act; 42 CFR 1003 et seq.
33 29 USC § 1001 et seq.; 29 CFR § 2509 et seq.
34 29 USC § 1002(1).
While ERISA may offer some advantages, enrollees in ERISA plans are not protected by state regulations. ERISA allows multi-state employers to design consistent benefit programs across state lines without regard to individual state benefits requirements. ERISA plans are less costly due to their exemption from state financial requirements, fees, taxes, and benefit mandates. These state requirements, however, establish more substantial financial and quality standards. The ERISA preemption creates an unlevel playing field for Californians in ERISA plans versus state-regulated plans.

5. Office of Personnel Management

The U.S. Office of Personnel Management (formerly the Civil Service Commission) oversees health benefits for over nine million non-military federal employees and their dependents. The Federal Employees Health Benefits Program is the largest beneficiary pool in the U.S. Three basic types of plans are available: managed fee-for-service, HMOs, and point-of-service plans.

6. Department of Veterans Affairs

The Veterans Health Administration provides hospital, nursing home, outpatient medical care, and dental care to eligible veterans. It operates 173 medical centers, 376 outpatient clinics, and 131 nursing home care units. It also provides for similar care in non-VA inpatient and outpatient settings.

7. Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS)

OCHAMPUS, under the authority of the Assistant Secretary of Defense for Health Affairs, administers health and medical programs for retirees, and dependents of active duty, retired, and deceased Uniformed Services members. OCHAMPUS contracts for health benefits, and provides utilization review, peer review, and quality assurance. This program includes regional managed care for military treatment facilities and civilian sources.

8. The Department of Justice

The Department of Justice and the Federal Trade Commission review mergers, acquisitions, and contracts for antitrust violations. The Office of the Attorney General under the state Department of Justice performs similar functions. Health care fraud has now been elevated to one of the top two areas of investigation within the Federal Bureau of Investigations.

IV. Private Regulatory Structures for Managed Health Care

A. Quality Measurement and Accreditation Organizations

With the growth of managed care, employers and consumer groups wanted more information to evaluate their purchases and improve quality. As a result, several groups have developed quality measures. Two types of quality measures are available: process measures such as childhood inoculation and adult mammography rates and risk-adjusted outcomes measures for particular diseases.

There are three major obstacles to developing quality measures. Each is addressed in other Task Force recommendations. First, to allow valid comparisons, all measures must use standard definitions and methods. There is wide disagreement about what those standards should be. Second, outcomes data must be risk-adjusted to compensate for patient differences. Risk adjustment is still an inexact science. Third, data collection is expensive. Few organizations have the information infrastructure to collect quality data automatically; therefore, paperwork and cost are prohibitive. Despite calls to create information infrastructure for decision-making at both the state and federal level, little progress has been made.

Quality measurement has evolved into accreditation programs. Large purchasers and consumer groups have demanded accreditation to guarantee minimum quality. Typically, accreditation involves scheduled on-site audits and the provision of limited quality measures.

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36 Federal Employees Health Benefits Act, 5 USC 8901 et seq.; CFR 890 et seq.
37 38 USC 1701 et seq.; 38 CFR 17 et seq.
38 10 USC 1071 et seq.; 32 CFR 199 et seq.
Several private and joint public/private groups are addressing quality measures and accreditation needs. Many are financed in such a way that conflicts of interest are not insignificant problems.

1. National Committee of Quality Assurance (NCQA)
NCQA's board of directors includes employers, consumers, labor, health plans, quality experts, government regulators, and physicians. NCQA accredits various health care organizations and has established quality measurement standards. NCQA has accredited managed care organizations (MCOs) since 1991.\textsuperscript{39} In 1997, NCQA will begin accrediting managed behavioral healthcare organizations (MBHO). Also this year, NCQA is rolling out an accreditation program for medical groups and Independent Physician Associations (IPAs). Beginning in 1999, NCQA will concurrently assess an MCO's medical and behavioral health programs and award a single decision.

Managed Care. A team of physicians and managed care experts performs on- and off-site evaluations of the health plan's quality improvement, utilization management, provider credentials, preventive health programs, members' rights and responsibilities, and medical records. A national oversight committee of physicians analyzes the findings and assigns an accreditation level: full accreditation for 3 years (to date 40% of reviewed plans), one year accreditation (37%), provisional accreditation for 1 year (11%), or denial (11%). Health plans can request a review of the initial decision; 1% of plans are currently listed as under review. Accreditation status reports are available on NCQA’s web page.

Medical Groups and IPAs. NCQA recently created a Physician Organization Certification (POC) program, based on a subset of the MCO Accreditation Standards.\textsuperscript{40} The same categories are reviewed. NCQA will initially offer one year certification; subsequent certifications may be up to 3 years. This certificate will replace duplicative inspections for NCQA's MCO accreditations; however, MCOs will remain responsible for quality of the medical groups.

Health Plan Employer Data and Information Set (HEDIS). NCQA developed HEDIS to measure health plan quality for purchasers and consumers.\textsuperscript{41} HEDIS measures effectiveness of care, accessibility of care, satisfaction with care, health plan stability, use of services, and cost of care. In the future, NCQA will license auditors to conduct HEDIS audits. NCQA's Quality Compass, a national database, includes comparative HEDIS scores and accreditation data from 250 health plans. HEDIS is criticized for focusing on utilization management and preventive care process measures rather than chronic or acute disease outcomes measures.\textsuperscript{42,43}

2. Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)
JCAHO accredits hospitals, health plans, medical groups, home care agencies, long-term care facilities, behavioral health organizations, laboratories, and outpatient services. JCAHO's on-site audits focus on member rights and education, organization leadership, human resources, information management, and performance improvement. JCAHO requires detailed process standards for accreditation.

In February 1997, JCAHO launched ORYX, which integrates performance measures into the accreditation process of all organizations. Under the ORYX program, JCAHO created a list of 60 acceptable performance measurement systems. By December 31, 1997, organizations must choose and begin to phase in their measurement system(s) and measurements. Integrated delivery systems and health plans will be required to collect at least 10 measures from up to five approved measurement systems. Initial data must be sent to JCAHO by the end of first quarter 1999. JCAHO will use the data to review performance between on-site audits.

\textsuperscript{39} NCQA web page, www.ncqa.org.
\textsuperscript{41} National Committee for Quality Assurance, web page, www.ncqa.org.
3. Foundation for Accountability (FAcct)

FAcct promotes shifting from process measures to outcomes measures. To date, they have developed for use by other organizations patient satisfaction, disease prevention, and outcomes measures for diabetes, breast cancer, and major depression. Large employers, consumer groups, and government sponsor FAcct.

4. The Medical Quality Commission (TMQC)

TMQC's board consists of health plans, providers, purchasers, and consumers. Since 1990, TMQC has accredited medical groups and IPAs based on 14 review areas. Approximately 50% pass with complete, 3 year accreditation; 25% receive provisional accreditation and must improve by the 6-month re-inspection; 25% are not accredited but are re-surveyed after 6 months; and 3% fail completely. Currently, 22 medical groups are accredited in California, covering 2 million capitated lives. 1.8 million of these are commercial; 175,000 Medicare; and 25,000 Medicaid. In the future, TMQC will release the names of groups that fail the accreditation process and the results of the audits.

TMQC and PBGH are conducting a study of quality outcomes by following 55,000 HMO and 4,000 PPO/FFS enrollees for 2 years. They are measuring patient satisfaction, change in health status, and receipt of services for hypertension, high cholesterol, and prevention. At the end of this period, the results will be compared between HMO and PPO/FFS enrollees. In addition, the results will be correlated with medical group attributes, such as clinical guidelines, disease management, amount of capitation, years experience with capitation, and governance structure.

5. California Cooperative Healthcare Reporting Initiative (CCHRI)

CCHRI is a joint effort by California health plans, medical groups, and employers to produce comparable quality data for use by clinicians, purchasers, and consumers. An independent research firm gathers HEDIS and patient satisfaction data on preventive care from 24 health plans (95% of commercial HMO membership). The data are then reviewed and used to score plans as above average, average, or below average.

6. Consumers Union

This organization is a good example of private sector involvement in efforts to improve the managed care marketplace. Consumers Union, the publisher of Consumer Reports, analyzed 1994 HEDIS data. Based on this analysis, they produced a preventive-care index that implies the best plans provide the most preventive care. In addition, they produced a utilization measure for three commonly overused procedures: gall-bladder removal, prostate surgery, and hysterectomy. According to the article, high utilization plans are suspect for unnecessary procedures, while low utilization plans are suspect for inadequate care. Consumers Union reviewed nine California plans; one provided data too late, three plans refused to send their data, and one plan supplied inconsistent preventive care data. Consumers Union then made suggestions to improve HEDIS related to inconsistencies in how data is measured and collected, the lack of risk-adjustment, and the lack of outcomes measurements. In addition, Consumers Union surveys their 4.5 million subscribers in HMOs and PPOs for customer satisfaction and makes that information available to the public to enhance decision-making.

7. Individual Health Plans

Health plans and medical groups use customer satisfaction surveys for internal and external purposes. Internally, surveys support strategic planning, marketing, quality improvement, provider profiling, and provider payments. In 1995, over 95% of HMOs and about 55% of PPOs reported using consumer surveys to monitor care patterns. Externally, many employers are requiring customer satisfaction data at the plan level. Like other quality measures, employers and consumers want standard satisfaction measures that help them compare different health plans. The U.S. Agency for Health Care Policy and Research

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(AHCPR) has developed prototype satisfaction surveys. This prototype is modular, with different sections for different types of organizations.

B. Purchasers
Large purchasers can use their negotiating power to influence the health care system. They enable their consumers to choose the best value plan for their needs by establishing three important market-enhancing conditions:

• **Choice.** Consumers choosing among multiple plans tend to be more satisfied with their coverage, as they can make appropriate selections based on their needs, preferences, and established relationships with providers familiar with their case history.

• **Standards.** Consumers must be able to make valid comparisons among multiple plans. Large purchasers can negotiate prices on standardized benefits packages with several health plans, enabling consumers to compare products more easily. Large purchasers can also require standardized information about covered benefits and quality of care for consumers to compare as they make their decisions.

• **Financial Incentives.** Consumers must be able to share in the cost savings of lower-premium plans. Employers that pay all or most of plan premiums give HMOs an incentive to shadow-price the more expensive plans. This policy undermines purchasing power.

Given potential customers with a wide choice of plans, the ability to compare them, and a financial incentive to seek value for money, health plans competing for business have good reason to provide high quality care at low rates. Some large California purchasers (including government purchasers) are working to create these conditions for consumers, but as of this date, they are not available to the general population.

1. **Pacific Business Group on Health (PBGH)**
PBGH is an association of 32 public and private employers covering 2.5 million lives. It includes such employers as Bank of America, Safeway, and Pacific Telesis. Seventeen of PBGH’s employers participated in the 1996 health plan negotiations, representing $400 million in premiums. Most PBGH employers require, or will soon require, employees to pay the difference in premiums for more expensive plans. PBGH contracts require health plans to meet performance standards on quality of care, customer service, and data provision. In 1996, each health plan put 2% of premium at risk for all performance standards, weighted according to each health plan’s relative weaknesses.

PBGH designed a web page to help consumers compare health plans and hospitals. For health plans, PBGH lists CCHRI’s HEDIS scores, PBGH’s customer satisfaction measures, Medicare HMO disenrollment rates, and NCQA accreditation status. PBGH annually measures customer satisfaction with each of 16 plans and with each type of plan (HMO, POS, and PPO/FFS). In analyzing hospital performance, PBGH publishes data on cesarean section births and on transplant outcomes.

2. **Health Insurance Plan of California (HIPC)**
The HIPC offers a choice of 25 health plans to nearly 7,000 small businesses (2 to 50 employees) throughout the state. Before the HIPC, small-firm employees seldom had a choice of plans. Participating employers are required to contribute at least 50% of the low-priced premium. To make the HIPC attractive to firms with younger, typically healthy employees, the HIPC offers rates by age category and family size. In addition, the HIPC adjusts health plan payments based on average risk profile of enrollees, using diagnostic information. This risk adjustment ensures that health plans that attract higher risk populations will be compensated for their additional costs. The HIPC provides health plan quality and access information to enrollees.

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3. California Public Employees' Retirement System (CalPERS)
CalPERS purchases health care benefits for people working in over 1000 participating public agencies. The State is the largest participating employer, representing almost 640,000 (67%) of CalPERS’ enrollees. Prior to 1992, the State paid 100% of individual premiums, up to the average of the four costliest plans. By shielding individuals from information related to price and from exposure to cost differences, this formula arguably denied low-premium health plans a marketplace reward for reducing premiums, thus contributing to inflation. In response to the 1992 fiscal crisis, the State froze its maximum contribution at the 1991-92 level. This change put employees at risk for future premium increases above that price freeze. In 1995, however, 19 of 24 health plans’ individual premiums were below the defined maximum state benefit contribution level and thus were completely paid by the State. This contribution policy undermines CalPERS’ negotiating power in that their price position is known prior to negotiations. CalPERS is the second largest beneficiary pool in the nation. Despite its vast size, it was only able to negotiate a 1.1% decrease in average premiums for the 1994-95 contract period.

4. Other Purchasers
Two California universities have increased their purchasing power by altering their contribution policies. They offer an example for other employers, though their size may limit their effect on the health care system.

Stanford University offers employees a choice among four HMOs. One HMO includes a full-provider-choice point of service (POS) option that covers out-of-network care, after a deductible and increased cost-sharing. Since 1992, Stanford has required employees to pay the full difference in premium for the most expensive plan. As the policy successfully reversed premium growth, Stanford increased employer contributions to share the savings with employees.

The University of California (UC) used to pay the full premium, up to the average of the four costliest plans. In 1993, UC established a contribution set at 100% of the lowest-priced plan serving all campuses.

V. Streamlining Regulation
A. Regulatory Processes
In many areas, managed care regulation is inefficient or duplicative. In order to obtain a license from the Department of Corporations (DOC) to operate as a Knox-Keene regulated health care service plan, an entity must file numerous documents detailing its administrative framework, financial standing and capitalization, premium, revenue, cost and utilization projections, health care delivery network, contracts with providers, benefit disclosure documents, marketing materials, documentation pertaining to the quality assurance program and utilization review processes, and contractual documents with employers and individual members. Whenever any of this information materially changes, the health care service plan must file an amendment to these documents.

This regulation consumes a significant amount of time and resources of both DOC and the health care service plans it regulates. The regulatory processes are complex and often the relevant law and regulations are subject to various interpretations, which can lead to inconsistencies. Some of the regulatory processes are duplicated by other federal and state government entities, purchasers, and other private bodies that regulate health care service plans.48 In contrast, medical groups/IPAs are not directly regulated. Indirect regulation of provider groups through up to a dozen or more contracting health care service plans results in duplication of regulatory oversight.

B. Regulatory Redundancy
Currently, some companies offer more than one plan model type: health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO), traditional, unmanaged, fee-for-service

indemnity, Blue Cross, and Blue Shield plans ("indemnity"), and exclusive provider organization (EPO); and many serve a variety of markets: commercial, Medi-Cal, Medicare, HIPC, workers compensation. As a result of serving multiple markets, multiple state and federal regulatory bodies (i.e., California Department of Health Services (DHS), DOC, California Division of Workers’ Compensation, and the federal Health Care Financing Administration (HCFA)) and private bodies (e.g., California Cooperative Healthcare Reporting Initiative (CCHRI), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA)) perform quality and financial audits of health care service plans, often requiring much of the same information in different formats or focused on different populations. In addition, the California Department of Insurance (DOI) conducts financial audits of indemnity (excluding Blue Cross and Blue Shield plans), PPO, and EPO plan insurers, even though the products they offer are similar in many respects to HMOs. Currently, these bodies operate independently of others and do not accept licensure by another agency. However, DOC coordinates quite closely with HCFA regarding Medicare related matters, and with DHS regarding prepaid Medi-Cal matters. HCFA requires DOC licensure of HMOs for Medicare Risk products (although not for provider service organizations (PSOs)), and DHS requires DOC licensure of health care service plans (although some demonstration projects and plans are exempted) that wish to contract as a prepaid health plan with DHS for Medi-Cal.

1. Medical Groups and Other Providers
Unlike much of the rest of the nation, large medical groups in California often assume financial risk from HMOs and responsibility for caring for the population of patients they serve. In doing so, the medical groups also undertake most of the utilization and quality management responsibility. Under current law, however, the contracting HMOs remain accountable to the regulatory authority for the quality and financial solvency of their affiliated medical groups, many of which contract with most of the health care service plans and health insurers offered in their area.

The government does not directly regulate medical groups that similarly assume financial risk from HMOs despite their direct involvement in patient care. Private sector accreditation requirements also hold HMOs accountable for the care provided by their contracting providers. To satisfy regulatory and private sector accreditation requirements, HMOs, or the regulatory or accreditation agencies, perform multiple audits (e.g., medical quality and solvency) of the medical groups and other providers with which the HMOs contract. Not only does this duplicative process require every HMO to pay for the accreditation or audit of the same providers, but it also often requires providers to submit to and bear the expense of multiple audits by the same regulatory or accrediting bodies. In addition, medical groups and other providers understandably resist providing information that they consider proprietary to the HMOs with which they negotiate payment rates. In contrast, the HCFA delegates Medicare hospital inspections, thereby avoiding redundancy.

2. Ongoing Streamlining Efforts
Private sector purchasers, health care service plans, health insurers, and medical groups in California have recognized the special structure into which the market has developed and the resultant need to reach through HMOs to medical groups for much of the quality and other information that is relevant to consumers. As a result, in 1996 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. (See Attachment I: Quality Measurement and Accreditation for additional information). In a similar effort, the non-profit NCQA has created a medical group certification. Contracting health plans need not inspect certified medical groups for NCQA accreditation.

C. Accelerating Industry Change Creates Challenges for DOC
Notwithstanding the best efforts of the legislative process, some of the drafting in the Knox-Keene Act, as in other laws, lacks specificity and precision, frequently resulting in inconsistency, especially when compounded by lack of resources for administering the law.
The general provisions of the Knox-Keene Act have enabled the DOC to be responsive to plan requests to interpret statutory provisions which clearly apply to new or innovative products or activities. If the basic provisions of the Knox-Keene Act had been highly prescriptive, or if the DOC had refused to be flexible, insisting on new legislation or rule making before considering new products or proposals from plans, the market may have been frustrated and enrollment in managed care in California may have been stunted.

The DOC’s policy and practice is to avoid inconsistency to the maximum extent possible under the circumstances, and to resolve inconsistencies when found. However, apparent and actual inconsistencies inevitably exist. Many (but by no means all) of the inconsistencies which have been alleged over the years, upon investigation, have been found not to be inconsistencies, but consistent applications of a statutory provision to two different factual situations.

The DOC adapts certain provisions for certain circumstances. For example, in rural areas it may be difficult for health care service plans to contract with sufficient primary care providers and hospitals to satisfy the 30 minute/15 mile accessibility guideline presumed by the Knox-Keene Act. In this instance, the DOC has shown flexibility by allowing health care service plans to provide other evidence of reasonable accessibility. In other instances, no guidelines exist, and to DOC-regulated health care service plans, DOC decisions seem inconsistent, subjective, and arbitrary, or very different from those that have been imposed on other health care service plans. In such an unpredictable regulatory environment, regular business planning becomes difficult, often resulting in unnecessarily higher costs which are ultimately born by consumers. However, while the lack of specific, detailed, rigidly prescribed requirements creates a somewhat unpredictable regulatory environment, it is also a more flexible one. This flexible environment, however, should be better managed to avoid inconsistent decisions.

The DOC is required under Section 1352 of the Health and Safety Code to respond to plans regarding material modifications within 20 business days "or such additional time as the plan may specify." Despite this requirement, with the increasing pace and volume of change in the health care industry the DOC has not been able to consistently respond within this time period. The DOC's response may be a deficiency letter indicating missing information, unclear provisions, and/or noncompliance, allowing the plan to submit information resolving the problems. The total time from date of submission to date of approval may take up to six months or more, depending on the health care service plan's priorities and ability to demonstrate compliance and the plan's and the DOC's workloads. 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.

Delays may be the result of under-staffing, in which case the recent $6 million DOC budget augmentation may remedy this situation. Delays may also be the result of many factors including lack of experience of newly hired counsel assigned to review plan filings, or shifting filings from one counsel to another. Counsel who are inexperienced or unfamiliar with other filings by the plan may raise previously resolved and thus often unnecessary objections to items, which requires time and explanation and increases the total time and cost for approval, particularly if the filing must be appealed to a supervisor.

VI. Options for Reorganization

A. Criteria for Appraising Options
The yardsticks against which any organizational option-including the status quo-should be measured include:

(a) **Fairness**—different health system actors should be held to equivalent high standards, regardless of how they organize themselves, and like regulated entities should be charged roughly the same amount.

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49 Knox-Keene Act, Rule 1300.51(H).
(b) **Capability (Expertise)**—the regulatory authority must be at least as technically sophisticated as the industry and be staffed sufficiently to keep pace with this rapidly evolving industry that directly affects the health and productivity of the population.

(c) **Accountability**—individual complaint cases must be disposed in the light of day, where aggrieved parties can know who made the decision, and their reasons. By the same token, state policymakers (the Governor and the Legislatures) are entitled to appointed regulatory personnel who will faithfully implement the policy that elected leaders set.

(d) **Efficiency**—regulation should rely on, and not interfere with, the disciplining force of market competition (which can encourage improvements in quality, access, and cost), unless the market fails to achieve particular public purposes. Where market failures exist, public policy must recognize, compensate for and/or address the failures to enable appropriate cost, quality, and access for consumers.

(e) **Strict enforcement**—the regulated community must trust that the regulator is ensuring that the health care industry meets high quality standards and that low performers are consistently culled from the pool of choices available to consumers.

(f) **Systems approach**—the regulator’s jurisdiction should be broad enough to encompass all important segments of the health industry whose behavior might be affected by regulatory decisions; and the regulator’s leadership and staff should have a broad vision of the desirable evolution of the entire industry.

(g) **Adaptability**—the regulator must be able to encourage, and assuredly not retard, desirable evolution in this fast-changing industry.

(h) **Low net fiscal cost**—any change in organization will have transition costs. Either those costs should be kept quite low, or there should be subsequent savings that defray most of them.

The debate over regulatory organization in 1996 and early 1997 centered on whether responsibility for regulatory oversight of Knox-Keene plans should remain at the Department of Corporations or be shifted to another state organization. Among those alternatives to the status quo that were cited were the Department of Consumer Affairs, the Insurance Commissioner, or the Health and Welfare Agency.

The authors wish to point out that Task Force recommendations on regulatory organization will be most thoughtful if they include 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. Components of “how” are addressed in a number of Task Force papers. Therefore, here we will offer recommendations only about “who”. First, however, some observations about “what” should be regulated.

The health care industry is evolving quickly, with substantial consolidations occurring both vertically and horizontally. The regulatory architecture must be modernized to keep pace. There are substantial advantages to consolidating regulation of different segments of the industry in the same organization, where those segments are emerging as partial substitutes. For example, as health plans shift more financial risk onto medical groups, those groups will begin to act increasingly as substitutes for the plans. Whatever argument compels regulation of health plans should apply to pseudo-plans, such as risk-bearing medical groups, as well.

**B. What Should Be Regulated?**

If the jurisdiction of a regulator should extend beyond traditional prepaid health plans, how far should it go? It could include the following, in order of priority:

(a) **Medical groups**, for the reason cited above. One approach would be to broaden the issuance of limited Knox-Keene licenses. However, an alternative approach is to hold health plans accountable
for the errors of their vendors, including medical groups, and make the plans responsible for policing their suppliers. That is DOC's approach today; however, it can be strengthened and streamlined, as recommended in Section V above.

(b) Indemnity health insurance, including PPOs and EPOs, because it is a substitute for prepaid health plans (albeit with a shrinking share of the market).

(c) Individual health professionals' licensure, which primarily emphasizes basic competence, not other criteria such as financial solvency.

(d) Health facilities (hospitals, outpatient clinics, or nursing homes).

Collectively, this group encompasses the jurisdictions of portions of the Departments of Corporations, Consumer Affairs, Health Services, and the Insurance Commissioner.

Proposal #1: The Task Force proposes that regulation of Knox-Keene plans be consolidated with elements (a) and (b) from the list in the previous paragraph. In addition, the Office of Statewide Health Planning and Development (OSHPD), which has many synergies with oversight of these other components, should be consolidated into this function. Furthermore, the consolidation of the regulation of indemnity insurance with prepaid plans should be implemented over one year.

C. Who Should Be the Regulator?
Fundamentally there are three classes of options:

(a) Status quo: make no organizational changes, but reduce friction and duplication among regulators.

(b) Move regulation of Knox-Keene plans, and other segments of the health system as desired, to a different, existing organization. (Or the reverse: move non-Knox-Keene responsibilities out of DOC and focus it exclusively on health system regulation).

(c) Create a new organization.

Proposal #2: The Task Force proposes that a new freestanding office outside of the agency structure (like the Office of Administrative Law or the Office of Emergency Services) be created. Our working title for this organization during the work of the Task Force has been Office of Health Systems Oversight (OHSO).

This approach is fundamentally a compromise, because each of its alternatives has substantial disadvantages. If consolidation is limited to health insurance and other industry segments are omitted (as we recommend), then an alternative and possibly more descriptive title would be “Office of Health Systems and Insurance Oversight (OHSIO)”.

There are two alternatives to a new stand-alone organization that are not recommended but that each have merit:

(a) Retaining Knox-Keene responsibility at the Department of Corporations (with increased resources devoted to quality of care oversight), but shifting securities functions to another department, most likely the Department of Financial Institutions. This is probably the best alternative to a brand-new OHSO.

(b) Consolidating Knox-Keene and indemnity responsibility in the elected Insurance Commissioner. While this approach nominally makes regulation more directly accountable to the voters, many have argued that the accountability is more theoretical than real. Commissioners need to raise campaign contributions from the regulated industry, which can present conflicts. For similar reasons the California Constitutional Revision Commission in 1995 recommended that such regulation be the responsibility of a gubernatorially appointed official, not an elected one.
Two other options were viewed less favorably: shifting health plan regulation to (c) the Department of Consumer Affairs (DCA); or (d) the Department of Health Services (DHS). DCA includes 14 boards that certify health professionals. DHS would face a conflict: the same organization should not both regulate plans and be one of their largest customers.

OHSO should be charged with regulation not only of health plans, but of other segments of the health care/finance industry which bear risk, as outlined in section B above. Beyond the specific regulatory functions that it would inherit from current organizations, OHSO’s leader(s) would be expected to exercise leadership in advocating and helping implement broad health system reforms. Therefore that leadership should have experience in, and a vision for, the desired direction for the evolution of the health care marketplace (and government’s role in affecting that evolution).

Guiding principles of OHSO’s operation should include:

(a) Regulatory processes should be as efficient and streamlined as possible.

(b) Regulation should be conducted in cooperation with other public and private bodies that also regulate health care service plans and health insurers.

(c) Regulation should recognize and expedite beneficial innovations (i.e., those that consumers want, improve quality, or save costs without causing harm).

A design detail of OHSO pertains to the organization of its leadership. There are two main questions:

(a) Should the office’s leader(s) be a single individual, like most departments in state government today, or a board/commission of several people?

(b) If a board, should the appointing authority be mixed between the Governor and the Legislature?

Individual leadership offers the greatest accountability to the appointing authority—there is no question about who is responsible for decisions—but the least transparency. A board gains transparency by sacrificing individual accountability—especially if appointments are mixed.

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.

VII. Conclusion

The Task Force believes that what is needed is oversight realignment into a single oversight organization (for instance an Office of Health Systems Oversight) that oversees clinical quality and financial viability for every health care company involved in the insurance and delivery functions. The consolidated oversight organization should have jurisdiction regardless of what the entity calls itself (HMO, PPO, POS, Indemnity FFS, PSO, Medical Group, etc.).
There are at present several pressures that can be combined to create positive synergies. These include: new federal legislation allowing new market forms (e.g., MSAs and PSOs); 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, at present, an unusual opportunity for transitioning to an integrated and sophisticated oversight structure to keep up with this rapidly changing, dynamic marketplace.

Inherent in our recommendations is the belief that the past dichotomy between “business” regulation (which has been emphasized) and “quality” regulation (which has not) no longer is strictly necessary or desirable.

Summary of Task Force proposals:

1. California should consolidate the oversight of health plans with any other segments of the industry that bear risk and consider phasing in all health care regulation in time.

2. That organization should be devoted exclusively to health systems oversight, led by officials experienced in the industry.

Transferring and consolidating the components should be done in a phased manner, to allow time for the inevitable teething problems. However, the first organizational moves should occur in 1998, ideally by July 1. The Governor and Legislature should review this new organization annually, with an eye to incorporating additional state organizations as they deem appropriate.
Expanding Consumer Choice of Health Plans
Background Paper

I. Principles
In a system of managed health care plans that limit patients’ choices of providers, choice of health plan,¹ at the individual or family level is very important to a satisfactory competitive managed health care system for several reasons.

A. Maintain Ongoing Provider-Patient Relationships
If an individual does not have a wide choice of plans or access to a health plan with a wide network, switching plans may mean switching providers. According to a recent national survey, of those changing managed care plans, 39% had to change doctors.² For patients with ongoing relationships with providers, this may mean disruption of the relationship, inconvenience and discontinuity of care. For providers who have ongoing relationships with patients, switching often means a loss to the patient of extensive knowledge of his or her condition and history. These relationships are expensive (in terms of visits, diagnostic tests, etc.) and time-consuming to replicate. In addition, preliminary studies suggest that long-standing physician-patient relationships are associated with less hospitalization and lower health care costs (see Task Force paper on Physician-Patient Relationship).³ Point-of-service (POS) plans and preferred provider organizations (PPOs) offer “open access” to providers for those willing to pay more for it. However, because of substantial deductibles and unlimited balance billing by non-network providers, cost can be a substantial barrier to access to non-network providers for many people.

B. Facilitate Patient Willingness to Work with Providers
It can be hard for a provider to establish a good provider-patient relationship with a patient who has not chosen that provider or prefers to see another provider outside the plan. This explains the historic position of HMOs that members should have choice of plan.⁴

C. Improve Consumer Satisfaction with Health Plans and the Health System
Consumer satisfaction, with health plans and with the health system as a whole, is likely to be much higher if people have a choice of plan. Different health plans have different operating rules, some of which will be burdensome to some, acceptable to others. For example, one HMO might require women to have a referral from their primary care provider for every visit to the obstetrician-gynecologist while in another the standard practice might be for primary care providers to make standing referrals. People with preferences will be happier with choices. Moreover, if individuals do not have a choice of plan, market forces will not have an opportunity to pressure the plans with unpopular practices to change. Rather, purchaser pressure will be the only tool for cost containment. If people are forced into a plan by an employer, they are more likely to be unhappy with the plan and, by association, with the health care system in general. Today, in California, 46% of employees do not have a choice of plan through their own employment.⁵ If instead, people have a menu of options and make a choice, they are more likely to accept some responsibility for that choice and to show greater tolerance if problems occur. Indeed, the Kaiser/Commonwealth National Health Insurance Survey indicates that having a choice of plans is linked to satisfaction with services, choice of physicians, and insurance plans. Those in managed care

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.
⁵ Hunt K, KPMG Peat Marwick, Analysis conducted for the California Managed Health Care Improvement Task Force, Tysons Corner, VA: 1996.
who did not have a choice of plans were 57% more likely to be dissatisfied with their insurance plans; 22% were very or somewhat dissatisfied with their insurance plans compared to 14% of those with a choice.6

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<th>Adults in Managed Care Plans Ages 18-64</th>
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<td>15%</td>
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<td>Care received</td>
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D. Allow Competition at the Individual Subscriber Level to Discipline Price

For competition to work to discipline price, demand for health insurance must be price-elastic, i.e. if a seller lowers price by X%, it must attract more than an X% increase in the number of customers to offset the revenue loss associated with lowering price as well as the additional cost of caring for the additional customers. Increasing the incentive for health plans to lower price requires individual choice of plan. If there is only group choice of plan, the whole group must change plans to take advantage of a lower price offered by another plan. Some members of the group are likely to have strong provider-patient relationships and be unwilling or unhappy to change (unless the new plan offers the same providers, which can happen). If there is individual choice of plan, those individuals who are willing to change for better value can do so, and make it worthwhile for the competitor to lower price. A key component to making this strategy work to create price-elastic demand and price discipline is economic responsibility of the individuals making the choices for premium price differences. In addition, standardization of benefits and comparative quality information helps to facilitate choices by making it easier to compare alternatives.

Alternatively, there could be an incentive for health plans to offer lower prices with group choice if the choices available were among plans with similar, broad networks of providers, as is the case among many plans in California today. On average, physicians in California contract with 15 managed care plans.7 The principal basis upon which to choose a plan under these circumstances would be price, because individuals would not have to change providers when they changed plan. In this case, it would be easier to change plan to get better value. The trouble with this model is that it does not create price competition among medical group/IPAs, the level at which most decisions about spending are made and thus where the potential for cost savings lie. In this model, a medical group/IPA cannot attract more customers by cutting price. This mitigates pressure on medical group/IPAs to hold down costs. Moreover, if the health plan must try to be all-inclusive of providers, then by definition it will include inefficient as well as efficient providers. The need to be all encompassing weakens a health plan’s ability to select providers based on quality and to conduct value-based contract negotiations.

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 assume economic responsibility for assessing premium price differences and comparative quality information, and would likely require some standardization of benefits within groups.

There is a tension between standardization of benefits to facilitate comparison and improve competition among plans on the one hand and wide product choice on the other. Complete standardization would simplify comparison, but would eliminate product choice and block innovation. On the other hand, complete lack of standardization would promote wide choice of products, but would make plan comparison more difficult. In addition, where products compete, less restrictive plans (e.g., PPOs and POS plans) suffer from adverse risk selection (i.e., sicker people choose them to ensure they can obtain care from out-of-network specialists, causing prices to escalate). Risk adjustment can help to level the playing field (see Task Force paper on Minimizing Risk Avoidance Strategies). The greater the variation among plans, however, the more difficult it is to risk adjust.

II. Choice in California Today

In California today, more employed individuals have choice of plans than the national average, though fewer employees of smaller firms have choices than employees of larger firms, according to KPMG Peat Marwick data (see Figure 1). This data indicates that 54.5% of employed individuals in California whose employers provide health care coverage have a choice of two or more plans through their own employment (i.e. not including options offered through their spouse's employment). California's record with regard to individual choice of plan is mixed. In comparison, only 48.2% of employees nationally have a choice of plans through their own employment (see Figure 2). This implies that California is doing slightly better than the national average in providing choice of plans to consumers.

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<td>3.7%</td>
<td>12.9%</td>
<td>39.3%</td>
<td>79.2%</td>
<td>23.0%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

Figure 1
Percentage of Covered Employees by Choice of Plans Offered - California, 1996

<table>
<thead>
<tr>
<th></th>
<th>1 to 49 employees</th>
<th>50 to 199 employees</th>
<th>200 to 999 employees</th>
<th>1,000 or more employees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Plan Offered</td>
<td>83.0%</td>
<td>67.4%</td>
<td>47.4%</td>
<td>13.0%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Two Plans Offered</td>
<td>12.9%</td>
<td>24.4%</td>
<td>24.6%</td>
<td>14.3%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Three or More Plans Offered</td>
<td>4.1%</td>
<td>8.2%</td>
<td>28.0%</td>
<td>72.7%</td>
<td>32.4%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

Taking into account options through both spouses' employers would increase substantially the proportion of those offered 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 Perception and Experiences with Managed Care). Similarly, the 1997 Kaiser/Commonwealth National Health Insurance

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Survey found that 52% of all adults age 18 to 64 in working families have a choice of two or more plans through both spouses, compared to 36% with choices through their own employer.8

Those with no choice of plan are more likely to be working for smaller employers. In California 66.4% of employees working in employment groups of fewer than 50 employees had no choice of plan through their own employment, compared with just 7.1% of employees in groups of 1000 or more employees (see Figure 1 above). However, about half of the working population in California work in small groups with between one and 49 employees (see Figure 3). According to KPMG Peat Marwick, this is approximately twice the national average.9 Small employment groups are important because they are more likely than large employers to have difficulty offering a choice of health plan and health care coverage at all. California has almost twice the proportion of covered employees in employment groups of 50 to 199 (18.1%) compared to 11.5% nationwide. Forty-two percent of these employees have no choice of plan (see Figure 1 above).

Figure 3
Percentage of All Employees by Size of Employer - California and Nationwide, 1996

<table>
<thead>
<tr>
<th>Employees</th>
<th>1 to 49 employees</th>
<th>50 to 199 employees</th>
<th>200 to 999 employees</th>
<th>1,000 or more employees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>51.0%</td>
<td>18.1%</td>
<td>10.5%</td>
<td>20.5%</td>
<td>100.1%</td>
</tr>
<tr>
<td>Nationwide</td>
<td>25.6%</td>
<td>11.5%</td>
<td>13.6%</td>
<td>49.4%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

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 do nationally. More than a quarter of working Californians whose employer provides health care coverage has access to only an HMO with a closed-end provider panel (see Figure 4). In contrast, only 11% of workers nationally are offered only one health plan that is a closed-end HMO (see Figure 5).

Figure 4
Percentage of Covered Employees Without Choice by Plan Type (HMO or other), as % of Total Population, California 1996

<table>
<thead>
<tr>
<th>Employees</th>
<th>1 to 49 employees</th>
<th>50 to 199 employees</th>
<th>200 to 999 employees</th>
<th>1,000 or more employees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One plan only, HMO Only</td>
<td>34.5%</td>
<td>31.8%</td>
<td>11.7%</td>
<td>1.3%</td>
<td>25.3%</td>
</tr>
<tr>
<td>One plan only, but not HMO</td>
<td>31.9%</td>
<td>10.2%</td>
<td>10.2%</td>
<td>5.8%</td>
<td>20.2%</td>
</tr>
<tr>
<td>66.4%</td>
<td>42.0%</td>
<td>21.9%</td>
<td>7.1%</td>
<td>45.5%</td>
<td></td>
</tr>
</tbody>
</table>

8 Op-cit., Davis and Schoen, 1997. The estimate by the Kaiser/Commonwealth survey of the percentage of those covered employees with choices through their own employer nationwide (36%) differs from those presented by KPMG (48.2%). Staff was unable to obtain a satisfactory explanation for this discrepancy.

9 KPMG could not explain the significantly higher proportion of employees in small groups in California compared to the national average.
In addition, where employees have a choice of plan, it is often a choice of plan model type (see Figure 6). 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.\textsuperscript{10} For example, if an employee has a choice of two plans, but one is an HMO with, for example, $10 copayments and one is a PPO that, for example, requires members to pay 20\% of costs after a deductible, an employee who is attracted by the low cost-sharing requirements of the HMO may not be willing to incur the extra cost to select the PPO even if he or she is unhappy with the HMO’s service or provider panel.

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. In California, only 28.7\% of employees whose employer provides health care coverage have a choice of more than one plan of any coverage model type (i.e., HMO, POS, PPO or indemnity).

\begin{figure}[h]
\centering
\begin{tabular}{lrrrrr}
\hline
\textbf{One plan only, HMO Only} & 1 to 49 employees & 50 to 199 employees & 200 to 999 employees & 1,000 or more employees & Total \\
\hline
20.0\% & 14.9\% & 5.5\% & 1.4\% & 11.0\% \\
\hline
\textbf{One plan only, but not HMO} & 63.0\% & 52.5\% & 41.9\% & 11.6\% & 40.8\% \\
\hline
83.0\% & 67.4\% & 47.4\% & 13.0\% & 51.8\% \\
\hline
\multicolumn{6}{l}{Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.}
\end{tabular}
\caption{Percentage of Covered Employees Without Choice by Plan Type (HMO or other), as \% of Total Population, Nationwide 1996}
\end{figure}

\begin{figure}[h]
\centering
\begin{tabular}{lrrrrr}
\hline
\textbf{Offered One or More Plans, but Only One of Any Plan Type} & 1 to 49 employees & 50 to 199 employees & 200 to 999 employees & 1,000 or more employees & Total \\
\hline
Offered One or More Plans, but Only One of Any Plan Type & 85.8\% & 89.2\% & 54.7\% & 19.5\% & 71.3\% \\
\hline
Offered More Than One Plan, and More Than One of the Same Plan Type & 14.1\% & 10.8\% & 45.3\% & 80.5\% & 28.7\% \\
\hline
\multicolumn{6}{l}{Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.}
\end{tabular}
\caption{Percentage Of Covered Employees Offered More Than One Plan of Any Plan Model Type (HMO, POS, PPO, indemnity), as a Percentage of the Total Population, California 1996}
\end{figure}

III. Obstacles to Choice
The reasons why individuals do not have greater choice are numerous and varied.

A. Individual Market
Individuals (not in groups) theoretically have an unlimited choice of coverage options, so 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 perceived to be unhealthy or high risk individuals). High risk individuals may enroll in the state “high risk” pool. However, since the state subsidy is capped, the number of persons that may enroll is limited to those that can be supported by the subsidy and enrollee premiums (i.e., 19,500 individuals). For this reason, the pool usually maintains a waiting list and has a limited $50,000 per year benefit maximum.

Guaranteeing access to coverage and choice of plans to unaffiliated individuals in a system of voluntary health insurance has proved to be very difficult problem because of the particularly acute problem of adverse selection in the individual market and attendant premium increases or “death spirals”. Typically, those most interested in coverage are those who need coverage most. Those who are healthy are more likely to choose to forego coverage, opting instead to rely on the public safety net if necessary. This creates adverse selection and an upward spiral in premiums. In order to protect themselves against potential adverse selection, health plans serving this market rely on underwriting to identify costly individuals, raise premiums for the sick (perhaps to the point of unaffordability) or refuse to cover them at all. For the same reason, purchasing groups so far have not offered coverage to individuals.

Federal laws, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provide for coverage of individuals who leave or change jobs and who wish to maintain continuity of their previous employment-based coverage. In addition, 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.

Potential protections include limited open enrollment periods, the use of pre-existing condition exclusion periods, statewide reinsurance, a prohibition against switching between high and low cost-sharing insurance products on demand, or tenure discounts where persons enrolled for longer periods of time get a price break. In addition, age-sensitive premium rating and a risk adjustment process could help spread risk across the market. 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 matenity 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.

Individual access to coverage is also less available than employee access because federal tax law allows 100% deductibility of premiums to employers and 100% excludability for employees, but does not offer similar tax benefits for individual coverage. However, the 100% deductibility and excludability of premiums have reduced employer and employee cost consciousness. In addition, an extension of this aspect of tax policy to individuals has been rejected by Congress because of its impact on the federal budget.

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13 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.
14 Personal communication from Gary Christenson, head of the Washington Health Care Authority, November 21, 1997.
B. Employment Market
Unlike other nations (and albeit with decreasing frequency even in the United States), the majority of Americans and Californians receive health insurance through their employment group. In 1973, Congress adopted the HMO Act, which required most employers to offer a group practice and an individual practice HMO as choices where they were available and wanted to be offered. This provision ensured a choice of plans in employment settings until this aspect of the law was repealed.

Size of employer is an important determinant in whether employees have a choice of plan. Employers in the small group market typically offer choice of plan least often, as Figure 1 above indicates. Reasons include the following: (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burden when offering multiple plans, and (3) employers prefer to offer their whole group to one insurer in exchange for the best rates possible. This last strategy is short-sighted. Even if an employer achieves slightly reduced premiums for the first year or even two, as soon as the contract expires, their bargaining position is greatly weakened because it is difficult to require an entire employment group to switch plans and perhaps providers. In addition, the employee dissatisfaction and potential time lost from work to establish new provider relationships are unlikely to be worth the savings. Nevertheless, some employers may be willing to switch plans frequently.

In 1993, AB 1672 established rules in the small group market (currently groups of 2-50) such as guaranteed issue and renewal, limits on pre-existing condition exclusion periods, and limits on medical underwriting in response to problems of access to choice of plans. Data indicate 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. (See Task Force paper on Minimizing Risk Avoidance Strategies.) Proponents also suggest that issues such as 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.

IV. Purchasing Groups
One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups aggregate the buying power of many individuals or groups. In theory, they act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level. Like large employers, purchasing groups can:

- achieve substantial economies in administration
- set the rules to ensure equitable coverage of all persons in the sponsored group such as guaranteed issue and renewal

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16 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.
18 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.
19 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.
• create and administer an open enrollment process
• require individuals to bear full responsibility for premium differences
• standardize benefit options within the group
• provide comparative quality information
• minimize the incentive and ability of health plans to select risks
• negotiate more favorable prices than could an individual employer.

“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. Purchasing alliances perform the roles of purchasing groups described above. 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 alliances.

A. The Health Insurance Plan of California (HIPC)
The 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 (See Government Regulation and Oversight of Managed Health Care paper section on Purchasers). However, HIPC growth has been disappointing relative to the size of the small group market. After three years of operation and steady growth, the HIPC covers approximately 130,000 employees and their dependents in California. While substantial, this number is very small compared to the more than ten million Californians working in small employment groups and their families.

Theories abound about the reasons behind the limited growth of the HIPC. They include the following: (1) insufficient or inappropriate marketing effort; (2) lack of broker-agent support due originally to unattractive (flat rate) financial terms offered to broker-agents by the HIPC (now largely ameliorated); (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.

B. Other Purchasing Groups
In addition to the HIPC, several other public and private sector purchasing groups have formed to service certain market segments. These include CalPERS, which serves over one million public employees, retirees and their dependents; the Pacific Business Group on Health (PBGH), which serves large employers with more than 2000 employees and purchasing groups (including the HIPC and CalPERS) and is unique in that it is neither a marketing group nor a purchasing alliance, but rather a “negotiating alliance,” not involved in the administration of contracts between employers and plans; Benefits Alliance a newly formed marketing group for medium-sized employers with between 50 and 5000 employees in the ten-county bay area; and California Choice, also new, is a statewide marketing group that competes with the HIPC (see the Task Force paper on Government Regulation and Oversight of Managed Health Care for a more extensive description of these purchasers).

C. Prospects for New Purchasing Groups
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

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21 Currently, tension seems to stem from the HIPC’s explicit reporting of the broker/agent fee, rather than incorporating fees into plan premiums as in the rest of the market.
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 through high premiums to unattractive employers, 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 cannot 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.

To encourage the formation of new purchasing alliances and to set certain financial solvency and consumer disclosure criteria with which they must comply, California Senator Steve Peace sponsored Senate Bill 1559, which was enacted in 1997. Under the new law, any purchasing alliance, with the exception of the HIPC, must obtain a certification by the DOI. They may be either for-profit or non-profit entities, trusts, partnerships, or sole proprietorships, but no owner, officer, partner, board member, or manager of a purchasing group may be affiliated with an agent or broker. While this prevents potential abuse by agents and brokers who could exclude unhealthy groups from the purchasing group, it also deters those with the most knowledge and likely the greatest interest in forming purchasing groups. Also, under the new legislation, the DOI is required to make a determination concerning the application to become a purchasing alliance within 180 days of the application date. So far, only one purchasing alliance has applied for certification.

The requirements established by the Peace bill do not apply to marketing groups. Agents and brokers may continue to form and operate marketing groups. New marketing groups would continue to obtain approval through the DOC.

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.

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.

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22 Testimony presented or given to the Managed Health Care Improvement Task Force by Benefits Alliance and California Choice.
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 care23 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 stakeholders24 should be convened to examine the issue of how to increase consumer choice of providers on a cost neutral basis.

23 The Department of Corporations, the Department of Insurance, or their successor.
24 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
Background Paper

I. Today’s Problem: Adverse Selection

Today, payors (i.e., employers and employer groups) almost universally pay health plans the same premium for caring for a healthy adult and for a patient with serious, costly chronic conditions. This is true even though a seriously ill patient might cost many times as much per year to care for. Typically the same thing occurs in fixed, periodic, per capita or “capitated” payments from health plans to providers (i.e., medical group/IPAs, hospitals, and other providers including appropriately licensed health professionals operating within their scope of practice), though there are some contracts in which the capitation payments are adjusted for age, sex, and less frequently severity.  

There is a serious problem with this practice. One might argue that the law of large numbers would cause the incidence of high cost cases among health plans to be spread evenly, so that no health plan would be likely to be injured in the competitive marketplace by unfavorable or “adverse selection” of high cost patients. This might be so if somehow patients were randomly assigned among health plans. This might also be the case if everyone purchased health insurance through their employer and all employers chose one health plan for their entire employment group, though this scenario would be undesirable because it would eliminate individual choice. However, high cost cases are definitely not spread evenly when people have choices among health plans and associated providers.

When people with chronic conditions have choices among health plans, they will naturally seek out and choose those health plans contracting with providers who are known or believed to be best at treating their costly diseases. Thus, in a competitive market, the health plans whose doctors have the best reputations for, say, treating heart disease or breast cancer or AIDS will attract the most patients with those costly conditions. Therefore, if payors pay the same amount for each enrollee, health plans will be punished with an extra cost burden for contracting with the best doctors. Or, if the one-size-fits-all capitation payments are passed through to the medical group/IPAs, the providers with the best reputations for treating costly diseases will be punished with an extra cost burden, a burden that may even threaten to drive them out of business. In this way, price competition is attenuated if plans receiving unfavorable selection are not able to compete with plans getting favorable selection on a level playing field.

In this case, a survival strategy for a medical group/IPA is to avoid developing a reputation for excellence, or (since the word is likely to get around) to avoid developing excellence itself. This is clearly an undesirable incentive. We all want a health care system that will provide the best care and technology when we or our family members become seriously ill. However, the existing standard payment methodology can work powerfully against this.

Adverse selection was a less serious problem before the era of vigorous price competition among health plans. In those times, most employers and employees behaved in a cost-unconscious manner. Typically, employers paid the entire premium, whichever plan an employee chose. In such a market, a health plan suffering unfavorable selection could always raise its rates, so was not seriously disadvantaged.

That situation is different today because increasing numbers of employers (e.g. the federal government, University of California (UC), Stanford University, and employers participating in the Pacific Business Group on Health (PBGH)) require their employees to pay the difference in premiums if they choose a more expen-

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1 Health insurance arrangements or health benefits financial intermediaries.
2 “The Physician Group Assessment of HMO Performance, 1997,” Pacific Business Group on Health reports that 68.8% of HMOs adjust capitation payments to medical groups to account for differences in patients by age and gender, but only 10.3% adjust for disease severity. The survey question does not distinguish whether HMOs adjust all or only some of their payments to physician groups.
sive plan. Given a price sensitive choice, the healthiest—those who have the least reason to care about the quality of their doctors—are likely to choose the lowest priced plans, while only the sickest are likely to be willing to pay the extra cost associated with health plans and providers that have attracted the sickest patients.

Adverse selection is an especially important issue for academic medical centers (AMCs). Since they typically have deserved reputations for being among the best and most technologically advanced, they are likely to attract the sickest patients in a competitive managed care arrangement. Thus, if health plans pay unadjusted rates, AMCs will not be able to compete to provide clinical services on a level playing field. Such adverse selection is one part of the economic problem posed for AMCs by competitive managed care (see Task Force paper on Academic Medical Centers).

People frequently criticize health plans for employing strategies that attract healthy patients and avoid enrollment of high risk or very costly patients, commonly known as “skimming.” Critics should realize that this incentive is not the creation of the health plans; it is the consequence of payors paying health plans in such a way as to create the perverse incentive to skim. That payors have behaved the way they have can be explained by a lack of understanding of the implications of the recent changes in the health care system, the lack of consensus on methods for correcting the problem, the lack of data available to improve current methods, and the lack of institutions to carry out solutions. Still, the payors must reform their payment methodology if the negative incentives are to be corrected.

II. A Solution: Diagnosis-Based Risk Adjustment

Perhaps the most cogent plea for risk adjustment was offered by the late Cardinal Bernardin, Archbishop of Chicago and leading spokesman of the Catholic Church in the United States on health policy. He said,

... We must develop and adopt methods to compensate health plans that enroll disproportionate numbers of sick people at the expense of plans that enroll disproportionate numbers of healthy people. 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. (Italics added.) These methods, known as “risk adjustment,” reduce incentives for managed care plans to compete based on enrolling only healthier populations.

Thus it is the responsibility of purchasers, especially major purchasers with resources and market power, to reform the payment system in a way that gets the incentives right. Getting the incentives right does not mean a complete reversal from capitation. Rather, what is needed is 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. By leveling the playing field, diagnosis-based risk adjustment can be expected to improve price competition among plans.

A. Methodology

Adequately compensating health plans can be done today by “risk adjusting” premiums. In its most recent form, the risk adjustment process entails the following:

• gathering diagnostic information on each enrolled patient, using each health plan’s computerized database on its patients;

• using econometric methods to convert diagnostic information into expected or average cost of care per patient per year for such a patient (i.e., the enrollee’s risk);

• adding up the expected costs for enrollees in each health plan and converting the totals into each plan’s relative risk among competing health plans;

3 Cardinal Bernardin, “Managing Managed Care,” May 13, 1996.

• adding a surcharge to the premium of each plan experiencing favorable selection, and using the proceeds to compensate the plans that experienced unfavorable selection. This step is would be performed by the sponsor or central clearinghouse.

Risk adjustment enables health plans experiencing unfavorable selection to offer a lower premium in the marketplace and therefore to be competitive with plans that experienced favorable selection. It is important to note that for risk adjustment to achieve its purposes, the adjusted payments must be passed through the health plans to their contracting medical group/IPAs, hospitals or other providers.

As an approach to compensate for adverse selection, risk adjustment improves upon reinsurance of high cost individual cases because (1) it is based on the expected medical needs rather than actual medical needs, and (2) it is based on the whole covered population, not just those people who become high cost cases. These characteristics of risk adjustment preserve a health plan’s incentive to treat even high cost cases efficiently.

B. Adequacy of Risk Adjustment Methods

Substantial research has been conducted on risk adjustment, but there has been controversy over the adequacy of existing methods. Recently, a consensus has emerged among the leading experts—Professors Harold Luft and Joseph Newhouse among others—that good enough methods are now available and ought to be put into practice.

So far, risk adjustment has been tried on a limited scale. From the outset of its health maintenance organization (HMO) program, Medicare has used a formula that adjusts payments to HMOs based on age, sex, location, institutional and welfare status of the patients. This method has been widely criticized for not including diagnostic information. However, the Health Care Financing Administration (HCFA) has begun through demonstration projects to test better risk adjustment methodologies for Medicare. Starting in 1995 with a $500,000 grant from the Robert Wood Johnson Foundation, the Health Insurance Plan of California (HIPC) with Coopers & Lybrand LLP, their consulting actuaries, introduced a risk adjustment model based on diagnostic information from hospital inpatient records, the best information available at the time. The HIPC put its risk adjustment model into practical operation to very good effect in less than two years. All concerned recognize that a more comprehensive model is needed using both inpatient and outpatient information. However, the experience shows that risk adjustment is practical on a large scale.

C. Risk Adjustment Sooner Rather than Later

There are several reasons to begin to implement risk adjustment as soon as possible. Because of problems of data availability, it will take several years to complete implementation.

• First, risk adjustment can help to correct the serious problems discussed above, that is, to get the incentives right.

• Second, risk adjustment will begin to level the playing field, in particular, by defraying the economic damage to AMCs and other providers of recognized excellence—the ones we want to be around when our family members become seriously ill.

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5 For example, a research project by the Society of Actuaries (Dunn D, Rosenblatt A, et al., A Comparative Analysis of Methods of Health Risk Assessment, Schaumberg, IL: Society of Actuaries, Monograph-HB96-I, October 1996) found diagnosis-based risk adjustment models over-predict for persons with low expenditures and under-predict for those with high expenditures; different risk adjustment models resulted in different transfer amounts, particularly among different plan model types (HMOs, PPOs); many studies have focused on Medicare Risk plans, rather than the working, non-elderly population; risk adjustment is untested at the individual provider level; risk adjustment requirements may impede innovative forms of reimbursement; and serious practical problems in implementation of any risk adjustment system need to be addressed.


Third, some kinds of managed care products that offer wider access to providers naturally tend to draw unfavorable selection compared to narrow access products because the people who choose them are more likely to have health problems. Adverse selection is likely to drive these products out of the market unless there is risk adjustment to allow them to compete on a level playing field. Their demise would narrow consumer choice, weaken competition, and reduce consumer welfare.

Fourth, risk adjustment methodology does not have to be perfect to make an impact. Arguably, some adjustment is better than no adjustment. The implementation of current risk adjustment methods will instill greater urgency among participants in the effort to improve them, such as by developing the information infrastructure required to produce outpatient data efficiently.

Finally, and in a sense most fundamentally, risk adjustment is needed to inspire confidence in the moral integrity of the health care financing system.

Progress related to risk adjustment has been slow for several reasons. For one, as explained above, the problem has emerged as a serious one only quite recently. Moreover, research producing persuasive results on methods is relatively new. Beyond these reasons, with the exception of the federal government, no individual purchaser has found introduction of risk adjustment to be beneficial because there is a collective action problem. That is, one employer acting alone cannot affect the incentives of a large health plan. For risk adjustment to be effective in addressing incentives, many firms, very large firms, or some large purchasing groups need to introduce it. In addition, for employers that offer to pay an amount related to the price of the low-priced plan, risk adjusting payments may increase the price of the low-priced plan if that plan got favorable selection, thus increasing the employer contribution even if prices overall decline. For example, under the present contribution formula, risk adjustment in CalPERS would likely cost the state several tens of millions of dollars. Employers need to adopt contribution approaches that do not tie contributions only to the low priced plan.

III. Recommendations

Risk adjustment entails some extra cost and effort in the short run, such as to build the requisite information infrastructure. The information, however, would be valuable for other purposes including quality management. Moreover, risk adjustment is worth the additional cost. 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.

Assuming agreement that risk adjustment is a worthy goal, getting started remains a problem. In California, the two leading concentrations of commercial purchasing power rest with PBGH and CalPERS. DHS holds the analogous power on the public side. CalPERS' size, clout, competence, effectiveness as a purchaser, and unique position as public purchaser of commercial insurance, makes it the ideal candidate to lead the effort toward risk adjustment for commercial populations. The University of California has similar characteristics. PBGH as leading innovator of improved purchasing methods, to the extent it is willing and able, and DHS should also use their purchasing power to implement risk adjustment.

The following steps would bring the number of Californians under risk adjustment to some six million or more. This would likely be sufficient to change incentives. Risk adjustment would benefit the purchasers involved by saving money from unnecessary windfall payments to plans experiencing favorable selection and by making it rewarding for plans to attract the sickest patients and treat them efficiently. In addition, a risk adjustment system would enable these purchasers to price more accurately the risks being covered.

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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8 The term “state entity for regulation of managed care” refers to the Department of Corporations or its successor.
Standardizing Health Insurance Contracts
Background Paper

I. Health Insurance Contracts
A health insurance contract consists of a list of covered services (i.e., services that will be paid for in whole or in part by the insurer) such as preventive services, physician services, etc. Covered services are subject to a schedule of deductibles, coinsurance and copayments, to limitations such as 30 days per year for inpatient mental health, and to exclusions such as of medically unnecessary services, experimental or investigative therapies, and certain procedures. In managed care, covered services must be obtained from contracting providers. Medical necessity is determined by the judgment of the participating physician(s) or the plan’s medical director, and in many cases must be approved in advance of treatment. In response to the demands of payors for cost containment, exclusions of unnecessary and investigative services are enforced.

A. Inherent Complexity
Health insurance contracts are extremely complex and difficult to interpret, even for 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. Employers’ decisions are often influenced by the particular features of their employee relations. Evidence of coverage (EOC) documents are so over-burdened by regulatory disclosure requirements that finding relevant information can be a difficult task.

Even “simplified” presentations of health insurance contracts are not easy to understand. For example, the simple summary of California Public Employees Retirement System (CalPERS) covered benefits takes 45 lines to describe one plan. Previously, when each CalPERS health plan contract was different, understanding the alternatives would require mastery of about 1000 coverage items. Many of the important distinctions occur in the detailed descriptions, which are even more complex. Furthermore, individuals typically do not read their health insurance contracts until they need care, and they often cannot appreciate the subtle differences in the meaning of important terms until they have experienced a problem.

The complexity of health insurance contracts is compounded by the great variety of products health plans offer in response to consumer demand. Having a wide variety of products allows, for example, smaller employers to select more basic packages that do not cost as much, while larger employers can offer high-option plans. Individuals who can barely afford coverage may prefer plans with high deductibles and coinsurance so that monthly premiums are kept low, but coverage for major illnesses is maintained. Different consumers have different needs and different abilities to pay. Variety accommodates these differences.

The complexity of health plan contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance. Rather, the most promising method for achieving a satisfactory contract involves a large group that purchases a specified health plan contract, armed with the professional advice it can afford, that negotiates revisions based on the aggregate experience of the group as unsatisfactory provisions appear.

B. Insurance Strategies Based on Complexity
Complexity also 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.

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1 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).
First, insurers can differentiate their product from others' by offering a combination of features unlike those offered by any other carriers. This makes it very difficult for the customer to understand the differences and to make "apples versus apples" comparisons. This strategy shifts attention from price to features. By decreasing the ability of individuals to compare plans, product differentiation decreases the "price-elasticity of demand" which decreases the incentive for health plans to offer lower prices. Product differentiation raises "switching costs" by making it more "expensive" for a consumer to switch from one plan to another in the hope of saving money. Most consumers cannot afford to devote the days needed to understand the differences among policies in the hope that a smart choice might save $200 per year. Some people rely on experts (agents, brokers and consultants) for advice, but these experts may have their own economic interests and biases.

Second, insurers can segment markets by marketing product designs to targeted segments of customers that are different from the segments their competitors market to, reducing competition for the same customers. An example of this occurred at Stanford University in the 1970s. Employees were offered a choice of two plans. The first covered all the costs of medical services for pregnancy and delivery as part of its benefit package. The second was a prepaid plan that allowed employees to seek care at the local clinic, but did not cover pregnancy and delivery costs. The result, as could have been expected, was that those who were planning or expecting babies more often chose the first plan, while those who were not more often chose the second. In this instance, the two health plans were not in head-to-head competition for the same customers.

Market segmentation is a time-honored business strategy for raising profit margins and reducing competition in any industry. Market segmentation is particularly important in the case of managed care plans because the typical community will only be able to support several managed care plans and because there are many variables that can be used to segment markets. Health plans' ability to segment markets has been limited in the 2-50 group market by small group reforms, including guaranteed issue and renewal, limits on pre-existing condition exclusion periods, and limits on medical underwriting in response to problems of access to choice of plans. In addition, in order to be federally qualified, HMOs must community rate, which by definition precludes segmentation by risk pools.

Third, insurers can design health plan contracts to select risks. Despite laws that place many restrictions on Knox-Keene regulated health plans, there are many ways in which HMO and other health insurance contracts can be designed to make them unattractive to people with above average health risks, including limits on benefits and exclusions from coverage (refer also to Task Force paper on Minimizing Risk Avoidance Strategies).

Fourth, insurers can cut costs by including exclusions in health plan contracts. Given the length and complexity of the typical EOC, augmented by the many mandatory disclosure requirements, these exclusions may not be readily apparent in health plan contracts or read by most consumers.

II. Standardization to Simplify, Compare, and Reduce Costs

Purchasers and consumer advocates must help consumers overcome the complexity of health plan contracts. For the sake of equity and simplicity, purchasers should provide program participants with the same financial protection regardless of the plan they choose. To do so, major purchasers such as CalPERS, the University of California, Stanford University, Pacific Business Group on Health (PBGH), the Health Insurance Plan of California (HIPC) and others have adopted the policy of standardizing the coverage they buy. Typically, they buy one standard contract for all health maintenance organizations (HMOs).

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2 AB 1672, 1993.
3 Federal qualification requires strict community rating, community rating by class, or community rating within 10% of the other methods.
4 Knox-Keene regulated health plans must cover all basic health care services and may charge only nominal copayments, may not exclude any type of disease or treatment, must cover everything medically necessary as defined by the community standard of care, and may not exclude an individual that is part of a group nor fail to renew a group for health reasons.
ferred provider insurance, commonly called preferred provider organizations (PPOs), which pay providers a fee for service, must rely heavily on consumer cost-sharing since they do not have the ability of HMOs to control costs by putting providers at risk. Therefore, PPO contracts need to differ from HMO contracts with respect to cost-sharing, as is the case, for example, with CalPERS. Still, a standardization policy can seek to make contracts as similar as possible and different only where required. By standardizing the contract, management can have a much better chance of understanding what it is buying, administrative costs can be lower because staff in the benefits office need to learn only one contract, and participants can easily make comparisons among plans.

Even with acceptance of the goal of standardization, this policy is not easily achieved. Implementation of standardization has proven difficult at the level of detail. Issues regarding definitions and exclusions will continue to challenge attempts to standardize until greater clinical agreement exists, as will limitations in our ability to detect and reduce practice variations across plans. Several California purchasers, including CalPERS and PBGH, have attempted or are attempting to reduce variation among health plan contracts at this level.

Despite these challenges, standardization policies have worked successfully for major purchasers in California. They have greatly increased the incentive for health plans to offer low prices, which is the most powerful antidote to excess health plan profit margins. It has simplified administration. It has enhanced the bargaining power of purchasers such as CalPERS that must rely on bargaining. These purchasers would all affirm that standardization was a valuable ingredient in bringing prices down. However, while large employers and employer coalitions have the resources to assist their members adequately without assistance from regulators, small groups and individuals need help.

An important recent case of standardization was action taken by Congress in the market for supplemental insurance for Medicare, called the “Medi-Gap” market. In the previously non-standardized market, consumers were confused, often bought wasteful, overlapping coverage, and were not able to make economical choices. In response, Congress asked the National Association of Insurance Commissioners (NAIC) to design a set of standard supplemental health plan contracts, from the barest to the most comprehensive, with the clear understanding that purchase of a more comprehensive coverage would obviate the need for less comprehensive coverage. Congress then passed a law requiring that from 1992 on, only these “approved,” standard contracts would be authorized for sale in the Medi-Gap market. 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 have the same package as large employers. Standardization need not and should not be complete or mandatory, as this would reduce choice and stifle innovation.

A. Concerns Regarding Standardization

Standardization has been criticized as an example of “one size fits all thinking” and as denying people the choice of features they need and want. 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, special features of the health insurance market make some standardization desirable. Risk selection is an unfortunate fact of the health insurance market (See Task Force paper on Minimizing Risk Avoidance Strategies). If individuals want to buy a particular coverage feature, it is almost surely because they consider themselves to be more likely to use it.

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Suppose some insureds say “I neither need nor want coverage of durable medical equipment (DME).” If Plan A decides to exclude coverage of DME, it can be sure that it will not be chosen by patients who need DME. They will look elsewhere for coverage. This will put the plans who include DME coverage at a competitive disadvantage, which will force them to emulate Plan A or risk being driven from the marketplace. Under these circumstances, patients who need DME suffer. Whole groups must make a decision as to whether or not they want coverage of DME, 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 with respect to cost-sharing, 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:

- A uniform, national contract, as is the case of Medicare. Given the current political climate and the need for continued innovation and different benefit packages to satisfy different consumers, there is no support for this proposal at this time.

- 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. There is little support politically for this option either, since the benefits of standardization can be achieved by standardization within groups without requiring standardization across groups.

- A set of “endorsed 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.8 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 stakeholders9

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8 Throughout this document, the state entity(ies) for regulation of managed care refers to the Department of Corporations, the Department of Insurance, or its/their successor.

9 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.
New Quality Information Development
Background Paper

I. Introduction
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:

• 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, health 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.

The state government is an entity with institutional stability. It should work with the private sector to provide publicly available information that is reliable and verifiable with equal access to all. The State should also provide objective analyses of outcomes of care, access to care and patient satisfaction through collaboration among state agencies and in partnership with the private sector.

The State should be aware of, participate in and actively help where possible, ongoing private sector efforts to provide health information for the following purposes:

• To help California consumers make informed choices about health plans, providers, and treatment options.

• To help health plans and providers improve the quality of health care by determining what works, when it works and why it works. This information would add to the developing cache of evidence-based medicine being pursued by health professionals and researchers. Risk adjusted measures of outcomes are an essential component of evidence based medical research (see the Task Force paper on Minimizing Risk Avoidance Strategies).

• To help public and private purchasers better determine the value derived from their health care purchases.

• To help policy makers to better safeguard the public’s health.

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.

1 “Health plans,” refer to any health insurance arrangements, also known as health benefits financial intermediaries.
II. Findings and Recommendations

A. Transition from a Statutory to a Regulatory Approach to Data Collection

Direct legislative management of data collection is a cumbersome approach to data collection intended to improve the quality of health care for Californians. The practice of medicine and information technology are both changing so rapidly that a more flexible approach to data collection is needed in order to encourage innovation in both areas. Legislating each data element should be replaced with regulatory oversight to allow greater flexibility and room for innovation.2

1. Recommendation to Transition from a Statutory to a Regulatory Approach to Data Collection

(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 care3 should approve data requests (e.g., data elements) and make specific findings regarding cost and benefits.

(b) An advisory body composed of stakeholders,4 should be authorized 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

Physicians and health care organizations will be more supportive of data collection and evaluation efforts if they perceive that information about their performance and outcomes is gathered for purposes of improving the quality of care. For example, shared information about improvements in hip replacement surgery led to reduced patient days in intensive care. Functional outcomes and overall mobility improved more rapidly for patients as well. It also reduced the total days required for hospitalization.5 Improvements in coronary artery bypass graft surgery (CABG) have been shown to improve patient outcomes and reduce hospital days when a minimum of 200-300 surgeries are done per year. Because volume has been correlated with improved outcomes, patients and purchasers should have ready access to this information.6

Evaluating and improving the entire continuum of care requires clinical information that is too costly and ponderous to collect with paper charts. To be useful, information should be efficiently collected and distributed at a reasonable cost. The Task Force encourages creating a comprehensive, electronic medical record. The Task Force also recognizes there will be significant cost and technical complexity associated with such an effort. As a starting point, certain medical record data lend themselves more easily to automation than others. For example, many hospitals and medical group/IPAs already automate laboratory, pharmacy and radiology data. Others also automate encounter data that typically includes the patient’s name, the provider’s name, diagnosis and procedures performed by date of service.

Creating electronically storable and retrievable encounter data is a logical first step to using information as the cornerstone of quality improvement. Encounter data will allow groups and providers to monitor and improve their own practices. Health plans will be able to monitor groups. Purchasers, accreditation organizations and the entity(ies) for regulation of managed care will be able to monitor health plans and medical group/IPAs. Encounter data will allow purchasers and health plans to implement adequate risk adjustment

3 The state entity(ies) for regulation of managed care refer to DOC, DOI, or their successor.
4 The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, health plans, and purchasers.
6 American College of Cardiology recommendation.
mechanisms across health plans and providers. Following encounter data, clinical data should be incorporated into the electronic medical record to optimize the quality improvement potential of the system.

A variety of electronic media including intranet, internet, smart card technologies and others in development should be considered as vehicles for collecting and distributing health care information.

Working with the states and the private sector, the federal government should have the responsibility for determining national standards for technology and for data communication. For example, the federal government sets the standard for 87-octane gasoline so that whether you fill your gas tank in California or Florida, the basic composition of the gasoline is the same. To ensure national data compatibility and comparability, technical standards such as uniform identifiers for patients and uniform language and definitions should be identified at the federal level.

Electronic collection of patient information will be a sensitive, complex and costly undertaking. Great care should be taken to safeguard patient privacy and confidentiality. Federal involvement in developing patient privacy and confidentiality protections is also necessary. Strong fire walls are needed to ensure privacy for patients. However, fire walls should not be put in place to protect providers from reasonable accountability for the health care services that they give their patients. The entity(ies) for regulation of managed care should actively work with and facilitate private sector efforts in this area to avoid costly redundancy and duplication.

2. **Recommendation to Advance Implementation of Electronic Medical Records**
   (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**
Quality of care information should be collected and disseminated not only at the plan level, but also at the treatment level if and when possible. The choice of a health plan and a provider are personal and local decisions. Aggregate health plan performance in Northern California may not be as pertinent to consumers in Sacramento as information specific to that area. Health care quality data should help consumers to make better decisions at the local level.
The feasibility, utility and cost of a “Super Directory” of health plans, physician choices, hospital choices, treatment options and health outcomes should be studied and considered. If feasible, the “Super Directory” should be provided through various technologies to achieve maximum exposure, e.g., on-line, touch-tone phone, paper, videotape and others yet to be invented. Some of this information could be made available through employers’ benefit offices, the internet and public libraries (see the Task Force paper on Consumer Information, Communication and Involvement).

3. Recommendation to Collect Health Information at the Treatment Level
   (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 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 distribute 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. Recommendation to Ensure Basic Safety Standards for Patient Care
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.

III. Conclusion
New quality information should be developed within a learning cycle of continuous improvement. In order to improve something you need to be able to measure it. To measure something as important as the quality of health care you need an efficient, reliable and cost-effective system for collecting and analyzing important data. The benefits of increasing the current array of health care quality data include:

- Creating better tools for physicians to use to conduct risk adjustment and outcome studies, design clinical pathways and practice guidelines, and generally add to the research and development of evidence based clinical medicine.
- Improving the quality of relevant information made widely available to patients, consumers and employers to help them choose a health plan, doctor, hospital, or treatment.
- Developing more statistically reliable ways of measuring patient and consumer satisfaction with the health care services chosen.
- Helping policy makers to better safeguard the public’s health.
There will be significant 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 managed health care available. If we do not make this investment, attention will focus on cost and we will know little about value.

To preserve flexibility of the information environment, regulatory rather than statutory oversight should be adopted. Regulatory oversight as well as the tools used to collect and distribute information should be developed by public/private partnerships to encourage technically driven and market driven innovations. Clear target dates and deadlines are necessary to move these initiatives forward. A mechanism for piloting different information initiatives is desirable so that perhaps one or two or more will have value, produce desirable results and earn acceptance in the marketplace. The recommendations proposed in this paper are intended as a starting point. Once implemented, they must be evaluated and shown to have proven their worth. Improvement is a dynamic process that must constantly incorporate change, innovation and better ways of insuring the health of the people of California.
Improving Managed Health Care in California Volume Three

Improving the Dispute Resolution Process in California’s Managed Care System
Background Paper

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 plans1 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.

III. Current Dispute Resolution Processes
Task Force staff and members of the dispute resolution group reviewed literature on a wide range of dispute resolution processes, existing systems, and proposed models.

A. Consumers’ Experiences
Currently, limited data exists relating to consumers’ problems, the severity of those problems, and the relationship of problem experience to consumers’ complaints and resolution. In particular, current data sources give little information about the severity of the problem. According to Section 1397.5 of the

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).
Two recent surveys conducted, one for the Task Force\(^2\) and the other for three foundations\(^3\), 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. The Health Plan Value Check survey conducted by the California Public Employees Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH),\(^4\) found that in 1995 26% of PBGH members surveyed reported having a complaint or problem with their health plan. The percentage was slightly lower for health maintenance organization (HMO) and indemnity plan members and higher for point-of-service plan (POS) members.

Of those who complained, 30% were satisfied or very satisfied with the way their health plan handled their most recent problem, while 52% were dissatisfied or very dissatisfied. The rate of satisfaction varied among health plans, from 19% to 47% satisfied with the way in which problems were handled. Dissatisfaction may be due to many reasons. However, the survey found that 63% of those who complained said “I had to explain the problem over and over”, and 42% said “I was given incorrect information”. On the other hand, the survey also found that 47% said “Someone at my health plan took responsibility for resolving the problem”.

According to the Health Plan Value Check survey, 12% of disputes were resolved on a same-day basis, another 14% were resolved within 10 days. Twenty-six percent of complaints took more than 30 days to resolve; 35% of complaints were still pending as of the date of the survey.

In 1995, CalPERS conducted an exit survey of individuals switching health plans during the open enrollment period.\(^5\) Typically, less than 5% of enrollees voluntarily change plan at open enrollment. They found that almost half of those who changed plans voluntarily had some difficulty with the dispute resolution process. Among those who changed plans for reasons related to the dispute resolution process, 33.4% said claims issues were not resolved to their satisfaction, and 14.8% said appeals were not resolved to their satisfaction. Slightly more than a quarter said that their problem with the dispute process was the most important reason for changing plans. Seventeen percent said that claims not resolved was their overriding reason for changing plans, 5.4% said that appeals not resolved and 4.2% said that disappointment with their plan’s appeals process was their overriding reason. Plan-specific scores on these measures varied significantly.

### B. Current Health Plan Practices

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 them to proceed to binding arbitration rather than to court.


Several laws require, and several accrediting and other organizations recommend, certain elements of the dispute resolution process. For Knox-Keene regulated health plans, in 1995, SB 689 (Rosenthal) comprehensively reformed existing law pertaining to plan grievance processes, requiring health plans to resolve “whenever possible” or respond to non-urgent grievances within 30 days, to create an expedited review process for grievances pertaining to life-threatening conditions, to inform their members in every correspondence pertaining to a grievance and through plan documents of their ability to submit grievances to the DOC, and to track and report to the Department those grievances that remain pending unresolved for more than 30 days. In addition, SB 689 funded and directed the DOC to create a toll-free telephone hotline through which enrollees could submit their complaints, before or after arbitration, to the DOC, on an expedited basis if warranted. Section 1397.5 of the Knox-Keene Act requires the DOC to report data on the hotline complaints. Some health plans feel that it may not be appropriate for the DOC to investigate consumer complaints because, under political pressure, DOC may favor consumers, ordering health plans to pay even when they are not contractually obligated; plans comply because DOC has so much power over them. Some consumer groups, on the other hand, argue that the DOC favors the health plans.

Current law also establishes standards regarding arbitration for Knox-Keene regulated health plans including the following: AB 3260 (Bornstein), which requires Knox-Keene regulated health plans that require arbitration to inform new health plan members that enrolling with the plan waives their right to jury trial; SB 1660 (Rosenthal), which provides that cases involving less than $200,000 would involve a single neutral arbitrator, requires plans to have expeditious processes in place by which arbitrators are selected, and requires plans to have provisions for hardship waivers. In addition, the State Supreme Court established, in Engalla v. Kaiser, that an individual may withdraw from the arbitration and pursue court action if he or she can demonstrate that the process was tainted by fraud, material misrepresentation or misfeasance in the performance of the arbitration agreement. Arbitration, however, is rarely used for medical delivery issues except by health plans that indemnify their physicians against medical malpractice. Most grievances that seek a reversal of a Knox-Keene plan decision can be handled through the plan or DOC process. When medical malpractice has occurred, the only resort is arbitration or lawsuit because usually the only remedy is monetary compensation.

While these provisions apply to Knox-Keene regulated health plans, they do not apply to Department of Insurance (DOI) regulated plans. However, members of plans marketed by DOI regulated-insurers may also call a toll-free number for assistance with grievances. The Knox-Keene provisions also do not apply to coverage provided by self-insured employers, which are preempted from state law by the Employee Retirement Income Security Act of 1974 (ERISA). In addition, if an ERISA plan loses a court case, damages are limited to recovery of costs and may not include punitive or compensatory damages.

Besides the formal grievance process in health plans, there may be external grievance structures available to consumers that parallel or supplement these processes. Examples include processes through employers and employee benefits departments (though rarely available through smaller employers), and, for Medicare or Medi-Cal beneficiaries, formal rights to an independent hearing and access to judicial review. Furthermore, Medicare beneficiaries have available to them Health Insurance Counseling and Advocacy Programs (HICAPs) which assist them with filing appeals and exercising their rights.

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6 For HMOs and other Knox-Keene regulated health plans, Knox-Keene Health Care Service Plan Act of 1975, including amendments enacted in 1996, Section 1368 and Barcays California Code of Regulation, Section 1380.68 and Health and Safety Code, Section 1368-1368.1; For PPOs and FFS plans, Insurance Code Section 510, 12921.1, 12921.3, 12921.4; For Medicaid plans, Welfare and Institutions Code, Sections 10950, 14450 and Regulations, Title 22, Section 5104.1, 53858, 53893, 53914; For Medicare plans, Federal Register, HCFA Regulations 42CFR Part 417. Other standards include, Federal HMO Qualification Requirements, Health Plan Requirements Guide June 1994; Health Carrier Grievance Procedure Model Act, National Association of Insurance Commissioners, 1996; 1997 Data Collection Tools and 1997 surveyor Guidelines, National Committee on Quality Assurance Joint Commission on Accreditation of Hospital Organizations; and IPA Association of America: Complaint, Grievance and Appeal Procedure 1995.

7 Knox-Keene Act, Section 1368.01.
Consumers may also get assistance from their providers, agents/brokers, consumer advocates, and attorneys. We currently lack sufficient evidence to know how widespread the availability of these ancillary processes is and whether particular processes or types of assistance are working well or consistently. The potentially most costly and least efficient method of resolution is through the courts. However, the court system is not always available. When plan members agree to submit to binding arbitration, they also agree to forego resolution through the courts.

IV. Observations on Health Plan Practices

The observations below stem from an informal review of internal plan materials (including evidence of coverage, descriptions of grievance processes on file with the applicable regulatory authority, sample correspondence with grievants, etc.) as well as responses to specific survey questions submitted to Task Force staff and members of the dispute resolution group by several HMOs and PPOs in California describing their dispute resolution processes. The dispute resolution group survey generated insufficient responses to draw firm conclusions. In addition, internal documents may not be completely consistent with actual practice.

A. Lack of Consistency

There are many differences among plans and across the industry in processes, timing, definitions and categorization of complaints, grievances, and appeals. Examples include (1) the “statute of limitations” for filing appeals and grievances ranges from 60 days to unlimited; (2) health plans use different terms to describe the same or very similar processes (e.g., inquiry, concern, complaint, grievance, and appeal are used inconsistently); (3) health plans use different descriptions for the reasons members complain; and (4) some health plans allow consumers to appear in person at all stages of review, others allow consumers to appear only at one stage or set up special processes; and (5) health plans differ in the extent to which they allow consumers to have someone assist or represent them at a plan’s review.

B. Ineffective Communication

Letters from plans to consumers explaining denials do not consistently include sufficiently detailed explanations to enable an individual to judge the basis of the decision or to determine whether further action would be worthwhile. Some plans do not provide specific information to consumers about what materials were reviewed in making the decision, so the consumer can not determine whether a thorough review occurred.

C. Variable Reporting

Certain plans may not track, or were unable to provide on request, a summary of the disposition of complaints. Some plans use a category of “inquiry” or similar term for an initial complaint, which if resolved satisfactorily is not recorded or tracked for summary level reporting.

D. Use of Complaint Data for Quality Improvement

In general, health plans that are HMOs have specified procedures to use grievance data for quality improvement in accordance with Knox-Keene requirements. Some plans appear to use effectively grievance data for quality improvement and internal monitoring of dispute resolution processes. For example, some plans have used grievance data to clarify the description of the grievance process in the Evidence of Coverage and Member Handbook and to modify and update medical treatment policies to reflect current practice.

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 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 stan-

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8 The term “state entity(ies) for regulation of managed care” refers to the DOC or the DOC and DOI or its/their successor.
9 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.
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.

(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 researched), 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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Notes:
1. Knox-Keene Act, Section 1368.01(a).
2. Knox-Keene Act, Section 1368.01(b).
3. The Knox-Keene Act currently requires the disclosure of the grievance system and the DOC hotline.
4. 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.15

(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)' 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;16 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.17

(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.

(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.

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15 DOC has already developed common complaint categories for its hotline for the classification of types of complaints.
16 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.
17 The Knox-Keene Act requires such notices at every stage.
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

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18 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.
curtailment of care based on medical necessity, appropriateness, and all “experimental-investigational treatments.”18 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.
Financial Incentives for Providers in Managed Care Plans
Background Paper

I. Introduction
Enrollment in health maintenance organizations (HMOs) and other forms of managed care continues to grow in California. Although most enrolled residents of the state are accustomed to their pre-paid health system, there are concerns that the financial incentives in some managed care arrangements could erode the basic tenets of the provider-patient relationship and undermine quality of care. Managed care changes traditional unmanaged fee-for-service (“indemnity”) insurance by integrating the financing and delivery of health care services, with the aim of controlling costs and improving quality.

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.

This paper will outline: (1) the range of provider incentive models that are currently being used in California and around the country, (2) issues that must be considered in structuring these compensation plans, (3) research that attempts to determine whether managed care can decrease utilization while preserving quality of care, (4) governmental responses that have occurred at both the federal and state levels in the area of financial incentives for health practitioners, (5) the issue of disclosure of incentive information to consumers, and (6) general findings and recommendations.

II. Models of Provider Compensation and Incentives
All compensation arrangements contain incentives, which may have positive and negative effects. In general, managed care plans compensate health practitioners using a combination of basic reimbursement and incentive reimbursement. Basic reimbursement models include (1) fee for service (FFS), (2) salary, and (3) capitation. Practitioners receive the bulk of their compensation from their basic reimbursement. These forms of basic compensation have inherent in them different incentives that can affect physician behavior in different ways. 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. Unless a provider's practice is too busy, he or she may have an incentive to “over-treat” the patient. In some cases, there may be risk to the patient from such over-utilization of services.

Compensation through salary provides an incentive to provide appropriate care, but may impede productivity. Under a salary arrangement, a health practitioner receives a fixed amount from the health plan no matter what services he or she provides.

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. With individual provider capitation, the provider receives a fixed fee per member enrolled in

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4 Throughout this paper, the term “health plan” refers to any health insurance arrangement or health benefits financial intermediary.
a particular health plan and is at risk to provide a set of services within that fixed amount. The capitation payments received on behalf of the majority of members subsidize the costs of care of those few who are sick.

Many providers participate in bonus and withhold incentive arrangements that may be designed to encourage quality and consumer responsiveness, or may be weighted excessively toward financial considerations. Health plans often try to enhance or temper the incentives built into basic reimbursement models by using targeted incentive payments such as (1) bonuses, (2) withholds, and (3) sub-capitation. Incentive payments can be used to elicit a range of desired behaviors from providers. They can also be used to encourage the provision of certain types of services, such as preventive care or counseling. For example, where the basic compensation is FFS, a health plan may use incentive payments to encourage cost-effective care. Where the basic compensation is capitation, a health plan may give incentive payments to reward quality. Often plans will use a combination of basic reimbursement and multiple incentive arrangements.

Bonuses are rewards. Health practitioners can receive extra money if they meet certain performance criteria. The performance criteria can be either financial or non-financial or both. As an example of financial criteria, the amount of the bonus may increase as the plan’s expenditures for patient care decrease. Non-financial criteria can include measures of outcomes, patient satisfaction and peer evaluation. Bonuses may be used by groups that pay practitioners on a FFS or salary basis as a way to encourage certain types of behavior.

Withholds are delayed payments, conditioned upon performance. Rather than receive their full basic reimbursement up front, practitioners only receive a percentage. The remainder is withheld by the health plan and typically put into a risk pool. Funds in the risk pool can be used, for example, to pay for referral or laboratory services authorized by the practitioners. Providers receive money from the risk pool at the end of the compensation evaluation period if costs have not exceeded budget. Plans vary on how they fund deficits in withholding accounts. Some of the options include increasing the percentage of payment withheld each year, liens on future earnings, or exclusion from the program. Some plans require that the providers repay the entire deficit amount, while others restrict this amount to a set percentage or amount per enrolled patient per year. Others retain reinsurance or stop-loss coverage to prevent such an eventuality. Withhold arrangements are used with FFS or capitation arrangements.

Under sub-capitation, a provider group receives capitation for a group of patients, and in turn subcontracts with certain providers, also on a capitated basis, to provide services.

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.

III. Growth of Incentive Arrangements

As managed care has spread throughout the country, so has the use of incentive arrangements. The Physician Payment Review Committee (PPRC) recently released two reports documenting the extent and growth of incentive arrangements nationally. They conclude that approximately half of all American physicians have at least some patients whose insurance plans place the physicians at financial risk through

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the use of capitation or of withhold modifications to indemnity plans. The studies also suggest that capitation arrangements are more common among primary care physicians and among physicians in group practices with over twenty-five physicians. Withhold-modified FFS arrangements are most common overall and are especially predominant among specialists and physicians in small practices.

Stephen Latham, Ph.D., Director, Ethics Division of the American Medical Association, comments,

...[d]ata from managed care organizations echo this physician data. The PPRC study of managed care plans indicated that nineteen percent of plans use salary as basic payment, thirty-seven percent use capitation and forty-three percent use FFS (see Figure 1). Twenty-five percent of FFS plans modify their basic payments with withholds or bonuses, as do over half of salary plans. Thus, over sixty percent of managed care plans place physicians at some risk, either through capitation or through withhold or bonus modifications of salary and FFS-based payment.

Further, 56% of the network or independent practice association (IPA) HMOs used capitation as the predominant method of paying PCPs, as compared with 34% of the group or staff HMOs and 7% of preferred provider organizations (PPOs). Withholds and bonuses are most common among network- and IPA-model HMOs. Seventy-two percent of these HMOs use withholds or bonuses in paying their PCPs, and 47% use them for payment of specialists.

A majority of HMOs (68.8%) in California adjust capitation payments to medical groups to account for differences in patients by age and gender; however, only 10.3% adjust for disease severity, according to a recent survey by PBGH. Most of the HMOs under contract to PBGH capitate medical groups with large case loads that may represent an average risk pool, in which case risk adjustment among provider groups may not be necessary.

![Managed Care Plan Payment](image)

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>43%</td>
</tr>
<tr>
<td>Capitation</td>
<td>37%</td>
</tr>
<tr>
<td>Other Salary</td>
<td>19%</td>
</tr>
<tr>
<td>Salary</td>
<td>1%</td>
</tr>
</tbody>
</table>

Physician Payment Review Committee, 1995

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10 "The Physician Group Assessment of HMO Performance, 1997," Pacific Business Group on Health. Data comes from assessment of 272 physician group contracts in California, Washington, and Oregon. The survey question does not distinguish whether HMOs adjust all or only some of their payments to physician groups.
A study using data from a 1995 AMA survey of physicians found that capitation of physician practices is widespread and that physician involvement with capitated contracts increased sharply between 1994 and 1995. The study found that as of mid-1995 more than 33% of patient care physicians were in a practice that had at least one capitated contract, up from 26% in 1994.11

A 1995 study by James Robinson and Lawrence Casalino of the University of California, Berkeley, documents the growth of capitation at six large medical groups in California. They found that between 1990 and 1994, the number of HMO enrollees whose care was paid for through capitation increased by 91% from 398,359 to 759,474.12 These groups did not pay their member physicians through capitation, but rather paid a salary plus an annual bonus based on the physician's productivity, patient's satisfaction, and profitability of the group.

IV. Issues and Trends in Provider Financial Incentives

Financial incentives for health practitioners practicing in managed care settings are indisputably complex. As Dr. Alan Zwerner of the American Medical Groups Association said, “if you’ve seen one incentive plan, you’ve seen one incentive plan.”13 However, several common characteristics and issues emerge from the literature that should be considered by policy makers debating this topic.

A. Two-tiered vs. Three-tiered Health Plans

Different contracting arrangements can elicit different types of provider behavior. Two-tiered HMOs are HMOs that contract directly with providers. Three-tiered HMOs are HMOs that contract with intervening entities such as medical groups, which then contract with providers.14 In three-tiered HMOs, the intervening entities may change the financial incentives so the HMOs do not directly impact the provider. In evaluating financial incentive arrangements, it is not enough to look at how the HMO pays the middle tier, policy makers must also look at the arrangements made by the middle-tier with individual providers.

The middle tier can use bonuses, withholds, or risk pools to transmit a portion of the risk, rather than complete risk, to providers. In comparing three-tiered HMOs and risk pools, Hillman argues that while they are conceptually and operationally different mechanisms, they play similar roles:

...they add a level of managerial authority, probably closer to the individual physician, but often with less complete power than a central HMO model; and they modify the sharing of risk between physician and central HMO, permitting other individuals, physician or non-physician, to share in that risk.15

Hillman believes that many studies do not adequately distinguish three-tiered HMOs and may therefore overstate the amount of direct capitation. His survey found that only 35% of the plans ultimately paid physicians by capitation, and most of these were two-tiered plans.16 Further, only 19% of enrollment is in HMOs in which PCPs themselves receive direct capitation. Many middle tiers that receive capitated payment from the HMO transform this payment into salary or FFS for physicians. No plan turned a FFS payment into capitation of physicians.17 This data is relatively out of date, but many HMOs appear to have three-tiered structures.

B. Primary Care Providers vs. Specialists

In early managed care arrangements, only PCPs were placed at financial risk, while most specialists were paid on a FFS basis. While this is still generally the case, the mix seems to be shifting. For example, the

33 Personal interview, June 10, 1997.
16 Ibid.
1995 AMA physician survey found that PCPs receive a significant share of HMO reimbursement through capitation, while most specialty care physicians still are reimbursed on a FFS basis.\footnote{Simon CJ, Emmons DW, “Physician Earnings at Risk: An Examination of Capitated Contracts”, Health Affairs, 16:3, 1997, 120-126.} The 1995 PPRC report on health plans shows that the use of capitation arrangements is spreading into the area of specialist compensation. Although FFS is still the predominant method for paying specialists, 18% of plans report using capitation as their main method of payment for individual specialists. If plans using FFS compensation modified by bonus or withhold arrangements are included, over half of network or IPA managed care plans and three-quarters of group or staff HMOs pass some financial risks on to specialists. PPRC notes that its survey may even under-report the degree of specialist risk-sharing because it does not capture plans’ capitation of groups of specialists.\footnote{Op cit., Gold M, et al., “Arrangements between managed care plans and physicians. Selected external research series no. 3.”, 1995.}

Dr. Alan Zwerner of the American Medical Group Association has argued that specialty capitation will work in some situations but not all. First, for capitation to be effective, practitioners must have some control over the health outcome. If their ability to act pro-actively or react is limited, then capitation cannot work. For example, anesthesiologists have little control over the outcome of a surgery and are not involved in primary care, so it makes little sense to capitate their services. Second, risk sharing works better for low acuity, high frequency events because their costs are easier to predict. For example, putting neurosurgeons at risk for brain surgery, a high acuity, low frequency event may not be fair, since it is both expensive and unpredictable. Third, the nature of the relationship between the PCP and the specialists with whom they contract can affect the decision to capitate. If the relationship is close and the PCP trusts the specialists to manage the care well, the PCP may be better off paying for services on a FFS basis. If the relationship is distant, the PCP may not trust the specialists to manage the care efficiently under FFS, then capitation might be a better option.

Capitation should only be undertaken if the health care system covers a substantial number of lives and if the capitation payment only covers services that are most often needed by the patient. Health care systems might also want to purchase stop-loss insurance to protect against the high cost of some procedures performed by practitioners receiving modified FFS payments. In addition, risk adjusted payments to providers that blend prospective adjustments with FFS payments for less frequent conditions/procedures can alleviate some of the potential problems with capitation.\footnote{Newhouse J, “Patients At Risk: Health Reform and Risk Adjustment,” Health Affairs, Spring (I) 1994, 133-146.}

C. Scope of Capitated Services

Health practitioners paid on a capitated basis can be at risk for a range of services, including only the services they provide, laboratory and other tests they order, all practitioner services, or all practitioner services plus some hospital services. In theory, capitation for a range of services provides no incentive to manage total costs. Capitation for a narrow range of services, for example, those provided by a practitioner directly, provides no incentive to contain total costs and could even drive costs up in other areas. According to Harvard’s Dr. Donald Berwick, in order for capitation to be a force for the redesign of care processes, however, the entity paid by capitation - the one that stands to gain from innovation - must be capable of achieving such redesign. Based on this analysis, he recommends that the services covered under capitated contracts should be those about which the risk-bearing entity can make relevant, clinically prudent choices, not those over which the entity has little or no influence or control. The GAO supports this conclusion in their 1988 report on physician incentive payments, recognizing that shifting financial risk to physicians can place them in a compromising position when treating potentially expensive cases. If an HMO physician must pay for specialty or institutional service out of his or her own account, the physician has an obvious incentive not to use such services. This suggests, for example, that capitating a PCP for referrals to specialists is not desirable. Rather, alternative incentives for controlling inappropriate referrals should be considered. There is no currently available information about the extent to which practitioners in California are capitated for referral costs.
D. Size of Risk Group
Consensus seems to be forming in the health care community against incentive arrangements that apply to individual PCP services and referrals. Hillman reported in 1987 that 18% of the HMOs responding to a survey held physicians at risk for deficits on the basis of their individual performance, as opposed to the collective performance of a group of physicians. He also found that for-profit plans are more likely than not-for-profit plans to place individual PCPs at risk for deficits. The PPRC survey found that among plans with withhold losses, 15% define the risk pool over which the withhold loss or gains is spread as the individual physician, 34% as a small group of physicians and 40% as all PCPs participating in the plan.21

The 1995 AMA Survey found that large practices are most likely to enter into capitated arrangements and that larger practices earn a greater share of practice revenues from capitated contracts than do smaller practices. However, 26.6% of solo practitioners and approximately 31.6% of physicians in practices with two to five physicians accepted capitated contracts in 1995.27 Physicians in solo practices reported 16.8% of practice revenues were earned from capitated payments, compared to 37.5% of revenues in the largest groups.

Latham describes two major reasons for disfavoring one-practitioner incentive arrangements. First, one-practitioner plans spread risk over too few patients. Their cost-incentive effects are therefore too intense. The Advisory Board characterizes arrangements in which individual PCPs receive capitated payments for all professional services including referral costs for specialty care as “nuclear force capitation” and notes that while they are “highly, inarguably effective,” they are “hazardous in the absence of strong controls.” The second benefit Latham sees of insisting that incentive plans run to groups of practitioners rather than to individual practitioners, ...is that group-based incentives do not depend for their efficacy solely on burdening individual clinical decisions. An incentive to a practice group is an incentive to cooperation among medical professionals in setting practice standards with which they can all live ethically and cost effectively.30

Berwick and the GAO support this position. Some physicians object to capitation of any group size. They argue that capitation is potentially dangerous for individual practitioners and their patients. As for groups, some private practice practitioners do not want to depend on others for their income. They feel that if they work harder, they should earn more.

E. Percent of Revenues at Risk
Berwick argues that “the magnitude of risk under capitation should not be so great as to influence an individual physician to make clinically imprudent choices for an individual patient.”33 The 1995 AMA

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22 Berwick D, “Payment by Capitation and the Quality of Care,” NEJM 1996; 335:1227-31.
31 Berwick D, “Payment by Capitation and the Quality of Care,” NEJM 1996; 335:1227-31.
physician survey found that physician practices are bearing risk: among all practices with capitated contracts, nearly 20% of all revenues were capitated. Fifty-seven percent of physicians indicated that their practices earned 10% or less of total revenues from capitated payments; another 15% reported that only 11% to 25% of revenues came from capitated contracts; and only 6.8% of physicians were in practices that earned 75% or more of revenues from capitated sources (see Figure 2).\(^\text{34}\) In the PPRC survey, health plans reported an average of 12% as the maximum percentage by which an individual PCP's annual income may vary each year as a result of financial incentives.\(^\text{35}\) More than a third of HMO managers surveyed by Hillman in 1988-89 believed that a withholding level equal to 16% to 30% of HMO income should cause some concern.\(^\text{36}\)

Further, in regulations governing physician incentive plans in prepaid health care organizations contracting with Medicare, the Health Care Financing Administration (HCFA) defines a physician or physician group as at substantial financial risk if the amount at risk for referral services exceeds 25% of potential payments for covered services.\(^\text{37}\)

\[\text{F. Frequency of Evaluation}\]

Latham and the GAO report also discuss the impact that the frequency of incentive payment calculations can have on the intensity of the incentive felt by a physician. For example, an incentive plan that offers an annual bonus of $24,000 if a physician spends less than $120,000 on referral services in a given year is less intense than one that offers the same physician $2000 in each month in which the physician spends less than $10,000 on referral services.\(^\text{38}\) Latham argues that this is because, ...costs are distributed over clinical decisions unequally. Extraordinarily high expenses for a single patient are averaged over the whole year in the former case, while in the latter case, those same high expenses are averaged over only a month's worth of patient encounters. In a shorter calculation period, even a single cost-outlier can impose the need for austerity measures if the incentive is to be earned.\(^\text{39}\)

\[\text{Figure 2}\]

<table>
<thead>
<tr>
<th>Percentage of Total Physician Revenues</th>
<th>Percentage of Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10%</td>
<td>57.0%</td>
</tr>
<tr>
<td>11-25%</td>
<td>15.0%</td>
</tr>
<tr>
<td>26-74%</td>
<td>21.1%</td>
</tr>
<tr>
<td>&gt;75%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

Source: Simon, 1997

\[^{37}\] HCFA Regulations 42CFR, Section 417.479.
\[^{39}\] Ibid.
The GAO also concluded that, “basing incentive payments on physician cost performances over a short period of time, such as a month, may increase the temptation to under-provide services.”

G. Thresholds
Several of the issues discussed above raise the question of whether there are thresholds above which financial incentives can be dangerous, and below which they have no effect. Finding the appropriate “band” or level seems to be the major challenge in structuring incentives.

Some areas where thresholds potentially may exist include:

Size of group. Regarding the size of the risk pool, Hillman was able to discern distinct thresholds necessary to reduce the impact of withhold account on physician decision making. He found that few managers believed that risk pools of only five physicians or fewer could counterbalance the impact of individual withhold accounts on decision making. However, the health care industry has not formed a clear consensus on the appropriate group size.

Percent of income at risk. Latham mentions anecdotal evidence, suggesting that “groups with over 40% of their income from ‘incentivized’ plans reach a ‘tipping point’ and begin to take incentive pressures seriously.” Similarly, Hillman reports that “more than 90% of respondents reported no noticeable effect on the ordering behavior of physicians at risk as individuals if the level of withheld funds is below 5% of total HMO payments.”

H. Role of Professional Ethics and Other Non-Financial Incentives
Financial incentives are not the only method health plans use to encourage health practitioners to control utilization and provide cost-effective, quality health care. Other, arguably more important factors at work include professional ethics and providers’ desire for the esteem of their peers.

Zwerner notes that most medical groups include some measure of peer evaluation, patient satisfaction, contribution to the group, and patient volume in their bonus plans. Supporters view these non-financial measures of quality as potentially effective tools for changing provider behavior.

The PPRC study found that health plans used several different non-financial methods to influence medical practices. For example, 79% of group or staff HMOs and 70% of the network or IPA HMOs required outcome studies for particular clinical conditions. Sixty-nine percent of the group or staff HMOs and 80% of the network or IPA HMOs used physicians’ profiles which measure physicians’ practice patterns relative to their peers. Practice guidelines were used less frequently. In addition, the study found that many plans used non-financial factors to adjust payments. Some of the factors included patient complaints or grievances, quality measures, consumer surveys, provider productivity, and enrollee turnover rates.

Latham discusses other non-financial pressures that could serve to temper the intensity of financial incentives. These are (1) marketplace competition based on quality of care; (2) the threat of medical malpractice liability if necessary care is denied; (3) utilization review and quality assurance review programs that operate to catch dangerous “under-care” directly; and (4) physicians’ professional ethics. He concludes, however, that possibly none of these pressures is strong enough to overcome a physician’s self-interest in every case.

An additional, non-financial manner in which to shape provider practice patterns is to provide clinical practice guidelines. Hillman describes the role of clinical guidelines versus financial incentives in influenc-

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42 Ibid.
43 Personal interview, June 10, 1997.
ing physicians' clinical decisions.\textsuperscript{45} When a single acceptable standard of care exists for a clinical scenario, then management needs only to monitor for compliance. However, good practitioners often disagree about the best clinical approach. Hillman argues that the advantages of clinical guidelines are that they provide a mechanism to disseminate new knowledge about appropriate, effective methods of treatment. They afford explicit criteria for evaluating compliance with new clinical approaches and may help physicians justify withholding unnecessary services from a demanding patient. If based on expert criteria and physician consensus, guidelines provide an opportunity to standardize the approach to some common medical problems, reducing confusion across treatment sites.

The peer pressure that results from groups of practitioners working together and sharing financial risk may be the most important non-financial influence on practitioner behavior. In Hillman's study of risk pools, he observes that,

\begin{quote}
...the advantages of risk pools may arise more from peer group effects (to intensify adherence to financial incentives or quality standards) than from the individual incentives themselves. Shifting the locus of managerial control through risk pools may be more important than shifting the financial risk.\textsuperscript{46}
\end{quote}

V. Evidence of Impact of Financial Incentives on Costs

Although this paper focuses on the issues surrounding financial incentives for health practitioners in managed care plans, a related question is whether managed care plans can actually contain health care costs and utilization while maintaining or improving the quality of care provided. Several studies have documented different utilization patterns between various types of managed care plans and regular indemnity plans, but none have shown differences in quality attributable to financing mechanisms (See Task Force paper on Impact of Managed Care on Quality, Access, and Cost). This is largely due to the difficulty in measuring quality of care. In addition, several factors, such as potential selection bias, difficulty isolating variables, and characteristics of local market conditions may cloud the results of the utilization studies.

Based on the results of a 1989 study, Hillman concluded that some financial incentives as well as the type of HMO can influence the behavior of physicians toward patients.\textsuperscript{47} Hillman surveyed HMOs and found that capitation and salary-based payment as well as group-model and for-profit status were associated with lower hospitalization rates. He also found that physicians with a higher proportion of HMO enrollees in their caseload were associated with more frequent outpatient visits for primary care per enrollee. Placing physicians at financial risk and imposing penalties for HMO hospital referral deficits beyond the loss of withheld funds were associated with less frequent outpatient visits by enrollees to PCPs, holding all else constant. Although some of these factors affect physician behavior, their effect on quality of care remains to be determined.

A 1995 study of managed care and capitation in California by Eve Kerr of UCLA discusses what she terms “internally imposed utilization management.”\textsuperscript{48} These are utilization management techniques that provider groups are initiating in response to capitation. Kerr argues that when medical groups and IPAs receive capitation from a health plan, the practitioners gain both managerial and financial control. In order to profit, their costs must be lower than the capitated payments. This financial risk,

\begin{quote}
...has challenged physicians to develop effective ways to manage their own utilization and costs while maintaining quality of care for capitated patients. Of the 133 groups surveyed, all used primary care gatekeeping and reauthorization, 79\% retrospectively profiled physician's utilization patterns, 70\% used practice guidelines, and 69\% had instituted some form of...
\end{quote}

\begin{flushright}

\textsuperscript{46} Op cit., Hillman AL, Pauly MV, Kertsein JJ, NEJM 1989.

\textsuperscript{47} Ibid.

\end{flushright}
managed care education (see Figure 3). Further, 62% indicated that 'financial control' had the greatest influence on the structure of the group's utilization management strategy, compared to 23% who indicated 'quality of care provided' as the greatest influence.

Finally, Robinson's study of six large medical groups paid through capitation in California found hospital utilization rates for HMO enrollees served by capitated medical groups to be 40% below the California average for all enrollees in commercial HMOs. The groups had rates of physician visits per enrollee in 1994 that were slightly lower than those for all California HMOs. These medical groups were all financially at risk for the cost of care and all managed utilization through their own medical directors and physician committees.

### Figure 3

**Physician Groups’ Methods to Manage Utilization and Cost**

<table>
<thead>
<tr>
<th>Method</th>
<th>Percent of Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care or Gatekeeping</td>
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<tr>
<td>Profile Utilization Patterns</td>
<td>79%</td>
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<tr>
<td>Practice Guidelines</td>
<td>70%</td>
</tr>
<tr>
<td>Managed Care Education</td>
<td>69%</td>
</tr>
</tbody>
</table>

Source: Kerr, 1995

### VI. Government Responses

In response to concerns about financial incentives in managed care, governments at both the federal and state level have taken actions to try to prevent the most egregious situations.

#### A. Federal Regulation

Federal actions governing financial incentives for practitioners have had mixed goals. Antitrust actions in the late 1980s led to a ruling favoring the use of incentive arrangements in creating managed care provider networks. Incentive arrangements, where providers share the risks of loss as well as of profit, provide antitrust enforcers a way to identify genuine network formation. According to Latham,

...the 1994 Statements of Department of Justice (DOJ) and Federal Trade Commission (FTC) Enforcement Policy on Physician Network Joint Ventures made clear that, for physicians to be immune from antitrust challenge, ‘the physicians participating in a physician network joint venture must share substantial financial risk.’ As specific examples of shared financial risk, the statements included capitated payments and the use of financial incentives such as withholds distributed to physicians, ‘only if ‘ cost containment goals are met.

Since then, the DOJ and FTC have somewhat softened their position. Their 1996 Statement says that, “[P]hysician network joint ventures that do not involve the sharing of substantial financial risk also may be lawful if the physicians’ integration through the joint venture creates significant efficiencies and the venture, on balance, is not anti-competitive.”

Federal antitrust enforcers, then, have consistently viewed

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83 Ibid.
86 Ibid.
physician incentive plans as indicative of managed care integration. They have therefore favored their use.

At around the same time the DOJ and FTC were developing their antitrust policies for physician networks, the US Congress came close to banning all physician incentive plans. Congressional action was in response to incentive plans like the one offered by one physician network. According to the GAO, the company’s plan, ...included a combination of features that together could provide hospital physicians too strong an incentive to undertreat patients. The Paracelsus plan distributed incentive funds monthly based on each individual physician’s performance in contributing to the hospital’s revenues. As a result of the Paracelsus case and concerns that other physicians may respond inappropriately to financial incentives, the Congress, through section 9391 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), prohibited, effective April 21, 1987, direct or indirect incentive payments by Medicare participating hospitals to physicians to reduce or limit services. The provision also prohibited HMOs with Medicare (or Medicaid) risk contracts from making such incentive payments, effective 1989.53

Congress postponed the effective date for this second provision covering HMOs in both OBRA 87 and OBRA 89. Congress then repealed the provision in OBRA 1990, replacing it with related language.

Latham writes that, “[b]y 1990, then, Congress recognized the importance of managed care incentive schemes in keeping health costs down. The movement to ban all such plans was dead; only hospitalsponsored incentive plans were outlawed.”54 In 1993, Congress passed the Ethics in Patient Referrals Act, commonly known as the Stark law. In general, ...the Stark law prohibits any payment to a physician that is tied to that physician’s referral record. True to the new congressional concern with keeping health care costs down, however, the law makes an explicit exception for physician incentive programs that are designed to reduce referrals through bonus or withhold payments. The only limitation to the exception is that payments may not be made to a physician or physician group as an inducement to limit services to a specific individual enrollee.55

The OBRA 1990 provisions (Sections 4204(a) and 4731, Public Law 101-508) permit physician incentive plans for Medicare-participating HMOs under certain circumstances. HCFA published final regulations (42CFR, Section 417.479) implementing these provisions in March 1996 which went into effect January 1, 1997. The rules, which apply only to those physician incentive plans that base compensation on the use or cost of referral services, have three main provisions. First, Medicare managed care plans may not operate incentive programs under which payments are made to individual physicians on the basis of their experience with individual patients. Second, managed care plans must disclose to HCFA their incentive plan arrangements in such detail as to allow HCFA to determine compliance of the arrangements with the regulations. Finally, if the incentive plan puts a physician or physician group at “substantial financial risk” for referral services: (1) there must be adequate and appropriate stop-loss protection, and (2) the managed care organization must survey current and previously enrolled members to assess member access to and satisfaction with the quality of services. HCFA defines “substantial financial risk” to exist if a physician or physician group is at risk for more than 25% of their largest possible annual income, inclusive of bonus or other incentive payments.

B. State Regulation

The California legislature passed AB 2649 in 1996, imposing two new requirements on health plans.56 The first prohibits certain incentive plans that limit the provision of specific, medically necessary and appropriate services provided to an enrollee or a group of enrollees with similar medical conditions. The language

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55 Ibid.
56 AB 2649, 1996, is now part of the Health and Safety Code, Section 1367.10.
does not prohibit incentive plans that reward preventive care or are designed to reward appropriate levels of care, nor does the law prohibit capitation or other shared-risk arrangements that are not tied to specific medical decisions involving specified enrollees or groups of enrollees. The second requirement deals with disclosure of incentive plans to consumers (see below).

Some organizations believe that AB 2649 is inadequate in several respects. The California Medical Association supports a specific prohibition against any incentive to induce a practitioner to change a treatment plan. They also believe there is need for greater monitoring and enforcement of the existing law. In addition, the CMA supports annual submissions by health plans of an actuarial report containing an opinion of a qualified actuary as to whether the capitation-based payment arrangements are computed appropriately.

C. Disclosure of Financial Incentives

Many believe that health care consumers would be better off if they were informed about the financial incentives that might affect their practitioner’s behavior. Those for whom financial incentives were important could switch provider groups or even health plans on the basis of this information. Others would simply be aware of the incentives and more inclined to question whether financial incentives played a role in practitioner decisions about their care. In addition, with disclosure, some undesirable incentive arrangements might be voluntarily modified. Several steps have been taken at both the federal and state level to increase the amount of information that health plans and provider groups must disclose. However, there is little evidence as to how consumers use the information that is available.

1. Disclosure To Regulators

In order to determine compliance with regulations described above, HCFA requires Medicare and Medicaid managed care plans to disclose information about both their direct contracting arrangements and their subcontracting arrangements. Provider groups that transfer substantial financial risk, and all other contracting relationships regardless of the level of risk transferred, must disclose the following information to HCFA on an annual basis: (1) whether referral services are covered by the incentive plan. If only services furnished by the physician group are addressed by the incentive plan, then there is no need for disclosure of other aspects of the incentive plan; (2) type of arrangement (e.g. withhold, bonus, capitation); (3) percent of total income at risk for referrals; (4) amount and type of stop-loss protection; (5) panel size and whether enrollees are pooled to achieve the panel size; (6) percentage data from the previous calendar year showing how capitation payments paid to PCPs were used to pay for primary care services, referral services to specialists, hospital services, and other types of providers; and (7) if the managed care organization is required by the regulation to conduct a customer satisfaction survey, a summary of the survey results.

In California, health plans seeking an HMO license must apply to the Department of Corporations (DOC). The application requires detailed financial information, including a copy of any contract between the health plan and any provider. Periodically, the DOC reviews and analyzes practitioner incentive information. The financial information submitted to the DOC is considered confidential and is not available to the public or to researchers, even in aggregate form.

2. Disclosure To Consumers

In addition to HCFA’s requirement that Medicare managed care plans disclose information about their physician incentive plans, HCFA also requires that contracting managed care plans disclose to Medicare or Medicaid beneficiaries who request it, information indicating whether the managed care organization or any of its contractors or subcontractors uses an incentive plan that may affect the use of referral services, the type of incentive arrangements used, and whether stop-loss protection is required. If the managed care organization is required to conduct a survey, it must also provide beneficiary requesters with a summary of

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57 Commentary submitted to the Managed Health Care Improvement Task Force, 1997.
survey results. HCFA suggests that health plans include instructions about how to request this information in their pre-enrollment materials and in their evidence of coverage.

California bill AB 2649 of 1996, now part of Section 1367.10 of Knox-Keene, includes the requirement that every health service plan “include within its disclosure form and within its evidence or certificate of coverage...the basic method of reimbursement, and whether financial bonuses or incentives are used.” The idea that consumers should be able to be informed of the general character of the financial incentives possibly bearing on their own practitioners’ decisions is reasonable and appealing. This can be material information. Such disclosure could go a long way toward clearing up the suspicion that exists today.

The main problems with disclosure are practical. For the most part, health plans do not pay practitioners directly. They pay participating provider groups (PPGs), i.e., medical groups and IPAs, and PPGs pay practitioners. Health plans contract with many PPGs. For example, one California plan contracts with over 190 PPGs. It would be extremely difficult for the health plans to include a report of each relevant PPG’s payment methods in its evidence of coverage booklet for each employment group. PPGs are often reluctant to share this information with health plans, considering it proprietary information. Furthermore, the payment methods used by PPGs are complex and fluid. The methods can vary by specialty and other particular circumstances. PPGs also may pay practitioners differently depending on the health plan, and some PPGs serve a dozen or more health plans’ patients as well as those covered under preferred provider insurance and other FFS arrangements. The practical implementation of disclosure thus becomes extremely complex and costly. It is therefore not surprising that HCFA and DOC have so far accepted statements disclosing the variety of payment methods used in each health plan in general, and have not required statements by contracting PPGs or practitioners. Therefore, the apparent intent of AB 2649 is not yet being implemented in practice.

One way to further this intention is for the legislature to grant DOC the authority to demand the disclosure statements from contracting medical groups and IPAs, and to specify the conditions under which they must be disclosed to consumers. However, it would be wise for DOC to precede general implementation with a demonstration project to permit assessment of which types of disclosure are most useful to consumers, and their costs and benefits, before full implementation is directed.

The AMA believes that to fully exercise their autonomy, patients need to be fully informed about the philosophy and goals of managed care. In its 1990 report, the AMA Council on Ethical and Judicial Affairs stated that “the physician’s responsibilities under managed care include a duty to disclose to the patient conflicts of interest that may affect patient care and medical alternatives that cannot be offered because of restrictions of the managed care plan.” That report specifically states that “physicians have a duty to disclose financial incentives, to disclose contractual agreements restricting referral, and to ensure that the managed care plan makes adequate disclosure of the details of the plan subscribers.” In updated findings the Council recommends that “[p]hysicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician’s obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patients’ managed care plans.” In addition, “any incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter.”

The CMA believes that health plans should be required to inform current and potential members, in easy to understand language, what specific incentives (e.g., withholds, bonuses) they use to influence their providers’ health care recommendations.
VII. Conclusion

The discussion of financial incentives for health practitioners in managed care plans raises the question of whether there are incentive arrangements that are inconsistent with the interest of patients and should be prohibited. The goal of any regulation should be to align the incentives of the health plan, the practitioners, the patients, and the ultimate payers (taxpayers, workers). Appropriate and transparent incentive arrangements are also important in restoring and maintaining trust in individual practitioners, entities, and the health care system as a whole. The outcome should be the provision of good quality, cost-effective health care. One way to contain the most egregious type of financial incentives might be to try to minimize the intensity of financial incentives felt by the practitioner. It is likely that the debate about appropriate financial incentives for practitioners in managed care arrangements will persist until the quality measurement problem has been solved.

VIII. 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.

Throughout this paper, the “state entity for regulation of managed care” means the Department of Corporations or its successor agency.

For purposes of this discussion, referrals do not include services performed in a provider’s office.
(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 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 stakeholders64 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.

IX. Other Options Considered

Further disclosure requirements could include requiring health practitioners to disclose proactively the method of payment received and the types of financial bonuses they receive.

Other limitations on incentive arrangements could include (a) prohibiting incentive payments to an individual practitioner tied to the cost or use of referrals for that practitioner's patients, and (b) prohibiting capitation payments or incentive payments to small groups of practitioners (e.g., 2-5 practitioners) for professional services that include the cost of referrals for the group's patients.

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64 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
Background Paper

I. Introduction
The physician-patient relationship is fundamental to health care delivery. Indeed, Consumer Reports found readers were most satisfied when they liked their doctors, had a choice of physicians, and were happy with their doctor-patient relationship.1 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.

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 may in general be applied to all appropriately-licensed health professionals operating within their scope of practice (“practitioners” or “providers”).

II. Significance
There is little empirical evidence of the effect of the physician-patient relationship on outcomes. However, several studies have indirectly attempted to establish a link. For example, in 1991, Weiss and Blustein studied the impact of physician-patient relationship duration among a large, nationally representative sample of elderly patients and their physicians on the processes and costs of medical care. The study found that longer relationship duration was associated with substantially lower costs of inpatient and outpatient care and with a lower risk of hospitalization.3 Weiss and Blustein also cite numerous other studies that suggest additional benefits of sustained physician-patient relationships, including greater satisfaction among patients, physicians, and other staff; fewer and/or shorter hospitalizations; fewer broken appointments; decreased use of laboratory tests; and decreased use of emergency rooms for care. In addition, increased patient disclosure of personal problems and better compliance with physician instructions has been reported.4

Evidence also suggests that patient involvement impacts patients' attitudes about their illness and recovery. Brody et al. studied adult primary care patients in a health maintenance organization (HMO) population to explore the impact of patients' perceptions about the roles they played during medical visits, and found that self-reported “active” patients reported less discomfort, greater alleviation of symptoms, and more improvement in their general medical condition than did “passive” patients. Active patients also reported less concern with their illnesses, a greater sense of control of their illnesses, and more satisfaction with their physicians.5

4 Op cit., Weiss and Blustein, 1996.
There is also some evidence about the impact of external factors on the physician-patient relationship. One recent study suggests that the availability of a choice of health plans impacts satisfaction with physicians. Preliminary data from the 1997 Kaiser/Commonwealth National Health Insurance Survey found that 18% of those enrolled in managed care with no choice of plan are dissatisfied with their physicians, compared with 13% of those enrolled in managed care with a choice of plans. The historic position of HMOs was that patients should have a choice of plans because they did not want to treat patients who did not choose to be treated by a given physician.

III. History
Views of physicians and patients as well as physician-patient relationships have evolved over time.

A. Physicians: From Parent/Teachers to Strangers
In 1935, Henderson described the doctor-patient relationship as a social system, stressing the importance of using the patient’s sentiments in modifying behavior and of making it clear that the physician is concerned exclusively with the patient’s welfare. In 1951, Parsons viewed the patient as helpless and in need of help, with an obligation to want to get well and to obtain help in doing so. The physician was held responsible by society for helping the patient recover, by applying the technical resources at his disposal. In 1963, Bloom questioned the assumption that the physician acts entirely as a rational professional and concluded that social and emotional factors are important. Also in 1963, Wilson compared the roles of physician and patient to parent and child, priest and supplicant, and teacher and student.

In the last 30 years, the physician-patient relationship, though also shaped by social, political, legal, and economic forces, has remained largely paternalistic and prescriptive. However, more recently there has been a shift toward greater communication between physician and patients. In 1980, Siegler offered a model of doctor-patient accommodation that respected the autonomy of both physician and patient and relied heavily on communication, discussion, and negotiation. In 1984, Siegler with Childress developed two new models of physician-patient relationship: “medicine of friends” which relies on trust rather than control, and “medicine of strangers”, in which rules, procedures, and guidelines become important. They concluded that during the 1980s analysts and regulators treated physician-patient encounters as if medicine were a practice among strangers rather than friends. In 1993, Siegler saw the economic and decision-making power in medicine as having shifted from those who provide medical care and those who receive such care, to those who pay for that care.

The Task Force heard testimony from one physician who complained that physicians are unhappy about managed care and warned of a deterioration in the physician-patient relationship and the quality of care. One study of physician satisfaction found that managed care is not uniformly associated with lower levels of satisfaction. Physicians practicing medicine under managed care perceived lower levels of autonomy.

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6 Throughout this paper, the term “health plans” refers to any health insurance arrangement or health benefits financial intermediaries.
in patient selection and time allocation measures, but higher levels of autonomy is hospital care, tests, and procedures.\(^17\)

**B. Erosion of Trust**

Trust is fundamental to the physician-patient relationship, and some suggest trust is undermined by managed care.\(^18\) Gray, however, suggests that skepticism about trustworthiness of doctors, especially under traditional, unmanaged, fee-for-service “indemnity” medicine, has a long history. He writes:

> For both patients and payers, trust in the competence and fiduciary ethic of physicians and health care institutions has 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, and an efflorescence of medical commercialism and conspicuous conflicts of interest.\(^19\)

Managed care, he suggests, has added sources of doubt in the trustworthiness of physicians by reducing physicians’ autonomy, introducing compensation arrangements that may create conflicts of interest and divide physicians’ loyalties, forcing external parties into the physician-patient relationship and implementing rules that limit the alternatives that physicians can offer patients.

**IV. 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 more likely to be satisfied.\(^20\) Many HMOs attempt to formalize this relationship through the designation of primary care physicians or providers (PCPs). Physician assistants and advanced practice nurses, such as nurse practitioners and nurse midwives, may also be designated as PCPs.\(^21\) In addition, existing state law requires plans to have policies in place allowing for continuity of care for an unspecified period of time when enrollees involuntarily change health plans.\(^22\)

Many continuity problems are general health care issues, rather than managed care issues, although increased competition has exacerbated the problems. For example, Americans rarely maintain the same practitioner for a lifetime. Practitioners move, patients move, needs change and preferences change.

**A. Closed HMO Panels**

A defining feature of HMOs is selective contracting with providers, provider groups and IPAs on the basis of quality and price. Selection allows HMOs to contract with appropriate numbers and types of providers while negotiating payment rates. With selective contracting, member choice of provider is most dependent upon choice of HMO. Thus, members of closed-end HMOs may be unable to continue with their current provider when joining a new plan. However, California medical practices had an average of 15 managed care contracts in 1995,\(^23\) so many physicians are available through several HMOs. Nevertheless, 45% of
Californians who receive coverage through their employer do not have a choice of plans (excluding choices through spouses' employers).24 (See Expanding Consumer Choice paper.)

B. Termination of Provider Contract
HMOs may terminate provider contracts at any time without cause, as may the medical groups or IPAs with which HMOs contract. When terminations occur, patients may be forced to change providers, sometimes in the middle of their contract period. Typically, the earliest time at which an enrollee may attempt to change health plans to recover a provider relationship is at the next open enrollment. If their employers do not offer a choice of plan, patients may not have the opportunity to stay with the same practitioner. Information regarding the prevalence of termination without cause is largely unavailable. Providers terminated for economic reasons rather than quality reasons often feel that the decision was unjust, as do their patients, who often feel greater allegiance to their practitioner than to their health plan. Currently, Knox-Keene regulated health plans must disclose the reasons for termination (or specific reasons if terminated for quality of care reasons) to the provider if the termination occurs during the contract year but not upon non-renewal of a contract.25 Popular medical group/IPAs cannot be easily terminated without the health plan losing customers.

In an attempt to provide greater continuity of care, the federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a recommendation to require plans to provide for consumers who are undergoing a course of treatment for a chronic 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 for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or through completion of post-partum care) to allow for transition of care.26 In a more decisive step, at least one California health plan, in response to a requirement established by CalPERS, relinquished some negotiating power in order to insist that contracts with its medical group/IPAs provide for 18 months of continuity for enrollees in the event of contract termination.27

C. Changes in Coverage by Employer
Employers may change health plans or coverage to lower costs as frequently as each year. While employee resistance and administrative costs keep changes in check, such change is not uncommon.28 When employers change or eliminate coverage, patients may be forced to select a plan that does not include their current practitioners.

D. Lack of Choice and Information
Consumers have never had adequate objective, comparative information for selecting practitioners. Rather, many people rely on opinions of friends, family and other practitioners. Though still in its infancy, some production of comparative data to inform consumers has begun (See Consumer Information, Communication and Involvement paper).29 For individuals choosing a new primary care provider, choice can be limited by provider capacity to accept new patients. Often, members are unaware of these constraints until after plan selection.

25 Knox-Keene Act, Section 1373.65.
27 Personal interview, October 1997.
V. Coordinating Role of the Primary Care Provider and Utilization Review

Based on the United Kingdom's general practitioner model, the intention of the PCP is to improve quality and reduce costs by coordinating specialty visits, procedures, and pharmaceuticals. For example, pharmaceuticals prescribed by different specialists should be checked for interactions, and the relationship between different conditions addressed. The coordinating requirement reduces costs by eliminating duplication and reducing the intensity of services through decreasing use of laboratory, specialty, and emergency room services.30

Studies show that an estimated 14% to 32% of procedures are unnecessary.31 PCPs are responsible for determining what care is necessary and denying patients access to unnecessary care. This aspect of coordination can strain physician-patient interaction.32 This problem is most likely among patients such as the chronically ill who are accustomed to using specialty care and emergency services and for whom the gatekeeper requirement may require some duplication of visits. Studies suggest that chronically ill patients are less likely than healthy patients to be satisfied with plans that restrict their choice of physician.33

Most HMOs in California delegate much or all of the financial risk of caring for patients to the IPAs or medical groups with which they contract.34 These groups (and the HMOs where they have not delegated the risk) also control utilization through some combination of prior, concurrent, and retrospective review processes. Some studies have shown that utilization review reduces inpatient costs,35 but questions remain about whether it reduces societal costs.36 Medical group/IPA or plan-level decisions may contradict provider decisions and patient desires. As a result, experience with prior authorizations has contributed to a negative opinion of managed care. Despite antagonism to utilization review, capitated provider groups rely on these techniques to roughly the same extent as do other types of organizations.37 Some studies have shown that utilization review organizations with high levels of physician control were particularly willing to interfere with practicing physicians' autonomy by questioning or denying authorizations.38

In addition, the referral process is new to many providers, is often clumsy, and needs further improvement. Patients may question denials because they are not used to limitations, are suspicious of financial incentives, have no personal incentive to economize, and unrealistically high expectations of health care.39 While denials of unnecessary care are appropriate, PCPs do not always communicate the rationale for their decisions effectively with their patients. In addition, many denials fall within a gray area, and some patients may be denied medically necessary care.

34 California Association of HMOs, 1997 Profile, 1997, p.21.
In order to address patient demand for broader access, many HMOs have developed new plans types. For example, some plans allow members to see a specialist without a referral within their PCP's medical group/IPA for a higher copayment. In addition, Point-of-Service (POS) plans allow patients to see out-of-network providers after payment of a deductible and copayment.

A. Controlling Access to Specialists
A defining feature of most HMOs is that PCPs initiate referrals to specialists. As a result, the scope of services many PCPs provide has expanded. This has caused some discomfort among PCPs and specialists alike about whether PCPs are encouraged or required to practice outside their scope of competence, especially when PCPs also face financial incentives to restrict use of services.40,41

Patients and PCPs may sometimes disagree about the need for a specialist. In addition, HMO utilization review committees may disagree with both provider and patient.

Another defining feature of HMOs is risk sharing. For example, many HMOs pay the PCP's medical group/IPA for all professional services. The medical group/IPA may then restrict most care to that medical group/IPA. Patients may not understand these restrictions during open enrollment. Alternatively, an HMO may deny or delay referrals requested by a patient's PCP. Although some denials may be in patients' best interests, HMOs and PCPs may also deny necessary care.

The Task Force's survey of literature on the public's perception found that time required to approve care is a consistent source of dissatisfaction across all types of plans. One 1994 national telephone study found lower satisfaction among managed care patients with some aspects of specialty care, but higher satisfaction than indemnity plan patients with the speed of referrals to specialists.42 (See Task Force paper on Public Perception and Experiences with Managed Care: Appendix).

B. Specialist to Specialist Referrals
When a patient's specialist decides that an additional referral is necessary, many HMOs require the PCP to generate that referral. As stated above, the intention is to coordinate care and prevent unnecessary expenditures. Patients may perceive PCP involvement as unnecessary bureaucracy, and their specialists may reinforce this perception. Furthermore, PCPs may disagree with specialists about needed care.

In response to customer demand, many HMOs have developed new products with improved access.43 In one innovative response to provider and patient complaints about specialist referral restrictions, an out-of-state health plan has organized specialty teams that follow treatment protocols. The plan pays the specialty teams a predetermined case rate for all care related to a particular illness or condition.44 The PCP must only make the initial referral to the specialty team, and the team makes further medical decisions without PCP authorization.

C. Denying Unnecessary Procedures/Tests
Part of a provider's role is informing patients when tests are "medically necessary" and when they are not. For example, if a pregnant woman requests an ultrasound that is not medically indicated, the procedure should not be covered. Some have described perceived and actual instances of HMOs denying necessary care, which has resulted in patient feelings of mistrust.45 Non-disclosure of payment and risk-sharing arrangements has augmented suspicion and distrust of care denials.46 This mistrust impacts the physician-patient relationship as described above.

41 Center for Studying Health System Change and Mathematica Policy Research Inc., nationwide survey of physicians.
42 Op cit., Blendon, et al., p.46.
D. In-Network vs. Out-of-Network Providers
HMOs often pay medical groups and IPAs a fixed periodic rate per member per month (i.e., capitation) for all professional services, creating an incentive to provide most care within the group. However, a patient or provider may feel that the best provider is outside the group, or even outside the network, and want the HMO or medical group/IPA to pay the cost. Often such out-of-network referrals make sense because appropriate care can also cost less. However, the PCP may disagree with a patient that an out-of-network referral is necessary.

VI. Informing Patients of All Options
Managed care expects patients to play a more participatory role in their own care. Thus, under managed care, patient access to more and better information is appropriate and necessary. The increasing use of the Internet for medical information reflects this need. Health plans should not constrain providers from presenting all treatment options to their patients. Rather, practitioners should feel obligated to help patients to make informed decisions based on the advantages and disadvantages of each option and the patient's personal preferences.

A. “Gag Clauses”
Some HMOs require physician confidentiality about proprietary plan information in their contracts; far fewer, if any, restrict physician-patient discussion about treatment options. California and federal legislatures have banned the latter, so called, “gag clauses”. In addition, according to the US General Accounting Office, contract provisions may not have a significant impact on physician practice because physicians do not carefully read their contracts with HMOs. Physicians reported that they freely communicate with their patients regarding all medically appropriate care because habitual practice, professional ethics, and fear of medical liability are stronger influences on their behavior than contract requirements. However, fear of termination by HMOs can bring significant pressure on physicians to modify their practice patterns or discussions with patients, without gag clauses. Both actual and perceived limitations can hurt the physician-patient relationships by reducing trust and openness.

B. Disease Management and Guidelines
Disease management is a systematic approach to treating chronic diseases which has been applied by HMOs and other managed care organizations. To care for the chronically ill, HMOs provide clinical guidelines, patient education, practitioner education, monitoring, prevention and outcomes measurement. Used both in disease management programs and general practice, guidelines can contribute to quality of care by reducing unwarranted variation in clinical decision making and by providing physicians with concise, practical advice on the diagnosis and treatment of illness. Most HMOs use guidelines only as recommendations to accommodate differences among patients and their preferences as is appropriate since the individual needs of each patient should ultimately determine appropriate care. In practice, studies suggest that guidelines have limited ability to change physician behavior. However, some practitioners may perceive guidelines as fixed constraints because they fear being an outlier.

48 US General Accounting Office, “Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain” (GAO/HEHS-97-175), August 1997. The study found, out of 529 HMOs, none used contract clauses that specifically restricted physicians from discussing all appropriate medical options with their patients. The study also found that 62% of plan contracts required physicians to maintain the confidentiality of proprietary information including the plan’s payment and incentive structure, medical management criteria, and clinical practice protocols. However, 70% of these clauses also included “anti-gag clauses” which state that provisions in the contract are not to be construed as prohibiting discussions of care related matters with patients. The study found fewer instances of non-disparagement (of health plan) and non-solicitation (to another health plan) clauses, many of which were also accompanied by anti-gag clauses.
49 Ibid.
50 Epstein and Sherwood. Annals of Internal Medicine, Volume 124, Number 832, 1996.
VII. Financial Incentives

While principally professional ethics and desire for the esteem of their peers motivate practitioners, they also face financial incentives. All compensation arrangements contain incentives that may have positive and negative effects on care delivery. Access to information about how medical care is paid for has become an important issue for patients (see Provider Financial Incentives paper). Several forms of compensation in managed care arrangements shift financial risk for caring for patients from health plans to providers. If undisclosed and too intense, these financial arrangements can create pressure to deny care that may be medically necessary. Putting providers at risk for the cost of care puts treatment decisions in providers' hands, where most people agree they belong (though some say this creates a conflict of interest), as long as providers consider patient preferences and patients know and understand the financial incentives their physicians and medical group/IPAs experience.53 Often, these decisions are not easy and cause discontent. Also, physicians serving as medical directors may be in the uncomfortable position of encouraging or requiring other physicians to deny services.54

Low patient copayments in HMOs may strain physician-patient relationships. With low copayments, patients' financial obligation is limited and their interest in cost-effective care may be reduced. In contrast, many HMO providers bear some financial risk and thus have an incentive to reduce unnecessary services. In testimony to the Task Force in Fresno, one physician explained that the reason he did not like managed care was because it made him and his patients adversaries.55 He used an example of a patient who wanted an ultrasound that he denied because it was unnecessary. In contrast, if his patient were instead required to pay for the same test, she might have been grateful to him for saving her the expense.

A. Capitation and Risk

The UK introduced capitation of PCPs to provide a simple payment system for budgeting without motivating overuse. In this country, Henry J. Kaiser adopted capitation when he paid fixed sums per-patient-per-month to Dr. Sidney Garfield.56 Mr. Kaiser had a predictable, controllable outlay, and Dr. Garfield had maximum freedom to allocate resources effectively.

Proponents of capitation suggest that it creates incentives to prevent diseases, diagnose early, and treat illness effectively. In general, denying necessary care increases costs in the long run. In addition, capitation offers the flexibility to introduce innovative programs, such as fall prevention and patient education. Capitation, however, may also create pressure to provide less care than needed to sick and vulnerable patients. To reduce this incentive, capitation payments should be risk adjusted (see Minimizing Risk Avoidance Strategies Task Force paper). To compensate, some capitated medical groups and small IPAs purchase stop-loss insurance for the most expensive cases.

Equally important, the introduction of capitation may also have changed patients' perceptions of their providers and their motives. Blumenthal suggests that this could lead to a generalized loss of trust in the medical profession and reduced satisfaction on the part of both patients and physicians.57 Many patients and physicians are uncomfortable trading off costs and benefit, and are concerned that capitation may affect physician ethics by creating undisclosed conflicts of interest.

B. Risk Pools

Provider bonuses and withholds were developed to encourage cost-effective practice by providers paid fee-for-service or salary, and to put capitated groups at risk for quality and patient satisfaction. Most groups limit bonuses and withholds to a small portion of physician income, and both federal law58 (applicable to

54 Ibid.
55 Public testimony to the Managed Health Care Improvement Task Force, Fresno, CA, June 20, 1997.
58 Sections 4204(a) and 4731, OBRA 1990, Public Law 101-508; and H CFA Regulations 42CFR, Section 417.479.
Medicare and Medicaid patients) and state law prohibit arrangements that are an inducement to limit or reduce necessary services to an individual enrollee. However, inappropriate risk-sharing arrangements may exist, and other incentive schemes are poorly understood.

VIII. 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. One study suggests that 46% of CalPERS members who switched health plans because of long appointment delays felt that one to six days was too long to wait for an appointment. Similarly, 52% who switched because of long waits at the physician's office felt that 30 minutes or less was too long to wait. Other studies have shown that patients on average make more visits in HMOs than in indemnity plans.

Adequate practitioner availability can prevent miscommunication, non-communication, disputes, and grievances. Current law regulating Knox-Keene health care service plans theoretically restricts physician panels to 2,000 patients per PCP. Availability, however, may depend on the practitioner and the patient panel. It would be relatively easy for an individual practitioner to provide 2,000 healthy people with access, but nearly impossible if all the 2,000 were seriously ill. In addition, some practitioners are better at building relationships with patients than others are. One practitioner can consistently satisfy patients in 10 minutes, while another can fail in 30 minutes.

A. Inadequate Visit Time

Provider visits are needed to discuss, diagnose and recommend treatment. Practitioner visit time may be inadequate under any model health plan. For example, one could argue that providers paid on a fee-for-service basis have an incentive to reduce visit time in order to provide more services. Under managed care, as under any type of health plan, providers may be encouraged or required to see more patients, resulting in less time per visit.

In response to shorter visits, some patients may organize questions in advance, and others may not ask questions at all. Some patients may not be able to clarify instructions, with adverse medical consequences. In addition, patients may feel short-changed because they are accustomed to longer visits. Patient feelings of dissatisfaction, whether due to perceived or actual problems, are valid and can damage the physician-patient relationship. In 1995, 7% of PBGH HMO members, 9% of POS members and 3% of PPO/indemnity members felt dissatisfied with the length of time their physicians spent with them during visits.

B. Appointment Availability

Similarly, if appointment availability does not meet patients' expectations, patients may feel that a health plan is not meeting their medical needs. For example, when PCPs accept large patient panels, patients may need to wait longer for appointments. In 1995, 17% of PBGH HMO members, 19% of PBGH POS members, and 12% of PBGH PPO/indemnity members felt that the last time they visited the physician, they could not get an appointment at a time that was convenient for them.

However, a national access survey sponsored by the Robert Wood Johnson Foundation suggests that HMOs provide better access to appointments by some measures: 13% of HMO enrollees reported waiting over 30 minutes compared to 17% of PPO enrollees and 20% of indemnity enrollees. In addition, 85%
of HMO enrollees reported a medical visit within the past year, compared to 80% of indemnity enrollees, and HMO members with a visit averaged 4.8 visits per year, compared to 4.0 visits per year for indemnity.

C. Non-Physician Practitioners

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. Some patients prefer nurse practitioners and midwives, finding them more compassionate or informative than physicians. Often, non-physician practitioners have better communication skills than physicians do. In addition, some physicians have more time for patients because of non-physician practitioners.

D. Developing Physician-Patient Relationships

All patient visits have both medical and emotional impact. If physicians and patients spend less time together, they may have difficulties building relationships. Patients may feel frustrated if their practitioner does not know them well. As a result, shorter visits that may be medically acceptable can still be a source of patient dissatisfaction.

IX. Quality Improvement Programs

Purchasers have largely driven quality measurement and improvement efforts. While not universal and hampered by lack of technological infrastructure, these quality measurement efforts offer feedback to providers to improve and information to purchasers and consumers to judge quality and service. HMOs that testified to the Task Force described quality improvement programs in California that have successfully addressed disease treatment (such as diabetes and asthma) and administrative processes (such as billing).

A. Increased Administration

The administration to support quality programs requires the investment of significant time and resources, though this load may be reduced as more electronic data becomes available. While the cost in hours is readily apparent to those required to provide the data, the benefit of quality measurement activities may not always be. In addition, as reported in the Task Force Government Regulation and Oversight of Managed Health Care paper, a variety of organizations require or conduct duplicative quality audits and studies which is clearly wasteful.

B. Disclosure of Quality Results

Several have noted that trust in physicians’ decisions is increasingly being supplemented by evidence. Blumenthal suggests that quality research efforts and sharing of results with patients could “powerfully reinforce and complement the professional ethic of the physician...”. This could be particularly important where financial incentives are seen to create potential conflicts of interest for providers. Physician data demonstrating superior performance can boost patients’ confidence and trust. However, for results to be valid, quality measures must use standardized definitions and adequate severity adjustment.

C. Not All Providers Are Alike

Not all providers have the same capabilities or experience. Studies have demonstrated that certain procedures are volume sensitive; the greater the experience of performing the procedure, the better that risk adjusted outcomes. The current system lacks a systematic mechanism for assessing and informing patients about the health care delivery system and personal physi-

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cian. In recognition of the variation among providers, the federal Advisory Commission on Consumer Protection and Quality in the Health Care System has made a recommendation to require physicians and facilities to disclose to patients their experience in certain procedures.

D. Patient Confidentiality

Quality improvement and similar efforts, as well as the delivery and payment of care, require the use of confidential patient information. The use of this information must be balanced with respect for patient privacy. In California, both the Insurance Code and the Civil Code, which regulate insurers and providers respectively, provide extensive protections for confidentiality of patient information. Such protections include strict limitations on the exceptions for which individually-identifiable health care information may be used without written consent as well as provisions regarding patients’ access and rights with respect to their medical records. The Insurance Code, however, because it is designed to address all insurers, does not necessarily use terminology that is appropriate to Knox-Keene regulated health care service plans. In addition, while current law prohibits use of individually-identifiable medical information for commercial purposes, it does not specifically prohibit health plans or providers from requiring enrollees, as a condition for securing health care services, to sign a release or consent form which waives these confidentiality protections.

X. 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.

(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:

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73 Insurance Code, Article 6.6, Insurance Information and Privacy Protection Act, Section 791.
74 Civil Code, Chapter 2, Disclosure of Medical Information by Providers, Section 56.10.
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. Physician 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, 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.
Consumer Information, Communication and Involvement
Background Paper

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. If these benefits are to be realized, consumers/patients need access to clearly communicated information relevant to decisions about appropriate treatment.

This paper explores the issues of consumer information and involvement in managed care. A discussion of effective communication of consumer information serves as a bridge between the information and involvement sections to highlight the importance of the manner in which information is collected and disseminated. The paper concludes with principles upon which the value of improving consumer information and involvement in health care are based, and presents recommendations for carrying these principles forward in practice.

II. The Role of the Consumer in a Managed Care System
A. Transition from Indemnity to Managed Care: From “Patient” to “Consumer”
The role of the consumers in the health care delivery system has changed dramatically with the rise of managed care. Traditionally, consumers were patients who went to their trusted doctors for treatment and either paid the bills or sent the bills to their insurance company for reimbursement. The traditional unmanaged fee for service “indemnity” system focused on the health of the individual, and physicians were perceived as patient advocates who would ensure that necessary and appropriate care was obtained. They navigated the system for the patients and were generally not bound by fiscal constraints. Most patient-physician relationships were characterized by trust. If patients were not satisfied with a physician, they could change immediately to another physician. Under indemnity arrangements, little formal information about physicians (e.g., quality or outcomes) was available, and in the absence of mistreatment or malpractice, physician authority was generally not questioned. Consumer involvement in the insurance process was minimal and generally administrative in nature; remote third party insurers paid whatever bills consumers or their physicians submitted without authorization or utilization review processes. This option has become increasingly unaffordable.

The move from a focus on the health of the individual under indemnity to the managed care system’s focus on population health has had a significant impact on the consumer. The consumer is conceived as an active participant in a “system” of care rather than an individual receiving a broad range of advice from a single trusted source. In response to this new consumer role and its accompanying responsibilities, the market has brought a great deal of information until recently considered “professional” into the public domain. Information on health and health care—from popular media presentations on the health system to internet databases, news groups and patient groups to consumer-oriented medical guides and magazine “rankings” of physicians, hospitals and health plans—now finds its way into a large number of American homes. Publications such as U.S. News and World Report and Consumer Reports, organizations such as the Pacific Business Group on Health (PBGH) and a broad range of private companies have produced a great deal of consumer-focused health information. In his paper “Trust and Trustworthiness in Managed Care,” Bradford Gray of Yale University introduces the notion that efforts to find alternatives to dependence on the historical physician-patient trust relationship have developed in recent decades as new organizational forms have emerged in the health care delivery system. Consumers now routinely seek second opinions, obtain services from “alternative” practitioners, and consume journalistic lists of “the best” providers and hospitals.1

1 Gray B “Trust and Trustworthiness in Managed Care,” Health Affairs, January/February 1997.
While consumers are faced with a much broader range of health-related information, it is not clear that they are able to use much of it to educate themselves or make effective decisions. Many consumer advocates are concerned that much of the information directed at consumers is incomplete, biased and conflicting, and serves to confuse consumers rather than help them.

B. Consumer Values in Health Care
Attempts to improve upon the current level and nature of consumer information and to provide the information consumers may need to assume the new role described above effectively 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.2

- 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 provider. 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: Providers 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.

C. The Consumer’s Need for Information
The advent of managed care and the efforts of government and employers to control costs resulted in dramatic changes in the relationships among patients, providers and insurers and significantly impacted the needs and responsibilities of the patient. Though many argue there has always been an ethical imperative for provision of consumer information—health plans,3 facilities and medical professionals face an ethical obligation to inform consumers about how their actions can affect the consumer’s life and health4 — there is now an organizational imperative as well. Optimal functioning of the system rests on the assumption that consumers (as “partners” in their own health care) will obtain and use information on topics such as health promotion, medical treatment and insurance administration that were long the exclusive province of professionals.

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2 These values have been developed by California Health Decisions, and are described in more detail in its “Condition Critical Project” report.
3 Throughout this paper the term “health plans” is used to describe health insurance arrangements, also known as health benefits financial intermediaries.
4 Medical ethicists ground this obligation in the principle of respect for an individual’s autonomy and their right to make choices about how they receive medical care. Beauchamp and Childress (1994) argue that “the obligation to respect patients’ autonomy requires equipping them to overcome their sense of dependence and achieve as much control as possible or as they desire.” Sofaer (1997) makes the additional point that consumers should have a right to this information even if it is technically difficult for them to understand.
Consumers dissatisfied with managed care often worry that they are unable to advocate effectively for themselves, and that their providers are no longer in a position to strictly represent their needs. The transition of the health care delivery system to a managed care focus has resulted in consumers taking on many of the responsibilities they assume when purchasing other goods and services; they must advocate for themselves, seek value and participate in their own care and treatment decisions. Proponents of managed care assert that the promise of a competitive and increasingly consumer-focused environment is that consumers will be able to choose among health plans providing a variety of value and cost propositions, and will be more satisfied for having been allowed to exercise choice. For consumers to benefit from this hypothetical scenario, however, they must have access to and an understanding of information that will allow them to assess differences among plans and providers. They must also have a choice of plans broader than that which many Californians currently enjoy. If and when choice of plans becomes more widely available, the effectiveness of the competitive market will depend on consumers being sufficiently educated to exercise informed choice.

D. Consumer-Focused Information

To successfully participate in health care decision making, consumers need both basic factual information and assistance with interpretation of complex clinical information. Several recent studies have shown that today’s consumers do not understand even the most basic details of their health insurance coverage. A Louis Harris/Towers Perrin survey conducted at the end of 1995 found that: 67% of consumers did not have a good understanding of the differences between traditional indemnity and managed care plans; a third of consumers had never heard the term “health maintenance organization” or had heard it but did not know what it means; 55% had never heard the term “managed care” or did not know what it means; and 77% had never heard the term “fee for service” or did not know what it means. The study found that people enrolled in managed care plans were as likely to be ignorant of managed care terms and concepts as those enrolled in indemnity plans. Another recent study of the “readability” of health insurance literature and contracts found that the average document was written at the reading level of between third/fourth year college and first/second year graduate school. 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.

Beyond understanding the basic operating assumptions of these two types of insurance, a truly informed health care consumer might be interested in a broad range of information about his or her plan and providers. When a consumer is in a position to select a plan, to choose wisely he or she needs access to and an explanation of the information that will help determine whether the plans meet the needs of his/her family. To be an effective (or well-informed) member, he or she needs information on accountability and on processes that exist should a problem arise, on incentives that might influence physician or plan choices, on self care and the ability to influence health outcomes and on the logistical and continuity of care implications of a change in the plan’s contracts with providers. An outline of the range of information a fully informed might want when choosing and receiving care under a health plan is presented below. This outline is presented with an important note: employers currently obtain much of this data and make decisions on behalf of their employees.

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6 Additional information from this survey is presented in Isaacs S, “Consumers’ Information Needs: Results of a National Survey,” Health Affairs, Winter 1996.
7 Hochhauser M, letter to the Editor, Health Affairs, September/October 1997, p 220.
9 Ideally, in choosing and using a plan, consumers with specific conditions would be able to receive a general standard of care protocol so that they could choose plans that best suited them. However, since there is minimal to no risk adjustment for physician compensation and ratings currently, the adverse selection created by such protocol disclosure would be too strong. This ERG group supports efforts at risk adjustment and would like disease specific information to be available once incentives can be aligned.
1. **Plan information**: licensure status; years in existence; provisions for confidentiality of member medical records; description of the responsibilities and functions performed by the plan in regard to specific insurance products.

Additional information about health plans that is relevant to consumer decision making and should be made available to consumers includes the plan’s tax status.

2. **Insurance product information**: covered benefits, limits on coverage, including annual limits, lifetime limits, limits for specific conditions and policy on coverage of experimental treatments and procedures; cost-sharing mechanisms; dispute-resolution mechanisms and legal remedies; provider panel and availability; utilization review procedures; care management information; and plan performance on quality measures.

While many consumers still do not have the option to choose among a variety of competing health plans, others are faced with an increasing number of health insurance products and features. As insurance providers broaden the selection of available products to meet the demands of a competitive marketplace, consumers (and employers, who are often making the initial plan purchase decision) are faced with an increasingly complex initial product decision that will have important ramifications for subsequent choices of provider, facility and treatment options. Consumers must have clear information on the product in which they enroll if they are to use services within it effectively.

3. **Information on networks, including medical group/IPAs and facilities**: accreditation status; volume of procedures performed; and performance on quality measures. Relevant information about networks includes rules regarding referrals to specialty care and centers of excellence; urgent and emergency care and coverage; and rules governing and coverage implications of out-of-network services; and information about the process through which the plan and its provider networks make medical decisions.

4. **Information on health care professionals**: education, board certification and recertification; years of practice; experience performing certain procedures, and performance on consumer satisfaction and quality measures. Consumer information about health care professionals might also include tax status and financial relationships of a provider’s practice, how the provider is compensated and the provider’s institutional affiliations and referral patterns.

A truly informed consumer would thus explore a broad range of issues in choosing a plan and navigating the health care delivery system. This information is increasingly being made publicly available through both government disclosure mandates and by non-profit and private organizations. Numerous studies show, however, that consumers have the capacity to process a limited amount of information at any one time and that they rely extensively on informal sources of information such as family and friends to help them make many of their health-related decisions. Consumers indicate that when examining health plans, they are less interested in standardized measures of performance and more interested in how the plan works for “people like me.” They also indicate that they continue to consider the primary health care system relationship they have to be with the provider, not the health plan. Sources of information and “quality” measures have expanded and increased, but it is unclear how much of this information is reaching and/or being used effectively by consumers.

### III. Consumer Information in Health Care: Current Law and Practice

The proliferation of consumer information in health care is a result of legal mandates for disclosure of information, large purchaser initiatives to provide information, private for-profit enterprises that have responded to consumer demand and the beginnings of a consumer movement. HMOs have always been required to comply with extensive disclosure mandates, but information disclosed under existing regula-

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tion has not resulted in a change in consumers' understanding of and involvement in health plan operations over time. Large, organized purchasers such as PBGH, through surveys and initiatives like CCHRI Health Plan and Physician Value Check surveys provide much of the health plan and provider group comparative data currently available. In addition, many private sector enterprises have formed to fill the information gap.

As mentioned earlier, individual consumers have not wielded much power in the health care delivery system except when they have had their interests represented by large employers or purchasing coalitions. While some consumers with special needs have recognized this problem and banded together with others with common health needs or disease states to form what have become fairly powerful lobbies, there has been no "general" consumer movement pressuring the health care delivery system, and efforts to encourage one would likely be confounded by the diversity of health care related interests in the general population.

A. Current Industry Practice: Information Collection and Dissemination

1. Government

The public sector, through the California Office of Statewide Planning and Development (OSHPD) and the Federal Employee Health Benefit Program (FEHBP) collects a range of information from the different components of the health care delivery system. OSHPD collects financial and utilization data from plans both on the general plan population and for specific health conditions. Some of this data is available through the internet, though data available through this forum is often insufficient for statistically significant analysis. FEHPB collects customer satisfaction, choice and access data annually. Both the FEHBP and HCFA have agreed to test the FACCT measures described later in this document as part of an attempt to provide information that is relevant to consumers.

To date, state regulation regarding information has predominantly required identification of physicians in health plans, a review of their credentials, and basic information on how medical group/IPAs are compensated. Complaints about California's public system of information access and provision have asserted that information is not complete, standardized or up-to-date, that certain information is not released to the public, and that information is often not easily accessible. In a 1992 study, the California Auditor General found that the DOC had been lax about maintaining its public access files, responding to complaints and performing required monitoring visits. In a 1996 report, Consumers Union documented the difficulties consumers have in obtaining information from the DOC. The report indicated that health plan surveys are not issued in a timely manner and do not contain information which is useful to consumers. According to the Consumers Union, since the report was issued there has been some improvement in the adequacy and frequency of the surveys. Nevertheless, it remains extremely difficult for consumers to get helpful information from the DOC. Although the Knox-Keene Act requires the DOC to educate and inform consumers about HMOs, this report indicated that DOC provides consumers with little information to assist them in choosing or using a health plan. Current law requires the DOC to make summaries of surveys available to consumers, but a Consumers Union survey revealed that only the most assertive consumers are able to obtain even this information. The DOC also publishes a report on consumer complaints pursuant to a statutory mandate. This report details the number and type of grievances filed with the DOC for each health plan in the state. It is difficult for consumers to use this information in evaluating a health plan, however, because this report does not indicate the severity or validity of the complaints or if any action was taken by the Department or the plan in response to the complaint. (See the Task Force Dispute Resolution paper for a further discussion of this issue.)

14 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 U.S., Inc., West Coast Regional Office, April, 1996.
15 California Health and Safety Code 1342(b).
16 1997 survey by Consumer's Union West Coast Regional Office (unpublished).
2. Private Sector Organizations
A range of private non-profit and for-profit organizations such as independent quality monitors, purchasing coalitions, consumer advocacy groups and individual employers have recognized the consumers' need for information and have used purchasing power or potential media influence to demand and publicize plan information. A significant amount of plan-level information has been gathered and made available through the National Committee on Quality Assurance (NCQA) accreditation process and Health Plan Employer Data and Information Set (HEDIS) initiative. NCQA currently publishes a report called the "Quality Compass" which presents comparative HEDIS scores and accreditation information for 250 health plans. As the industry matures, more data becomes available and measures are refined, these surveys and reports are modified. HEDIS has come under criticism for focusing too heavily on prevention and utilization measures and failing to devote sufficient attention to treatment of chronic and acute diseases. Recent efforts have focused on developing and publishing meaningful outcomes measures. The other major criticisms of this data source are that plans are not required to participate in and publish HEDIS results and that the data are "self-reported," and are thus not as reliable as independently collected data. While the California Cooperative Healthcare Reporting Initiative (CCHRI) publishes independently audited HEDIS information for the 22 health plans covering 95% of the commercially enrolled California population, there are at least 24 additional small or specialized HMOs in the state for whom this information is not available.

Under the HEDIS programs, health plans compare themselves to health promotion and disease prevention targets established by the US Public Health Service, under the "Healthy People 2000 Initiative." HEDIS presents measures that are designed to be meaningful to both employers and consumers in the following areas:

- Quality of care, with measures including preventive services, prenatal care, acute and chronic illness and mental health,
- Member access and satisfaction, which presents such “access” measures as waiting time for appointments, general medical care and mental health care and “satisfaction” as the percent of members who indicate that they are “satisfied or highly satisfied” with the plan and the percent who indicate that they would renew their membership,
- Membership and utilization data include enrollment by age, gender and payer, disenrollment data, high occurrence/high cost DRGs, frequency of selected procedures, inpatient and ambulatory bed days, discharges and average length of stay, births and average maternity length of stay, inpatient and outpatient mental health utilization, inpatient and outpatient chemical dependency utilization and outpatient drug utilization and cost,
- Finance information, including cost per member per month, premium per member per month, medical loss ratio, administrative loss ratio, and indicators of financial stability, and
- Health plan management including percent of board certified primary care providers and specialists, basic information on physician turnover and physician compensation, and information on initiatives such as case management and utilization management programs.

The Foundation for Accountability (FACCT) is a not-for-profit coalition dedicated to helping consumers make better health care decisions. FACCT's board of trustees is made up of consumer organizations, corporate health care purchasers and government purchasers representing 80 million Americans. FACCT has released measures that attempt to create a relevant, comprehensive picture of quality of care for specific conditions—like asthma or diabetes, lifestages—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 Consumer Assessment of Health Plans Study (CAHPS), the Joint Commission on Accreditation of Health Care Organizations' ORYX and public health databases.
Most information, including HEDIS and FACCT, is collected at the plan (rather than the medical group/IPA or physician) level. In response to the fact that consumers are interested in physician-level information, PBGH and The Medical Quality Commission, recently undertook the “Physician Value Check Survey,” based on interviews with 58,000 consumers which produced rankings of 58 physician groups on a series of patient satisfaction and quality measures. The survey reviewed physician practice group performance on such factors as overall patient satisfaction, ease of getting referrals, and their record of keeping blood pressure and cholesterol under control and counseling patients on preventive care.

For additional information on the main public and private providers of quality and outcomes data and accreditation, see the Task Force paper entitled Government Regulation and Oversight of Managed Care.

Consumer advocacy groups and private individuals and entities use a combination of publicly-generated and market-generated information to provide consumers with health care system information and various types of “rankings,” generally at the health plan level. Publications such as Consumer Checkbook's Consumers' Guide to Health Plans, Newsweek Magazine, Bloomberg Personal and US News and World Reports Guide to HMOs select basic measures of health plan performance and rank health plans accordingly. Numerous “how to” guides counsel consumers on selecting plans and providers, navigating the health care delivery system and effectively advocating for themselves and their families. More recent developments include a broad range of internet sites which are designed to help consumers gain information and educate themselves through a broad range of applications. Several sites allow consumers to sort health plans and providers according to their own prioritization of factors such as quality, cost and location (using available data from NCQA and other sources). Other sites provide access to consumer-focused publications on management and treatment of common health conditions (using publications produced by organizations like the AHCPR and medical trade organizations). A broad range of sites provide “ask the doctor or nurse” question and answer forums for consumers. As stated earlier, these information sources present data not previously accessible to consumers, but because of they are produced and disseminated by independent organizations operating without an agreed-upon set of standards or a regulatory framework, they offer often-conflicting, biased opinions.

The developers of these publications and applications face many of the challenges described earlier. Individual consumers are interested in different features of plans and networks. Information is rarely collected in a consistent enough format to allow for true comparability and little consensus exists around how to validate quality or outcomes measures to ensure that information collection methodologies are not biased toward the measures.

3. Information Collected

Because there is little consensus on what information or measures are the “right” ones to collect and disseminate, it is instructive to examine what is becoming “customary” in the industry. A nationwide study of several large employers, health plans, purchasing groups and consumer advocacy organizations (including CalPERS, PBGH, Kaiser Permanente of Northern California the Managed Risk Medical Insurance Board, Medi-Cal, Health Choice, Inc. and the California Health Information Counseling and Assistance Program in the State of California) focused on what measures organizations use to present consumers' ratings of care in indemnity and HMO plans. The most commonly reported survey-based performance measures in the categories of “customer satisfaction,” “process measures” and “method of communication” follow:

Customer Satisfaction
- Satisfaction with waiting time for an appointment and in the physician's office
- Satisfaction with access to care
- Satisfaction with personal treatment during physician services
- Overall satisfaction with the provider

• Overall satisfaction with health care
• Satisfaction with the range of services covered

Process Measures
• Percent of children immunized
• Percent of women who received a mammogram
• Percent of adults who had their cholesterol level checked

Modes of Communication
• Consumers prefer personal communication of information (e.g. counseling sessions), because they find feedback on their personal health insurance situation more useful than general information
• Consumers prefer information in print so that they can take it home and share it with their families; “report cards” are the most popular format for conveying information in print
• Live presentations are most effective when health plans are working with low literacy populations
• Most health plans have not tested their informational materials with consumers. Those planning to test materials indicated that they would use focus groups and limited cognitive testing.

B. Cost/Benefit of Information Collection
Efforts to increase the amount and quality of consumer-focused information collected must take into account the cost of data collection relative to the benefit associated with additional information. As information systems make it easier to collect and process enrollment, encounter and survey data, it is important to understand what information is actually considered relevant by consumers. This will ensure that money spent on collection, production and dissemination of some types of information helps achieve the end of producing useful information. Collection of a considerable amount of information about the health care delivery system, though technically feasible, can be both very costly and of marginal value to the average consumer.

The California HMOs serving PBGH members created CCHRI to provide audited data on HEDIS quality measures. The study covers approximately 11 measures of quality for 22 plans. The out-of-pocket costs for CCHRI are approximately $2 million per year; the costs borne by health plans and providers to comply, supply data and answer inquiries come to at least another $2 million.18 PBGH surveyed 58,000 managed care consumers receiving care from 58 different medical groups in California to assess satisfaction and perceptions of quality. The cost to PBGH and other study sponsors was approximately $700,000.19

C. Standardization of Information
Standardization of survey sampling methods, data collection modes, survey questions, and analytic methods is necessary if comparisons of health plans are to be useful. This level of standardization requires a significant financial commitment as well as cooperation from the plans. Where there is standardization currently, it is generally at the local or purchasing organization level.

Commitment of public agencies will be necessary to achieve a level of standardization which would allow for meaningful comparisons of health plans. The Consumer Assessment of Health Plans Study (CAHPS), funded by AHCPR, is currently developing and testing methods for measuring consumers’ satisfaction with their health plan and ways to communicate the results to consumers.20

IV. 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 criti-
cally 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 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.

4. Health plans should be required to update the information for their participating providers 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

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21 Throughout this paper, the term “state entity(ies) for managed care” refers to DOC, DOI or its/their successor.

22 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.

23 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.

24 Throughout this paper, the term “provider” refers to physicians and other appropriately licensed health professionals operating within their scope of practice.
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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, lifestages—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 Healthcare Policy and Research’s CAHPS, the Joint Commission on Accreditation of Health Care Organizations’ ORYX and public health databases.

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.

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 FACCT framework is one example of a model for collection of data at the plan level.

25 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, lifestages—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 Health Care Organizations’ ORYX and public health databases.
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.

V. Effective Communication of Consumer Information

Mandating or encouraging provision of information to consumers will not ensure that consumers have the ability to act on the information. Information must be both relevant and comprehensible to consumers. In considering how health care information should be presented, one must consider several factors. If information is to be useful to consumers, it must be presented in an accessible language and medium. It should be presented with an understanding of the target audience and it should be easily accessible and current. The consumer's trust of and perception of the credibility of the party presenting the information is extremely important to his/her receptivity to it.

Because health care consumers are extremely diverse in health status, educational background and interest, selection of a relevant, meaningful subset of information to make available to consumers has proven extremely difficult. Several studies have been conducted, however, that attempt to offer insight into how consumers make health insurance decisions.

The DOC regulates both the format in which plan information presented and the content of marketing materials. Public and private sector health care purchasers, advocates, and plans, however, use a wide variety of approaches and media to communicate plan information. The state mandates that marketing material not be “untrue, misleading or deceptive.” If a plan’s materials are deemed unacceptable by these measures, the plan is prohibited from using it and/or is required to publish a correction or retraction in the same medium. Additionally, plans must have marketing/enrollment literature that uses a “disclosure form” or have “materials containing information consumers need to select a health plan and use it effectively.” This material must be presented in readily understood language and in a clearly organized form. Premium prices must be stated exactly.

In practice, health plans, purchasers and advocacy groups use a wide range of communication styles for marketing, consumer satisfaction data, process and outcomes measures, and general plan information. Media approaches to dissemination of this information by plans and independent agencies range from print, radio and television to telephone hot-lines and Internet sites. While some groups introduce and explain performance measures, many do not, reinforcing research findings that people often do not understand the managed care context and what various performance measures mean. Measures of consumer feedback mechanisms and relative consumer ability to “navigate” the plan are generally not included.

Non-profit and private sector organizations have made significant attempts to present information about managed care and the health care system to consumers in relevant, understandable language and terms. Organizations including the American Association of Retired Persons to US News and World Report and numerous small consumer advocacy organizations are interpreting and “packaging” information on health plan quality and cost and are disseminating reports through print publications and the internet. While these efforts succeed in bringing information to consumers who would otherwise not get it, they are often criticized for increasing consumer confusion by failing to use consistent measures and presentation of data.

27 Knox-Keene Health Care Service Plan Act of 1975: 1358.5.
VI. Consumer Involvement in the Health Care System

Although many experts agree that better information access and communication will benefit consumers and enhance educated choice, most feel that consumers will not be able to remedy problems they encounter in the health care delivery system without organized mechanisms of consumer involvement and advocacy. The health care delivery system in the era of managed care has become sufficiently complex to confound even the most educated and involved members. In his article, “Consumer Protection and Managed Care: The Need for Organized Consumers,” Marc Rodwin makes the case that formal, organized consumer advocacy is necessary, given the current organizational dynamics of the American health care system.28

Rodwin and other advocates of enhanced consumer involvement assert that formal consumer involvement tools and mechanisms are necessary to ensure that the consumer, once informed, has a “voice” in the health delivery system. The major difficulty is not with the amount or quality of data available, but that consumers lack resources and must deal with their problems as individuals.29 This problem is compounded by several industry factors. Individual members most often do not control the funds for purchasing the services they receive. Many consumers who receive health insurance through employment do not have a choice of plans, and thus are forced to be dependent on a health plan which they do not have the option of leaving if they are not satisfied. Individual consumers tend not to become involved in negotiations with their health plans until they have a problem, at which point—often facing the physical limitations, stress and cost of serious illness—they must be able to provide significant, detailed evidence of wrongdoing on the part of the plan;30 Finally, health plans and medical group/IPAs, in contrast to the vast majority of consumers, often have fiscal incentives and sufficient resources to address their interests proactively.

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.

While most health plans have some member involvement mechanisms in place (requirements under Knox-Keene regulations are enumerated later in this document), few have implemented extensive programs in this area. Most consumer activity has focused on issues such as review of marketing materials and grievance procedure policy development. Most 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.

Some purchasers and health plans have begun to adopt tools such as the “Consumer Feedback Loop,”31 to allow all parties in the system to obtain and benefit from the input of members. While purchasers, health

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29 Ibid., p. 113.
30 To appeal to the plan effectively, consumers must “know that they have been denied a service or received poor quality of care, believe that the plan has acted improperly, be hopeful that filing a grievance may provide a remedy, have the time and resources to pursue the matter, and think it worth the cost of doing so. (Handler in Rodwin)
31 The Consumer Feedback Loop, a tool developed by California Health Decisions, is a model for improving health care quality that involves patients, providers, 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.
plans, providers and consumers have all recognized the benefits of such involvement mechanisms, 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.

Consumer involvement currently takes on many forms: consumer advocacy groups petition governments and health plans to address their constituencies’ needs; and consumers become involved in process and policy discussions at the plan and medical group/IPA level through participation in member advisory committees and ombuds programs. Though purchasing coalitions might also require that plans employ member involvement mechanisms if they wish to be included in the coalition, the major California coalitions have not yet done so.

Examples of active consumer involvement mechanisms in California health plans include one plan which has included enrollees on its board of directors and has a very active member advisory committee and the plans participating in the Medi-Cal managed care “two plan” model, which are required to meet member involvement criteria.

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 continue 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.

Knox-Keene includes some provisions for consumer involvement in health plans’ governance, policy making and operational structures. 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.

**VII. Principles and Recommendations for Consumer Involvement**

**A. 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.

B. Recommendations for Consumer Involvement

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

   (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

   (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 agencies, contracting for health care should exercise their bargaining power to encourage 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.
I. Introduction

Providers and other appropriately credentialed health professionals operating within their scope of practice, in consultation with their patients, are most qualified to make medical decisions. However, neither providers nor medical science are perfect. The quality of medical decisions can and should be improved by stimulating the research and application of scientifically based outcome studies that consider both clinical and cost effectiveness (see the Task Force paper on New Quality Information Development). Encouraging valid and reliable evidence-based medicine will reduce unwanted practice variation outcomes and cost. As practice variation declines quality will improve and patients, in aggregate, will receive better care.

Continuous improvement of the quality of medical decision making should drive the process of care. The clinical process of care includes diagnostic evaluations, clinical judgments, surgery, therapies and drugs. Improvement of health and medicine in small incremental process adjustments as well as major innovations are needed. The practice of medicine in general, and practice within managed care in particular, needs the flexibility that the private sector can provide to make improvements. However, if the private sector fails to make changes in an equitable and responsible way, regulation may be necessary.

A. Prior Authorization/Concurrent Review as a Management Tool

There are pros and cons to prior authorization/concurrent review. This technique was first created by the managed care industry as a tool to curb the “cost-unconscious” practice of medicine. It was necessary to raise providers’ awareness that the cost of care needed to be considered in the practice of medicine. It was a useful tool for HMOs and other managed care organizations to better understand, inform and control a rapidly growing and changing industry. Prior authorization/concurrent review was one of many tools for managing consumer expectations. Consumers with low cost traditional unmanaged fee-for-service “indemnity” insurance (low cost to them) had been accustomed to receiving unlimited services at little, if any, personal financial or inconvenience cost. Prior authorization/concurrent review was used to sensitize providers, patients and consumers to the fact that health care had limits. Services being prescribed by clinicians and requested by patients carried a cost, and costs were spiraling out of control.

Some have argued that prior authorization/concurrent review is a key element separating managed care from 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. One HMO medical director testified to the Task Force that prior authorization procedures prevented unnecessary hysterectomies for women who may have wanted to have children. Prior to doing a test or a procedure the reviewer, who may be an HMO medical director (or more likely in California a medical group or IPA medical director) is theoretically given the opportunity to measure an impending medical decision against outcomes research, practice guidelines and relevant clinical algorithms. This should ultimately work to patients' benefit. The evidence of effectiveness is mixed.

The general perception is that treatment decisions are not always being reviewed by an appropriately credentialed physician, with adequate knowledge of the case at hand. In some cases care may be compro-

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2 Public testimony of S. Joseph Aita, M D, Executive Vice President and Medical Director of Lifeguard Health Care before the Managed Health Care Improvement Task Force, July 11, 1997.
mised 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 benefits 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 Relationship). 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.” 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, there is significant variation in medical practice. The Dartmouth Atlas of Health Care charts wide variation in both the uses of diagnostic and surgical procedures for individuals with coronary artery disease, prostate and breast cancer and back pain. The Atlas reports a fourfold variation in per capita rates of coronary artery bypass graft (CABG) surgery in 1992-93 for Medicare patients from one area to another. Researchers also found an eightfold discrepancy in rates of radical prostatectomy, a surgical treatment for early stage prostate cancer. Breast sparing surgery for breast cancer varied more than 33-fold.

This degree of practice pattern variation 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 want unnecessary services (see the Task Force

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4 Public Testimony of Mr. Harry Christie before the Managed Health Care Improvement Task Force, August 7, 1997. Mr. Christie detailed the many frustrations and roadblocks encountered in trying to obtain specialized pediatric services for his daughter Carly.
7 Throughout this paper, the term “health plan” refers to health insurance arrangements or health benefits financial intermediaries.
10 Op-Cit., Center For The Evaluative Clinical Sciences Dartmouth Medical School, The Dartmouth Atlas of Health Care, 113-144.
One doctor complained to the Task Force that some patients demand diagnostic tests or drugs for which no medical indication exists. The 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 very challenging.

Variation in medical practice has also been accompanied by variation in the payment for certain surgeries and treatments. For example, Medicare paid $5966 per enrollee in Miami, FL in 1993, nearly twice the rate paid per enrollee in San Jose, CA adjusted for age and utilization factors. From a population perspective, this represents a problematic allocation of national resources.

Given the wide variation that exists, there is legitimacy in HMOs seeking to influence medical practice in the direction of what more clinically conservative providers do to produce equivalent or better outcomes (e.g., ordering fewer tests, procedures and therapies). As a tool, prior authorization/concurrent review retains serious merit. However, its application has been problematic. In some cases prior authorization/concurrent review has diminished quality by distancing the medical decision maker from the patient, introduced untimely delays in the process of care, and created an additional layer of bureaucracy with which treating providers must contend. In general, patients and providers consider the additional step of obtaining prior authorization/concurrent review to be onerous, inconvenient and detrimental to the quality of care. This has particularly been the case for adults and children with chronic diseases who may be required to obtain approvals regularly. Some HMOs and other managed care plans have delegated prior authorization/concurrent review to their contracting medical groups, IPAs or other utilization management designees.

When there is no medical group or IPA to whom to delegate, other modification may be needed. One HMO has adopted a “gold standard” approach whereby a physician’s medical decisions are reviewed retrospectively over a period of time to ascertain patterns of care and consequent outcomes. If the physician’s range of referral patterns are appropriate and outcomes are good, the physician is considered to have met the “gold standard” and the HMO ceases to require prior authorization/concurrent review. This approach seems to makes sense when the HMO contracts with providers on a fee-for-service basis and the HMO has practice pattern data. It might also be applicable in the case of review within a medical group/IPA.

Large HMOs have argued that a “gold standard,” or an “exemplary practice” approach is not a feasible solution for them because they pay their medical groups on a capitated basis and do not receive information about patterns of care from the groups. Some medical groups and IPAs have argued that if decision authority has been delegated, the plans should not need this information.

For innovations to occur, better data interchange is needed. Those health plans that delegate utilization review and management to their contracting medical groups/IPAs and other independent utilization management designees cannot monitor quality and compliance without encounter data. To be useful, encounter data should include diagnoses and procedures at the treatment level, information which medical groups 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 (see the Task Force paper on New Quality Information Development).

Large plans would then have the opportunity to review physician practice patterns against a very large data set and be able to discern more statistically relevant patterns and ranges of variation in treatments and outcomes, increasing opportunities to improve the quality of care. Medical groups would also have the opportunity to better understand large-scale variations in practice patterns and identify areas to improve the quality of patient care.

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11 Public testimony of Dr. Zweifler before the Managed Health Care Improvement Task Force, June 20, 1997.
12 Op-Cit., Center For The Evaluative Clinical Sciences Dartmouth Medical School, The Dartmouth Atlas of Health Care, 187.
13 Information provided to the Managed Health Care Improvement Task Force, 1997. This HMO has complete encounter data on each participating physician and therefore has data on which to base such a determination.
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.

Alternatives to prior authorization/concurrent review are possible. There is room in the marketplace for a variety of innovative responses and expedited referral programs. For example, it would be desirable for some patients with chronic illness to receive their primary care from a specialist with the appropriate specialty credentials. In addition, some children with chronic diseases would benefit from receiving their primary care from pediatric specialists in the particular chronic disease. It would be in the best interest of adults and children for the treating specialists to have experience and training in primary care and to regularly provide primary care to these patients with chronic diseases.

Who should determine which chronic diseases should have prior authorization/concurrent review replaced by retrospective review of outcomes and patterns of care? What should be the standard of care against which providers’ patterns are measured? There is more than one answer to these questions. Health plans need to craft solutions and policies that fit their culture and the culture of their contracted medical group/IPAs. Practice guidelines, clinical pathways, pre-credentialing of providers, retrospective utilization review and outcome studies are potentially efficient substitutes for prior authorization/concurrent review. Exactly how they are applied would better be left to the health plans to determine in cooperation with those purchasing their services. This type of change could have a cost impact on the plan, medical group/IPA and premium. It would be wise to implement modifications incrementally so that changes can be evaluated for both clinical and cost effectiveness.

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 vulner-

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17 Public Testimony of Mr. Harry Christie before the Managed Health Care Improvement Task Force, August 7, 1997. Mr. Christie detailed the many frustrations and roadblocks encountered in trying to obtain specialized pediatric services for his daughter Carly.
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. 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.

The treating provider should know the most about a patient’s medical history, including which drugs have or have not been successful. Therefore, a strong case could be made that the choice of drugs should be under the control of the treating physician rather than the health plan. However, to lower pharmaceutical costs and maintain affordable drug coverage, a strong case could also 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 (see the Task Force paper on the Impact of Managed Care on Quality, Access and Cost). The committee could study the research pharmacology literature, analyze the group’s own data, consult with pharmacists and other experts and create a formulary or list of drugs based on scientific evidence. The
formulary could also identify “best practices” or guidelines for prescribing certain medications for specific conditions. Hospitals, medical group/IPAs, HMOs and Pharmacy Benefit Management (PBM) companies have such Pharmacy and Therapeutics (P & T) Committees and many have formularies. The involvement of practicing physicians in formulary design is key since their collaboration provides them a strong incentive to comply with the formulary.

Interpreting and understanding formulary requirements and restrictions can be a daunting task. 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.

Current prescription drug policies also cause confusion and difficulty for many consumers in managed care. Many managed care organizations have put in place systems that provide for coordination and quality review, but these same systems sometimes impede access to appropriate care for consumers. Improved coordination and access to prescription drugs is needed.

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.

(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.

F. Clarify the Benefit Language in Health Insurance Contracts

In discussions of health insurance, contract language, and managed care, there has been extensive debate about the pros and cons of medical necessity decisions, coverage decisions, experimental treatments and the existing language of most benefit contracts. Benefit language has traditionally relied on vague terms. Health plans have covered most things thought to be “medically necessary” or “appropriate” by providers, or that met a “community standard.” There has been a great deal of disagreement about what these terms mean.

Further study is needed to determine whether changing benefit language to maximize quality, improve health outcomes, improve functional outcomes and strengthen the scientific underpinnings of treatment decisions while controlling costs will work. All stakeholders in the health care industry as well as experts in this complex area should be involved in order to reach a broadly based consensus on defining new benefit language and the criteria to use for coverage decisions. Consumer involvement and consumer protections should be an integral part of this debate. Since no consensus exists as to how to make benefit language more precise, defining the criteria by which medical necessity is applied becomes important so that it can lead to improved quality, improved health outcomes, improved functional outcomes and better adherence to the scientific basis of treatment decisions. Criteria should be sensitive to 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.

Further study is also needed on how to isolate coverage decisions from treatment decisions. More science is needed to guide the creation of the database that should be used to determine the appropriateness and effectiveness of one treatment in deference to another. Consensus is needed before regulatory or statutory changes to current contract language can be recommended.

Debate about coverage and treatment decisions is not complete without more discussion about experimental treatments and therapies. Vague contract language has received added attention with the growth of managed care and the introduction of new, expensive and experimental medical treatments such as autologous bone marrow transplants (ABMT) for breast cancer. In cases where payers have not paid for something, expensive litigation has often ensued.

In 1996 the California debate over “medically necessary” experimental treatments and procedures, and the appropriateness of subsequent litigation with very large damage awards led to the passage of AB 1663. Known as the Friedman-Knowles Bill for Experimental Treatment Coverage: Independent Review, this law establishes a process for the review of coverage denials for experimental treatment procedures by independent medical experts, commonly known as independent third-party reviewers. Reviewed decisions are then binding on the health care service plan or insurer. Although enacted in 1996, the Friedman-Knowles Bill will not become effective until July 1, 1998 in order for the Department of Corporations (DOC) to accredit independent third-party reviewers before they are asked to examine specific cases. This new law creates another vehicle for dispute resolution that is reactive rather than pro-active. Philosophically it would be better to prevent disputes from happening in the first place. Changing benefit language and the criteria for benefit decisions to improve quality while reducing costs would be a step in this direction.

References:
27 In the case of Fox v. Health Net a California jury awarded the plaintiff $89 million in compensatory and punitive damages. The plaintiff was the family of a woman denied coverage for a bone marrow transplant for breast cancer because there was little data to support its effectiveness. No. 219692 (Cal. Supreme Court, December 28, 1993). The case later settled for a smaller but unpublished amount.
However, the question remains as to when a treatment crosses the line from experimental to accepted and non-experimental. More study in this area is also needed. It would be desirable for an independent, expert review panel of major stakeholders and appropriate clinical experts 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 the Benefit Language in Health Insurance Contracts
(a) Create a “blue ribbon” public/private work group of major stakeholders 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 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 has 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.

28 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.
Vulnerable Populations
Background Paper

“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

I. Characteristics Of Vulnerable Populations
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 recommendations that apply to all vulnerable populations as well as 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.

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

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.
behavior of both public and private health systems now thrown into direct competition for health plan membership will be significant.

Vulnerable populations may be defined in many ways. For the purposes of this discussion, “vulnerable” will be understood to include individuals or groups who because of age, ethnicity, race, economic condition, social circumstances, geographic location, gender, belief system, culture, education, language proficiency, or mental and/or physical condition do not have access to adequate health care services. By definition then, vulnerable populations encompass the more than 6.5 million Californians whose access to health care is severely limited because they have no coverage and more than 3 million Californians whose income or illness qualifies them for Medi-Cal.

The Managed Health Care Improvement Task Force has, for the time being, limited its discussions to the impact of managed care on individuals who are currently managed care enrollees. Therefore, within that narrower framework, vulnerable populations in the managed care system are those who are likely to require above average quantities and/or more complex mixes of services to maintain or improve their health status. They may be grouped into categories that describe their primary vulnerability, but that are not necessarily mutually exclusive. The following factors may render a population vulnerable.

1. **Nature of Illness or Condition**

Health care needs are less likely to be met for persons who have complex, chronic, unpopular or rare illness. Examples abound, but HIV/AIDS, chemical dependency and mental illness deserve special attention. Likewise, persons with restricted mobility, impaired mental processes, or sensory deficits will require ancillary services not readily available in primary health care settings.

2. **Social and Economic Circumstances**

To mention but a few, individuals caught in webs of poverty, imprisoned persons, persons without homes, migrant people and recent immigrants are more likely to have poor health status associated with lack of access to health and social services.

3. **Place of Residence**

People in isolated or hard to reach areas of the state, particularly those living in rural areas, frequently have difficulties accessing quality services. In urban settings there are communities where lack of safe transportation limits access.

4. **Age**

Children and the infirm elderly are dependent on their caretakers for their access to care. Adolescents may find few knowledgeable providers or services that conform to their needs for confidentiality and ready availability. Unless covered for a full range of reproductive and sexual health services, they may go unserved.

5. **Gender and Gender Identity**

“Women-specific” or in some cases “men-specific” services may be lacking. Cultural expectations and biases around gender identity and sexual preferences create barriers to access (See Task Force paper on Improvement of Managed Care Through Coordination and Integration: A Case Study on Women’s Health).

6. **Culture and Language Proficiency**

Cultural differences and lack of language proficiency are not the same, but are grouped because the misunderstandings around them may generate the same result: poor care and a lack of trust relative to health services.

The common denominator among people who might be termed vulnerable is the fact that they require a mix and an intensity of services that is not (by and large) the rule in managed care. We have used these characteristics in Table 1 (attached) to identify vulnerable groups and their special needs within the system. The governmental programs that offer support to many of these groups are also presented (see Table II attached). The list below summarizes a number of special needs and vulnerable populations, some of whom are highlighted in this report:
• 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 in Managed Care

The results of a recent study conducted by Robert Miller and Harold Luft of UCSF comparing the quality of care in managed care and indemnity settings indicate that 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 poor health, impaired or frail social HMO demonstration enrollees, and Medicare home health patients, many of whom have chronic conditions and diseases. While some quality of care results that show better or mixed quality of care in HMOs are at least partially based on data for patients with chronic conditions and diseases, the fact that three significantly negative HMO quality of care results for Medicare HMO enrollees with chronic conditions and disease raises cause for concern.

In addition, some advocates point out that there are not enough representatives of vulnerable populations in managed care currently to make a valid assessment about the quality of care. They feel that managed care was a system built around employable individuals to handle health care for the healthy, and MCOs have traditionally avoided the more needy populations. For example, in the case of chronically ill children in Medi-Cal, their primary healthcare needs are met through managed care, and California Children Services (CCS) “carve-outs” provide an indemnity arrangement for service related to their chronic condition. In California today, there is only one Medi-Cal managed care plan for acute HIV/AIDS patients. All other plans provide treatment in a managed care arrangement until the patient’s T-cell count falls below a certain level, at which point members become eligible for Social Security Insurance (SSI) and are rolled into an indemnity program to avoid adverse selection.

Essentially this situation is exacerbated by the perverse incentives built into the managed care financing model. It does not make sense economically for a health plan to be skilled at treating vulnerable populations, since they are often more costly to treat, and compensation is not commensurate with the additional time and expense. It is possible for a health plan to go bankrupt simply by being able to provide exceptional care for AIDS patients. The risk of adverse selection is therefore a special problem for vulnerable populations, since the incentive may exist for health plans to profit from subtly inducing sick persons to disenroll through such means as limiting access to needed services (particularly specialty care), poor service, and inconvenience. These incentives need to be adjusted by implementation of risk adjustment (See the recommendations in the Task Force report on Minimizing Risk Avoidance Strategies).

Data also suggest that managed care by its very nature may have less appeal than traditional unmanaged indemnity insurance for persons with chronic diseases. Several studies have been conducted using Medicare data and have concluded that managed care organizations tend to attract very good risk. Managed care

5 Miller R and Luft H, "Does Managed Care Lead to Better Or Worse Quality of Care?" Health Affairs, 16:5, September/October 1997.
6 Interview T Brigham, Director of Policy and Planning, San Francisco Department of Public Health.
organizations historically have had limited cost sharing, but also have provided limited access to specialists and hospitals, which does not appeal to those who anticipate high medical needs. 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 vulnerable 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

1. Under-Treating Patients with Chronic Illness
The inevitable tension that occurs between the drive for cost containment and the above average needs of vulnerable populations is significant. Payment through a poorly structured capitation arrangement could encourage providers to inappropriately restrict the amount of care they provide. Since members with chronic illness are most likely to need the greatest amount of care, these are the patients most likely to be affected by limits on services.

2. Restrictions in Seeking Specialists
The current practice employed by many managed care organizations of controlling costs by requiring prior authorization of every service not delivered by a primary care provider is not practical for enrollees who rely on specialists; nor is it necessarily cost effective. Certain studies show that use of a specialist as the primary care provider for a patient with a chronic condition can be more cost-effective in many cases.8

More important, however, is that restricted access to specialists may impact the quality of care in certain cases. A recent study on children with complex pediatric conditions found that some managed care plans impose restrictions on referrals to pediatric specialists and sub specialists which have been found to compromise patient care.9 The study also found that an increasing number of primary care physicians or adult specialists are attempting to treat severe conditions in which they have little experience. The Task Force report on the Impact of Managed Care on Quality, Access, and Cost cites additional evidence that primary care physicians may lack expertise in diagnosing or treating some chronic conditions, particularly psychiatric conditions. Even for those conditions where a primary care provider is thought to be equally as effective in diagnosing and treating the illness, skills among providers vary widely in any health plan, and there will be varying level of ability to deal with complex needs. Unless quality assurance of highest degree prevails, primary care providers will be extremely varied in their profiles, which conflicts with vulnerable populations’ need for access to the appropriate and necessary expertise.

3. Lack of Expanded Systems of Care and Limited Benefits Definition
Public health entities provide certain essential services to vulnerable populations for which privately owned managed care systems are not currently financed, or equipped. Gaps exist in the variability of service packages and in the capability of providers to link with other services necessary for acceptable levels of care. It is essential that plans be able to refer aggressively vulnerable populations to the necessary resources in their communities. Necessary services may include access to housing or disability benefits, advocacy and consumer organizations, childcare, and transportation. Likewise, persons with restricted mobility, impaired mental processes, or sensory deficits will require ancillary services not readily available in primary health care settings.

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8 Ibid.
4. Discontinuity of Treatment
Persons who require care for chronic or difficult to treat conditions require continuity of care and do best with predictable, competent providers with whom they have developed trusting relationships. In addition, transferring the large body of knowledge to a new provider is not only extremely costly, but may result in “gaps” in medical history and care. The disruption of the relationships with existing providers occurs when an enrollee joins a managed care organization that does not include the provider as part of their network or removes the provider from their panel. Fear of this disruption can discourage chronically ill from switching health plans (see the Task Force report on the Physician-Patient Relationship), even when it might be advantageous for them to do so. In addition, the unsteady state of coverage for individuals caused by Medi-Cal eligibility criteria and the on-again/off-again nature of many government programs further serves to exacerbate the problem.

5. Lengthy Time Frames for Authorization
The chronically ill and other vulnerable populations have non-traditional benefit needs that are not conducive to normal authorization time frames. For example, getting timely feeding supplies or wheelchair repairs are essential to the day-to-day functioning of these individuals and must be authorized without delay. In addition, lack of timely medical treatment, durable medical equipment, or physical therapy has been proven to accelerate functional deterioration unnecessarily in certain cases. In some instances in which the situation has been protracted, the dramatic functional loss has resulted in the need for part or full-timed attendant care at home, or long-term care coverage often not covered by managed care organizations.

6. Lack of Consumer Understanding
Vulnerable consumers may be more disadvantaged in their understanding of plan and quality information due to experience, language, culture, and other significant barriers, leading to less informed choice. Many quality indicators used by managed care organizations require sophisticated understanding of managed care and the Medi-Cal, Medicare, or other governmental programs. It has been demonstrated that there is widespread misinterpretation of HEDIS data, and this finding is more pronounced for the vulnerable. (See the Task Force report on Consumer Information, Coordination, and Involvement.)

7. Providers’ Failure to Diagnose Accurately
The provider may not have the necessary experience working with a particular vulnerable population to diagnose and treat accurately and/or effectively. Appropriate credentialing is necessary to ensure sensitivity, skills and competencies in regards to these populations.

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

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 follow 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

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10 Personal interview with Pat Strong, Services Center for Independent Living.
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 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 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]

- 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

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11 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.

12 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.
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 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 their HMO/plan, including the viewpoints of enrollees who are members of vulnerable populations. [Consumer Information, Communication & Involvement recommendation]

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.
### TABLE I: SPECIAL NEEDS OF VULNERABLE POPULATIONS *

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<tr>
<th>CATEGORY</th>
<th>TYPE/GROUP</th>
<th>SPECIAL NEEDS*</th>
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| Children/Infants | Premature infants and high risk babies | 1. Neo-natal intensive care (NICU)  
2. Case management  
3. Specialized OP care |
| | Foster children | 1. Annual physical exam  
2. Case management  
3. Abuse prevention |
| | Disabled children | 1. Special medical equipment  
2. Special transportation  
3. Case management  
4. Access to specialist  
5. Specialized diagnostic screening/therapy |
| | Abused children | 1. Mental health services  
2. Annual physical exam  
3. Case management |
| | Chronically ill children | 1. Access to specialized disease management  
2. Case management  
3. Health education |
| | Language disadvantaged minorities | 1. Culturally and linguistically competent medical care  
2. Health education |
| Elderly | Elderly frail/chronically ill | 1. Home and community based care  
2. Institutional care  
3. Case management  
4. Medical equipment  
5. Physical and respiratory therapy (PT/RT) services  
6. Infusion services  
7. Housekeeping services |
| | Elderly disabled | 1. Durable Medical Equipment (DME)  
2. Home/community-based care  
3. Case management  
4. PT/RT |
| Medically vulnerable | HIV/AIDS and other high risk medical conditions | 1. Specialized drug therapies  
2. Case management  
3. Hospice  
4. Mental health  
5. Specialized medical care |
| | Short-term major medical conditions | 1. Special therapies and procedures  
2. Case management  
3. Special health education |

* Note that these are representative, not all inclusive.

### TABLE II: TYPES OF VULNERABLE POPULATIONS

<table>
<thead>
<tr>
<th>CATEGORY OF VULNERABLE POPULATIONS</th>
<th>TYPE/GROUPS</th>
<th>GOVERNMENT PROGRAMS</th>
</tr>
</thead>
</table>
| Children/Infants                  | Premature infants  
Foster children  
Disabled children  
Abused children  
Chronically ill  
Disadvantaged minority children | CCS  
Medi-Cal/Special County Funds  
CCS  
None/Emergency Medi-Cal  
CCS  
Primarily School Based or Private Insurance |
| Teenagers/Adolescents             | Individuals with disabilities  
Pregnancy-sexuality | CCS  
Medi-Cal |
| Adults                            | Poor  
Chronically ill/HIV/AIDS  
Mentally ill  
Unemployed (not poor)  
Special medical needs/adults  
Women of childbearing age  
Minorities/Women | Medi-Cal  
SSI/Medi-Cal Limited  
Medi-Cal/SSI  
Limited Medi-Cal  
SSI/Medi-Cal  
Limited Medi-Cal  
No special programs |
| Elderly (65+)                     | Chronically ill  
Terminally ill  
Elderly with disabilities | Medicare/Medi-Cal  
Medicare  
Medicare |
Appendix A—Acknowledgement of Contribution

The Task Force would formally like to acknowledge and thank the following individuals and organizations in their valuable and tireless efforts:

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- Sandra Welner, M.D., Primary Care Gynecologist for Women with Disabilities and Chronic Medical Conditions, Private Practice
- Roberta Wyn, UCLA Center for Health Policy Research
Improvement of Managed Care Through Coordination and Integration: Case Study on Women’s Health Background Paper

I. Introduction

Managed care promises not only to contain health care costs, but also 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. While many plans can point to significant improvements over traditional indemnity plans in availability of services, utilization patterns continue to reflect the “fragmentation” that managed care seeks to correct.

Significant areas of opportunity for improvement exist in several areas in the managed care delivery system. Development of a truly comprehensive system requires effective integration along many dimensions, including the definition of comprehensive care, the provision of, access to and utilization of care.

Women’s health presents a particularly important case study in integration and coordination of care, as women are the primary consumers of health care (for both themselves and their families) and make up a majority of managed care enrollees. Women live longer than men, suffer from more chronic illness and have been the subject of less clinical investigation.

This paper will explore the ideals of coordination and integration of care in managed care systems. The potential for improvement of managed care through coordination and integration of care in both the early group and staff model systems, which were conceived and designed around these principles and the newer, “carrier HMOs,” (generally network and IPA models that contract with various medical groups), which are often not designed around these principles, will be considered. Following a brief discussion of existing patterns of care in managed care systems, examples from women’s health in the broad areas of coverage and comprehensiveness of services, access to and utilization of care and providers of care in a managed care system will be considered.

II. Managed Care- Ideals and Challenges

As envisaged by the pioneering organizations, managed care rests upon the tenets of population health, and offers the potential benefit of providing a coordinated system of health education, preventive care and treatment for illness. The overall premise is more pro-active 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. While proponents of managed care point to success in the areas of cost savings, increased prevention and health promotion 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 less qualified providers.

A. Defining Comprehensive Primary Care

There is a great deal of variation in the manner in which different health care systems, insurers and clinical authorities define and provide coverage for primary care. The Institute of Medicine definition of “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 challenges the reality of most primary care provision in our current system.

Health Maintenance Organizations (HMOs), the most tightly managed form of managed care, use the primary care provider (PCP) as the members’ point of entry into the health care system and point of departure for receipt of more specialized care. As the PCP controls a member’s access to the broader system of care, the system’s effectiveness in helping the member to achieve his or her optimal health status relies heavily on how the role of this practitioner or team is conceived and executed. The primary care model in practice throughout most of the past several decades, including the period heavily influenced by managed care, has been largely informed by a biomedical model, has included very little training for coordinating activities, and has rested on research focused primarily on men.

Newer conceptions of women’s health take a broader approach to the definition of primary care. Under these new definitions, women’s comprehensive primary care includes a broad range of components, including: medical disease areas (such as cardiology and rheumatology), reproductive care (including general gynecology, obstetrics and oncology), psychology and behavioral medicine (including depression, alcohol and drug abuse, eating disorders and domestic violence) and preventive medicine (including cancer screening). This “holistic” definition of primary care—a definition that corresponds more closely with the managed care goals of optimizing member health—presents significant implications for the task of integrating and coordinating needed care. The primary care needs of women also vary significantly across the different stages of their lives, and the most effective care model and provider team may be quite different at each of these stages.

B. Existing Patterns of Care

While many managed care organizations have worked to develop clear coverage and referral policies and processes, consumers continue to be extremely frustrated with many aspects of plan and provider operations. Consumers often do not understand plan communications, do not know what services are covered, are frustrated when their plan and their provider do not communicate about or agree on treatment options, and are confused by referral and authorization procedures. In the ideal integrated delivery system, the various components (insurers, providers and facilities) work together systematically in pursuit of common goals, linked together by incentives and information, in the interest of providing the patient with care that is effective in both preventing and treating illness and constraining costs. While few organizations have achieved this ideal, many are beginning to develop the systems they feel are necessary to do so. Alignment of incentives and integration of the various components of the increasingly complex health care delivery system are the primary levers through which players in the health care system are attempting to improve managed care.

C. Organizational Challenges for Health Plans

Many traditional indemnity insurers entered managed care by simply developing primary care provider (PCP) coordination and utilization review (UR) mechanisms in conjunction with capitation or discounted fee for service. These systems differ significantly from the group and staff model HMOs, which were developed as managed care plans and are managed “from the ground up.” While use of UR and capitation alone can result in decreased costs and elimination of some utilization, they are not sufficient to create the organizational change necessary to realize the potential for increased patient satisfaction and improved outcomes of truly integrated care.

An effective managed care system requires much more than a network of providers and an insurance mechanism. Additional necessary elements include information systems for enrollment, billing and patient tracking; recruitment and contracting with providers and plans; calculation of payment rates, often including rates for per-capita pre-payment; parameters on access and quality assurance; data collection and monitoring.

2 Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, Eds. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine, Washington, D.C., National Academy Press: 1996.
3 Members of less organized forms of managed care, particularly PPOs, may use the primary care practitioner or team as the focal point for primary care, but do not rely on the PCP to grant referrals to specialized care.
4 Carlson, KJ, Eisenstat, SA, Frigoletto, FD, Schiff, I, Primary Care of Women, St. Louis, Mosby: 1995.
Improving Managed Health Care In California Volume Three

systems to detect access and quality of care problems; and enrollment and education of members. While many managed care organizations are developing the information and organizational capacities to perform this range of tasks, many of the aspects of traditional indemnity coverage which resulted in patient dissatisfaction and elevated costs—namely lack of coordination of care, missed opportunities for process improvement and wide variations in practice—remain significant issues under managed care.

D. Coordination and Integration Trends in Managed Care

Managed care plans have always asserted that optimizing member health through strong prevention and primary care programs will lead to cost savings, but have focused much of their effort on eliminating “unnecessary” costs at the population and system levels through utilization review and management. As many of the initial efficiencies and cost savings of controlling access and utilization have been realized, plans have begun to focus on improving health and satisfaction at the member level. Prevention programs focused on population health concepts (i.e. more pro-active outreach programs for immunizations, screenings and health promotion) customer segmentation and personalized attention from member services departments have become more prevalent features of managed care plans.

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 more pro-actively coordinate 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 multidisciplinary expertise around common chronic disease states. While many feel that these programs improve health status and outcomes by pro-actively managing care and treatment, others are concerned that they risk being treated as “carve outs” by plans, resulting in fragmentation of care.

Many managed care plans have begun to devote resources to coordination and integration of services for individual members and groups with common health needs. Both within and outside of disease management programs, personal member representatives—essentially administrative case managers—are becoming a more prominent feature of plans. While “case management” has long been used to coordinate health and social services, it has not been a component of the traditional primary care model. The goals of case management—coordination of complex, fragmented services to meet the needs of the client while controlling costs—are consistent with the goals of managed care.

Women’s health programs, both within managed care organizations and as independent components of the health care delivery system, have been an area of rapid development and innovation in both non-profit and for-profit plans. These initiatives propose to provide “women-centered” care by focusing on both the care integration needs of women and women’s attitudes and preferences regarding how, where and by whom care is delivered. Health plans have offered women-only health centers as options for female members and have begun offering screening promotions such as “mobile” mammogram clinics. Medical groups and management organizations devoted exclusively to women’s health have become more prevalent and community reproductive health centers have begun to provide a broader range of primary care services to increase their likelihood of retaining contracts with managed care organizations.

III. Women’s Health–Challenges for Managed Care

Women’s health provides a very powerful example of both the failings and the potential of managed care systems 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

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5 A term pioneered by the Boston Consulting Group in 1993, “disease management” refers to a complete, systematic approach to treating chronic diseases to reduce complications, overall utilization and cost.
content 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 improvement through integration of the elements of comprehensive care. They include the following:

- 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 impact 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 National Institutes of Health 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

The issue of comprehensive primary care in women’s health is of particular importance because of the historical fragmentation of services. Fragmentation in women’s health care delivery is 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. Politicization of certain reproductive services has promoted organizational segregation of providers and sites of care.

1. Fragmentation in Coverage for Women’s Primary Care

Much of the backlash against managed care has been directed at plans’ use of the primary care provider (PCP) to coordinate—and in some cases restrict—services. The majority of managed care plans employing the PCP model have not convinced consumers that the PCP is performing a coordinating function—the perception is that the gatekeeper is a barrier to choice and access. (See the Task Force’s Physician-Patient Relationship paper).

Consumer reaction to managed care practices has resulted in a number of “direct access” legislation proposals across the country. In the 1996-1997 legislative session, a number of states introduced bills under which managed care consumers would have the right to self-refer to specialists. This legislation

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reflects a very real concern on the part of consumers and presents some interesting challenges for managed care organizations committed to pursuing coordinated and integrated care.

The most prominent example highlights the fragmentation between reproductive and other health services for women. The issue of legislative mandates requiring that plans allow women to “self refer” to obstetricians/gynecologists provides an interesting illustration of the trade-offs inherent in using direct access legislation to “force” health plans to provide access to specialty care. In the case of direct access to obstetricians/gynecologists, the legislation represents consumer demands for comprehensive primary care from organizations ostensibly organized to provide this care through coordination and integration of appropriate resources.

Women in managed care plans are often assigned to “generalist” PCPs who are unable to perform routine reproductive health tests and procedures. In order to obtain comprehensive primary care, their PCPs must refer them to a provider who offers these services. Many organizations have attempted to solve this problem (and to respond to preferences of women members) by allowing women to choose an obstetrician/gynecologist as their primary care provider. Many women who accept this option, however, chose obstetricians/gynecologists who are not trained or do not choose to conduct non-reproductive primary health tests and screenings. These women thus must also see multiple PCPs. The Commonwealth Fund Study of Women’s Health revealed that one third of women regularly seek care from both a primary care physician and an obstetrician/gynecologist; these women made 25% more primary care visits than women seeing only one practitioner. Use rates for different procedures—all of which are elements of comprehensive primary care—also vary by specialty of provider. Among nonelderly women, those with an obstetrician/gynecologist as a PCP had higher rates of Pap smear screening and breast exams, while those with an internist or general practitioner as a PCP had higher rates of mammography, blood pressure screening and blood cholesterol screening. Receiving care from both a generalist PCP and an obstetrician/gynecologist increased the number of recommended preventive services received.

Given these findings, it is not surprising to note that the study also found that utilization of both a generalist and reproductive PCP was positively correlated with both income and education.

By coordinating care, either through a team approach or through cross-training of PCPs, plans could provide women with greater continuity of care and enhanced access and eliminate duplicate visits that are costly to both the delivery system and the patient. While the legislative “direct access” strategy arguably provides women the access to reproductive care they need, it undermines important principles of the managed care system and may not result in women (particularly those who are poor and/or have a low educational level) receiving more comprehensive services. Unless managed care organizations are able to establish a higher level of trust with consumers and provide them with the assurance that the system is designed to provide comprehensive services, “self-referral” and direct access demands will continue to offer incremental solutions to the need for comprehensive primary care for women.

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10 The Commonwealth Fund Survey of Women’s Health was the first national survey of American women 18 and over that attempted to gain insight into the physical and mental health of women, use of health services barriers to care and health habits. This study covered both women enrolled in HMOs and women in indemnity plans. The study found that women outside of HMOs were more likely to have an obstetrician/gynecologist as their PCP. Women in HMOs were more likely to have an obstetrician/gynecologist in addition to a family practitioner or other PCP. Preventive services were more likely to be provided to women in HMOs, but these women were also more likely to report not having gotten needed medical care in the past year (reasons cited included high cost, inability to get an appointment and lack of coverage for the care in question).


14 Ibid., p. 32.
2. Benefit and Coverage Issues

As mentioned earlier, managed care has proven confusing to many consumers because of the broad variation in coverage and benefits (benefit design can vary significantly at any combination of the purchaser, plan and provider levels). 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 (i.e. copayments and deductibles) was a barrier to use of preventive services. 

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. Coverage of preventive services such as Pap smears and mammograms has consistently shown to be broader under managed care than under indemnity insurance. 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 confounded by leading authorities’ variations in guidelines for screenings for services such as the Pap smear and clinical breast exam. Increased, targeted studies of the benefits of comprehensive preventive services and interventions are needed if preventive care is to be expanded.

Mental health presents a striking example of how coverage decisions can confound appropriate coordination of care. Depression is twice as common in women as in men, and depressed primary care patients use two to three times the medical resources as their non-depressed counterparts. Many managed care plans will provide only limited coverage for mental health services, but will continue to cover the (more expensive) somatic manifestations of the mental illness. Delivery and financing of care have been structured around acute, curative care, with a bias toward funding for inpatient care and procedures. Medical studies have overwhelmingly focused on the health status and needs of men, and have not until recently acknowledged that women are sufficiently different to include them as subjects or issue specific guidelines for their treatment. For example, guidelines published as recently as 1996 by the Agency for Health Care Policy and Research for detection and treatment of depression in primary care are missing reference to the profound impact of gender based violence on the incidence of depression among women and fail to delineate the differences in selecting and prescribing psychotropic medications for women and men.

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 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

18 Ibid., p. 54.

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switch physicians, usually over problems of communication. Women are also more likely to choose to utilize advanced practice nurses as PCPs; thus the challenges of integrating non-physician providers effectively into a comprehensive system of care will disproportionately affect women. Studies show that advanced practice nurses score higher on health promotion and quality of care measures than physicians.

The managed care system has promoted short office visits for patients and clinicians—these productivity pressures on clinincians have been the focus of concern for consumers and concern some clinicians who feel they do not have enough time to involve patients effectively in treatment decisions. Some managed care organizations have responded to this concern by developing managed care teams with a range of providers, including nurses and social workers, with the goal of more effectively serving patients' needs for information and treatment planning. Continuity of care has also been an issue of concern for many under managed care. As employers and members switch plans with greater frequency and plans and providers' contracts change, many consumers find themselves having to switch providers. (See the Task Force's Physician-Patient Relationship paper for further discussion of these issues.)

1. Training of Providers

Primary health care for women has traditionally been provided by both generalists (internists, family practitioners and general practitioners) and obstetricians/gynecologists. The services offered by these two groups overlap in several areas, but women have customarily received medical care for episodic and chronic non-reproductive illness from the first group and gynecological and obstetrical care from the latter. Under current medical training, each specialty has some advantages and some disadvantages in serving as primary care provider.

The historical failure of the medical education system to address women's comprehensive primary care needs has been noted at a systemic level: The Council on Graduate Medical Education, The Federated Council of Internal Medicine, The Council on Graduate Medical Education, the Federated Council on Internal Medicine, the American College of Obstetricians and Gynecologists, the American Association of Family Practitioners and the National Academy of Women's Health in Medical Education have all delineated competencies in women's health that cross traditional professional boundaries. Changes in the medical education system are beginning to address the fragmentation problem in women's health care. The specialty of family practice has trained providers of both general and gynecological care (and often obstetrics). Some residency programs in internal medicine have included training in primary care gynecology to enable graduates to provide routine gynecological care. Finally, since 1995 residency training for obstetrician/gynecologists has included a non-reproductive primary care component, and postgraduate programs in general primary care have proliferated. The medical boards now include a section on women's health care. The nursing profession has historically placed more of a focus on women's health, developing graduate programs, conducting research and serving as advocates for women's health.

2. Cultural Competency

Women's health provides a particularly instructive case study in that it forces a consideration of the challenges the health care system faces as it attempts to adapt primary care concepts to account for behavioral, social and cultural factors. Many of the shortcomings in the current system can only be remedied through recognition of women's health seeking behavior and coordination and integration of care that responds to their needs in an effective, culturally competent manner across the different phases of life.

One prominent example in this area is the issue of sexually transmitted diseases (STDs). Though five of the 10 most frequently reported diseases in the US in 1995 were STDs, recent studies show that prevention and treatment of STDs are not being integrated into routine primary care because of service fragmentation.


inadequate provider training, provider discomfort in addressing issues of sexual behavior and biases regarding which patients are at risk. The Kaiser Study found that only 12% of women aged 18 to 44 who had a first visit with a health provider in the past year reported that their provider had raised the issue of STDs as part of their routine reproductive care. While STDs are a common component of outpatient medical practice, fewer than 20% of medical education programs provide adequate training in taking sexual histories and in STD evaluation and treatment. In this area, as in many areas of reproductive health and sexuality, “mainstream” PCPs are not adequately trained or motivated to provide for the needs of a large constituency. The knowledge and skills to provide STD and other “sensitive” services do exist in clinical practice, but often reside in practices excluded from the majority of managed care provider networks. Recognizing this problem, the state of California has required Medi-Cal managed care organizations in 12 counties to subcontract with local health departments for several public health services, including STD-related care.

3. Coordination of Providers and Managed Care Organizations

Studies have shown that the single greatest determining factor in women’s receipt of routine, clinical preventive services is whether they have a regular provider of care or a regular “place that they receive care” (i.e. a relationship with their health care provider at either the individual provider or clinic level). While uninsured women are more likely to lack a regular source of care, the problem is quite prevalent among the insured population: The Commonwealth Fund Survey found that one in five non-elderly insured women in the US did not have a regular connection to the health care system. As the trend in managed care is away from group and staff models and toward contracts with networks of providers, and as relationships between medical groups or individual providers and plans change frequently, managed care organizations face a significant challenge in developing systems to assist members in establishing a connection to the health care system and maintaining continuity of care.

Many plans are attempting to improve in this area by devoting increasing resources to population health practices and member outreach initiatives. Reminder cards, open houses, education initiatives, population segmentation and targeted “social marketing” campaigns, and collaboration with community resources such as family planning clinics, health centers and schools are all ways in which managed care organizations have attempted to increase “connection” to the system and utilization of wellness and prevention activities by their enrollees. Many have begun to experiment with the concept of designated member representatives—effectively administrative case managers—to provide an advocate for the member, to help the member navigate the system of care and to ensure that the member’s multiple providers are working with full information and as collaboratively as possible.

C. Access to and Utilization of Care

Access and utilization of care is related to, but not always determined by, plans’ coverage policies and benefit design. Women’s health needs and health seeking behaviors as well as their responsibilities for coordinating care for family members heavily influence their utilization patterns. Needs and access issues differ significantly in different phases of life, presenting additional challenges for organizations pursuing integration and coordination of care. The example of adolescents is extremely telling in this area. Studies show that adolescents are likely to participate in preventive primary care activities related to sexuality and reproductive health if they can be assured that confidentiality will be preserved.

By tracking and responding to both over and under-utilization of care, managed care organizations can begin to better address the factors that drive utilization of benefits.

27 Ibid.
28 Ibid.
30 Ibid.
1. Time and Cost Considerations

Access to care for women (and by extension for the family members whose care they coordinate) is also heavily affected by time availability. Commonwealth study findings indicate that 29% of women 65 and under had not received care they knew they needed in the prior year due to time constraints. The availability of services at times and sites convenient to women is clearly an important factor in improving access. Many women’s health advocates point to the time-sensitive nature of reproductive health services as a reason for allowing women access to obstetricians and gynecologists without a referral from a PCP.

Cost of care (including copayments and deductibles) is also a strong predictor of utilization. The Commonwealth study indicated that one out of three insured women surveyed reported that cost (i.e. copayments and/or deductibles) was a barrier to use of preventive services. This issue is particularly pronounced among poor women, single parents (who often cover out-of-pocket costs for several family members) and older women, who are twice as likely to live in poverty as older men, and whose health plans may not cover prescription drugs. A 1990 study of the 10 most common illnesses in persons with Medicare and Medi-Gap coverage for which there is consensus about treatment found that three out of the four illnesses with the highest out-of-pocket costs were more common in women than men, while four of the five with the lowest out-of-pocket costs were more common in men.

2. Authorized Providers and Sites of Care

Managed care organizations have endeavored to constrain costs through transferring care delivery to the “least expensive appropriate setting.” Though selective contracting and financial incentives linking providers with hospitals and clinics, they have attempted to lower overall costs of care by restricting use of inpatient care and expanding options for intermediate facilities and outpatient procedures and care. While this type of integration has been the source of significant savings in the industry, plans have not proceeded toward “resource optimization” without controversy and public sanction.

This issue has come under considerable controversy in women’s health in the specific area of mastectomies, raising the broader question of how incentives can be aligned so that they optimize resources without compromising patient care. In the recent controversy over mastectomy treatment, consumers and advocates launched a very visible campaign opposing the increasingly common managed care organization practice of providing mastectomies in outpatient clinics. The popular reaction against “drive-by mastectomies” (following closely on the heels of a similar campaign against strict limitations on maternity stays) highlighted public disapproval of health plans’ attempts to constrain resources by establishing “arbitrary” length of stay limitations.

As noted earlier, 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. Managed care organizations have interacted with these providers in a variety of ways. Some managed care plans contract with and reimburse community based providers; many others refer members these providers without referrals and thus without reimbursement. Selective contracting often overlooks community-based resources, including family planning clinics, STD clinics and community health centers because they are seen as providers of free care or care duplicative of that offered by the plan’s “provider panel.”

33 Ibid.
35 Reidy Kelch D, “The Health of Older Women in California,” California Women’s Health Project, CEWAER, June 1996, pp. 4 and 31. Note: Older women take an average of nearly six prescription drugs and three over the counter medications at the same time.
According to a 1994 GHAA/Kaiser Family Foundation survey 23% of HMOs had a contract with a family planning or abortion clinic. Studies show that women and their families continue to rely on these providers of care even when they are insured. The reasons they do so include proximity to their homes, cost (copayments can become prohibitive to many women, particularly if they are paying for frequent visits for multiple family members) availability of services not covered under their insurance, concerns about confidentiality, particularly in cases of domestic violence and reproductive care. Because plans will often not reimburse community health centers for services provided to their members, the utilization of these facilities and services by individuals covered by insurance plans results in “cost-shifting” from plans. The fact that over half of the plans participating in the above mentioned study indicate that they “intend to contract with these clinics in the future” points to a potential improvement in both financial and programmatic integration of these service providers as options for members of managed care plans.

3. Confidentiality
One area in which managed care financial arrangements are very beneficial relative to indemnity arrangements is in the protection of patient confidentiality. While most indemnity plans involve a “bill” for services which is submitted to both the primary plan holder and the employer, most services provided by HMOs and Point of Service (POS) plans are provided without a bill or invoice. This can pose an important confidentiality issue for women, as many women are covered as “dependents” on their spouses’ plans, and a report on any services they receive under an indemnity plan is automatically mailed to the primary plan holder. Many women and adolescents will seek certain services (domestic violence or reproductive health services in particular) only if they can be assured that they are doing so in a confidential environment. For some individuals this may imply that the plan offers them the option of seeing providers outside of the network or providers other than those who serve their family members.

V. Conclusion
Integration issues and examples present many challenges for those working to improve the managed care system, particularly for those concerned about how it can more effectively serve the needs of women and lead to improved health status for women and those family members whose care they oversee. 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 truly reflect the issues the comprehensive health needs and health-seeking behavior patterns of women.

Managed care organizations interested in attracting and retaining members in an increasingly competitive market are attempting to design systems that allow for integration of care at the member level. By applying a combination of population health principles, effective use of the primary care team, and customer segmentation and outreach, several HMOs are attempting to move to a more consumer-focused model of care.

The model managed care plan would focus on using demographic and encounter information to identify patients in need of specific care or services and proactively reach members with the information and assistance necessary to ensure that they get the care they need. By offering preventive services with minimal cost sharing, the ideal managed care plan would remove an important financial barrier to an enrollee’s receipt of recommended preventive screenings and care activities. Finally, the plan would consider how the primary users of services—women—can best access services once they are made available. Responses might be as simple as expanded clinic hours, locations and provider types and as complex as “case management” to coordinate a woman’s multiple needs or the needs of all of the family members for whose health care she is responsible. Some managed care organizations have begun to develop innovative approaches to the challenges of integration and coordination of care, and should be encouraged to work

38 Ibid., p. 24.
in partnership with consumers, clinicians and other advocates for women’s health to incorporate the
diverse and important needs of women into these improvements.

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.

A. Principles
• 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.
• Comprehensive primary care addresses both biomedical and psychosocial factors in health and
wellness.
• Provision of comprehensive primary care and coordinated care of chronic diseases will improve
health status and outcomes.
• 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 integrat-
ing 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 specifi-
cally 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-referring 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 repro-
ductive 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, whether 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.
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/La Jolla Thornton 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. This preeminence in research 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.  

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B. Transition of the Health Delivery System
AMCs provide 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 managed care 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. Financing
A. Overview of Finances
Traditionally, AMCs have funded a significant portion of their missions through cross-subsidies. The affiliated hospital and faculty practice plans (FPPs) provide support for various mission-related activities through the revenues they receive for providing patient care. In some cases, the support may be explicit, for example, taking the form of government payments for the salaries and fringe benefits of residents and faculty. In other instances, the support may be in forms other than cash, such as space for teaching or research laboratories. AMCs are concerned that recent demands by government, employers, and consumers to slow the growth in spending may threaten the ability of AMCs to continue to finance their missions using these traditional cross-subsidies.

No California AMC publishes a consolidated statement of total revenues and expenses. Audited California-specific data is collected for AMC hospitals by the California Office of Statewide Planning and Development (OSHPD), but audited data does not exist for the medical schools or the FPPs for California. Nationwide AMC data is only available through 1994. However, since this time, purchasers and government have become increasingly more aggressive in controlling costs, so caution should be exercised when extrapolating these findings.
Although the cost-contained environment is resulting in financial pressure on AMCs as their contract rates decline, through 1994, on a nationwide basis these institutions found ways to manage both their revenues and expenses, to maintain if not actually improve their financial status. In 1994, nationwide AMC hospitals had total margins of 3.7%. Margins were higher across the country in 1994 than in 1989. It is interesting to note that the margins of AMC hospitals in competitive markets were higher than AMC hospitals in markets with low levels of HMO penetration. This suggests that hospitals in competitive markets may be working aggressively to reduce costs in order to maintain their margins, while hospitals in less competitive markets may not yet have seen the need to do so. Average margins were 5.6% for UC’s AMC hospitals in 1994, higher than the national average. Nationwide data is not available beyond 1994, and the market has grown increasingly more competitive since then. California-specific data is, however, available through 1997 for some institutions. For example, for the period of 1993 through 1997, the UC system’s average margins were 4.4%, although UC San Diego and UC Irvine hospitals lost $20 million and $14 million respectively in 1996.

AMC hospitals have been able to increase their average margins by restraining the rate of growth in costs below the rate of growth in revenues. Also, during 1989-1994 Medicaid established policies for additional payments, generally referred to as “Medicaid Disproportionate Share” payments, that substantially increased Medicaid payment rates to hospitals. In addition, the maintenance of Medicare’s indirect medical education (IME) payment has enabled major teaching hospitals to maintain higher inpatient margins on their Medicare business (15.6%) than any other group of hospitals. However, the Balanced Budget Act of 1997 has put in process a substantial reduction in the subsidies for teaching purposes, which will decrease the profit margin from Medicare for teaching hospitals. Also, there is evidence that market forces are reducing margins in AMC hospitals in competitive locales. The margins of AMC hospitals in markets with high levels of HMO penetration fell from 4.6% in 1985 to 3.0% in 1993.

B. Data Analysis

According to the data, it appears AMCs were financially stable, at least through 1994. However, it is hard to be certain, as non-existent, contradictory, fragmented, and inaccurate data tells an inconclusive story about California’s AMCs. One of the most problematic parts of the data relates to the FPP revenues. The American Association of Medical Colleges (AAMC) when presenting its findings on medical school financing, indicated that although FPP revenues appear to be increasing, some of the “increase” in revenues is not an increase at all, but simply more accurate capturing of clinical income. The report indicated that these revenues have historically been underreported by an amount that has in some cases been substantial. Historically, FPP data was maintained by each clinical department independently, and there was no cohesive aggregated data at any institution.

Another problem with AMC data is that it is very difficult to identify revenues and expenses related to their various missions. AMCs have grown in terms of their dependence on clinical revenues. These revenues are used to cross-subsidize education, research, and care for the uninsured. In addition, funding streams coming from outside the organization are often used to support multiple missions. For example, the Medicare IME subsidy supports the indirect costs of medical education, but also helps support care for the uninsured. Funding for these missions has been implicit versus explicit, and most AMCs do not have an accurate understanding of the sources and uses of funds related to the various missions.

In addition to the fact that many of the funding streams that exist are not targeted, they also may contain perverse incentives. A good example of the perverse incentives that were built into the system is the

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4 Ibid.
5 "University of California Teaching Hospitals Quarterly Report, March 31, 1997,” Prepared by the Office of the Senior Vice President of Business and Finance.
recently modified Medicare GME funding. While there is little doubt that specialists are in oversupply, up until this year the federal government still subsidized GME with over $6.5 billion annually, most of which went to train more specialists. Until recently, many teaching hospitals have been reluctant to cut back because every resident translates into an average Medicare GME subsidy of $100,000 per year.8 "It has not been financially rewarding to downsize," said Muncey Wheby, Associate Dean for Graduate Medical Education at the University of Virginia.9 The new federal budget agreement has redesigned the Medicare GME subsidy, and now will pay AMCs to gradually decrease the number of young doctors they train.

Although these institutions are finding ways to manage if not actually improve their financial status, some of the changes that are taking place have the potential to affect the extent to which they are able to continue to perform their missions on the previous scale. Several areas of particular concern are deserving of future monitoring and research. First, clinical revenues per faculty member have been increasing nationwide, supporting the hypothesis that faculty are being asked to increase their revenue-raising, clinical activities. However, there is very limited evidence about the impact of increasing dependence on faculty clinical activities on either the quality or quantity of the educational or research missions. Second, the public AMCs that provide a disproportionate share of uncompensated care in the state may be particularly vulnerable as a result of the mainstreaming of Medi-Cal enrollees into managed care and a reduction in their paying patient base. Third, the position of AMC hospitals in their local markets is bad and getting worse. Other hospitals are restraining costs more effectively, widening the gap in costs per case. AMC hospitals must reverse this trend in order to attract privately insured patients.

C. Funding
In the past, AMCs used clinical revenues generated from hospital and FPPs to cross-subsidize their teaching and research missions. Revenues were generated by charging above-cost prices to insured patients. 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 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.

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.

III. Graduate Medical Education and Physician Supply
Unlimited growth in GME—principally fueled by unrestrained federal support—has apparently led to a physician surplus. In addition, there has been a fundamental shift in the ways in which physicians are incorporated into the system. This has restricted the employment of specialist physicians. Experts predict that this rationalization will continue over the next decade. Nevertheless, shortages of physicians persist in inner-city and rural areas, and there are limited training settings available in these areas for residents.

Regardless of the financing system in place, physician oversupply presents an important public policy issue. The Task Force’s Health Industry Profile paper presents the comprehensive statistics regarding physician supply, and some of the key findings, prepared with the assistance of the UCSF Center for Health Professions, are summarized below:10

9 Ibid.
• California has more than an adequate supply of physicians,
• Patient care physicians are poorly distributed across the state, excess supply in some regions accompa-
  nies shortages in others,
• California has more specialists than it requires,
• Most regions in California have inadequate to barely adequate supplies of primary care physicians, and
• Curriculum design does not focus on managed care and integrated settings or on team training and
cross-professional education.

As stated earlier, Medicare GME has recently been reformulated to pay AMCs to downsize their residency
training programs. However, even before implementation of this program, JAMA’s annual survey of GME
programs showed a reduction in the number of first-year residents in most major specialties and sub-
specialties.\textsuperscript{11} Minor reductions were initially noticed last year, but by 1997 the decreases were significant.
Nearly all the specialty residency programs that had difficulty placing their graduates for two consecutive
years reported at least 10\% fewer first-year residents than in 1994. More importantly, disciplines without
employment difficulties also reported downsizing, perhaps in anticipation of reductions in federal fund-
ing sources.

Competition for primary care physicians by health plans has led to increased wages in the field, and to a
narrowing of the income differential between specialists and primary care compensation in California.
Consolidation has also resulted in downsizing of specialty units. Specialists are suddenly having a hard
time finding jobs, and the word is filtering down. In 1994, 10 of 12 graduating anesthesiologists at UC
Davis were unable to find jobs in California.\textsuperscript{12}

Declining employment opportunities are not the only factors contributing to the shift in California’s
residency programs. In an agreement between the Governor, the Legislature, and UC, signed in May of
1994, UC agreed to develop a plan for increasing the emphasis on and resources dedicated to the training
of primary care physicians, and to implement the necessary offsetting reductions in specialty programs as
well. Collectively, these changes are expected to shift, by the academic year 2001-2002, the University’s
system-wide distribution of primary care and specialists to 53.5\% and 46.5\% respectively.\textsuperscript{13} In addition to
working with the AMCs, the state has passed legislation favoring the expansion of primary care. In 1993-94
the legislature passed a bill that required physicians to complete a family practice clerkship in order to
receive a California license.

However, neither the government nor the market seem to be able to significantly reduce the problem of
geographic mal-distribution. If AMCs train more primary care providers, many assumed their availability
would “trickle down” into rural areas and underserved urban areas once the “popular” markets are saturated.
Unfortunately this does not seem to be happening. The number of communities designated by the federal
government as health profession shortage areas rose sharply through 1995.\textsuperscript{14} In California, the federal
government has indicated that 124 inner-city and rural areas across the state have shortages of generalists.

In regards to curriculum, both young physicians and industry leaders report that the current system of
medical education is not preparing graduates for this new practice environment.\textsuperscript{15} Managers of HMOs
estimate that an additional one to two years of experience is required to prepare graduates of US residen-
tes for practice in a managed care environment.\textsuperscript{16} Some HMOs, such as Boston’s Tufts Associated Health

\begin{footnotesize}
\textsuperscript{12} Sparer M, “Laboratories and the Health Care Marketplace: The Limits of State Workforce Policy,” Journal of Health Politics, Policy
and Law, June 1997.
\textsuperscript{13} Memorandum of Understanding Between UC and OSHPD, 1993.
\textsuperscript{15} Veloski J, et al., “Medical Student Education in Managed Care Settings,” and Blumenthal D, and Their S, “Managed Care and Medical
Education,” JAMA, September 4, 1996.
\textsuperscript{16} Shine K, “Educating Physicians for the Real World,” Urban Medical Centers: Balancing Academic and Patient Care Functions,
\end{footnotesize}
Plan, have gone so far as to create their own managed care training institutes. Educational programs are not current in terms of focusing on intensively managed and integrated settings or team training.

IV. Research

Many are concerned that serious challenges to continued rapid progress currently face the research enterprise. The most serious threat comes from the possibility of simultaneous reductions in all of the revenue streams that have traditionally been provided in support of biomedical research. Efforts to balance the federal budget, strategies to contain prices in the health care marketplace, and increased price competition in the pharmaceutical industry all threaten the availability of funds for biomedical studies, which includes both basic and clinical research studies. Clinical research is likely to witness the greatest detrimental impact from these converging forces. This is due to the fact that clinical research has been more dependent on cross-subsidies from health care revenues. In addition, some clinical research participants have shifted from traditional centers of research activities (i.e., AMCs) to managed care, and clinical researchers have been less successful in garnering federal support than have basic researchers. By recent estimates, only 10% to 15% of National Institutes of Health (NIH) funds are currently allocated to support clinical research.17

The impact of managed care on clinical research has been a topic of concern, not only from a financial perspective, but also in terms of its potential to both impact the research agenda pursued by investigators and to retain research subjects. Some of the primary issues identified with managed care follow:

**Utilization Review**
- Reduced length of stay
- Limitation of coverage for diagnostic tests
- More stringent limitations or denial of coverage for experimental treatments

**Selective Contracting**
- Reduced patient flow if AMC not in network

**Primary Care Gatekeeper**
- Reduced patient flow to specialists

**Payment Rate Negotiation**
- Funding streams directly tied to clinical revenues, and ability to cost-shift removed
- Pressure on physicians to increase productivity leads to less time for clinical research

Two studies recently published in *JAMA* attempt to measure several of the perceived problems mentioned above. The results of the first study indicate that faculty research, clinical activities, and perceptions of departmental climate were significantly related to the competitiveness of local markets. The study found that in competitive markets the rate of publication for clinical researchers decreased, the percentage of young faculty with patient care responsibilities was greater, and lower levels of departmental cooperation were perceived by faculty. However, the study also stated that the percentage of senior faculty with patient care responsibilities remained the same, and that there were no significant differences in the amount of faculty-student contact by market stage.18 The second study provides evidence of an inverse relationship between growth in NIH awards to clinical departments and managed care penetration among AMCs.19 Whether this association is causal remains to be determined. However, this study was criticized as being misleading by the American Association of Health Plans (AAHP) because the authors did not investigate whether the slowed growth reflects changing national research priorities or if awards were going to other institutions in those communities.

18 Campbell E, et al., “Relationship Between Market Competition and the Activities and Attitudes of Medical School Faculty,” *JAMA*, July 16, 1997.
Although the limited studies and current trends prompt concern that clinical research may face difficulties in the future, no evidence collected through 1995 clearly demonstrates that the observed changes in health care financing are having a significant impact on activity in this area. (However, as noted earlier, this situation is changing rapidly, and to some in AMCs, 1995 appears to be a long time ago.) This sentiment was also echoed by clinical researchers in a recent study prepared by The Lewin Group to identify the impact of managed care features on clinical research. In a series of site visits and interviews with clinical researchers at several research-intensive AMCs, including those in California, it was determined that managed care has had limited impact on clinical research through 1995. The level of research had not decreased, nor had UR procedures had a significant impact on patient availability for clinical protocols. Also, in practice, many MCOs exhibit substantial flexibility about covering experimental therapies or paying for patients enrolled in clinical trials. Again, researchers expressed concern about what the future might hold based on their observations about managed care.

The ability to cross-subsidize clinical research through clinical revenues may be adversely impacted. However, observable events and trends do not support some of the concerns expressed above and identify opportunities for improved performance in the clinical research area. In particular, several California AMCs have experienced increased patient volumes, as many community hospitals have discontinued provision of more complex and costly services. The MEDSTAT Group Analysis, commissioned by the AAHP, confirmed that capitated plan members are cared for in major teaching hospitals. Overall, capitated plans admitted a higher percent of total admissions to major teaching facilities and a lower percent of admissions to non-teaching facilities when compared to FFS plans in 1994. Furthermore, capitated plans pay such hospitals more than they pay non-teaching facilities. Higher payments may be a reflection of AMCs market power in that managed care plans need to include them in their networks, or they may be a reflection of the higher costs associated with teaching and uncompensated care. Some AMC administrators have reported that the strong name recognition and status of their institutions may be worth 5% to 10% higher fees from managed care plans. In addition, one of the most important developments related to support for clinical research occurred in June of this year when the AAHP Board voted to establish an industry-wide relationship with the NIH to increase opportunities for health plans and their enrollees to take part in clinical research and to contribute to a national dialogue about health research needs. The AAHP stated that it supports providing patients with access to NIH-approved clinical studies and supports individual health plans’ linkages with NIH-sponsored clinical trials. The AAHP board believes participation in research offers the following opportunities: improving the quality, feasibility, and relevance of research by including a larger number of health plan enrollees; increasing choice available to enrollees to participate in studies of innovations in care; and strengthening existing relationships and establishing new partnerships with institutions involved in clinical research, such as AMCs. Currently, managed care organizations produce, sponsor and serve as partners in a variety of clinical research projects. For instance, a consortium of 10 not-for-profit health plans supports studies ranging from the mechanisms of disease to the impact of service delivery on treatment outcomes.

Finally, proponents of managed care have argued that managed care has had a very positive impact in terms of creating a broader, more health-focused and cost-benefit based research agenda. Managed care organizations provide a focus on maintaining health and preventing disease. This perspective has encouraged others in the medical community to examine these issues, which are important not only to cost containment, but also to the overall health of the nation.

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21 Ibid.
22 Personal interview with UC Office of the President and Stanford Medical Center.
23 "Revised Study Confirms that Health Plans Make Higher Payments to Teaching Hospitals," MEDSTAT Group Analysis for AAHP, June 1997.
24 Ibid.
27 Op Cit., "Interim Report of the NIH Director's Panel on Clinical Research (CRP)."
V. Clinical Care for Uninsured Populations

AMCs' main concerns about a more competitive health industry regarding uninsured, under-insured and low-income individuals who have limited access to health care services are related to funding and resident services. As with their other missions, a key form of support of the cost of care to vulnerable populations by AMCs has been through cost-shifting from private payors. Government price controls through Medicare, Medicaid and managed care eliminate the ability to do this. In addition, teaching hospitals rely on residents' services, and more importantly on the GME subsidy that accompanies them, to cross-subsidize health care to this population. With the pressure to reduce the residency positions at AMCs, this funding source is in jeopardy. These are some of the major contributing factors that are threatening the safety-net teaching hospitals such as U.C. Irvine and U.C. Sand Diego and explain their financial losses in 1996.

Results of a RAND study on uncompensated care suggest that much of the uncompensated care burden in California is concentrated within urban public hospitals and major public teaching hospitals. Major public teaching hospitals provide triple the amount of uncompensated care relative to their share of the overall hospital market. Some AMCs which serve a large share of the Medicaid population have absorbed an even bigger share of the uncompensated care burden in recent years. The implications are serious for Medi-Cal recipients being shifted into managed care settings. HMOs serving Medi-Cal patients are ratcheting down hospital payment rates and utilization, and the mainstreaming of Medi-Cal recipients is reducing the paying patient base of traditional indigent care providers, leaving them without a common source of funds used to support uncompensated care.

I. Introduction
California has led the profound and rapid national transformation of health care financing and delivery systems since the 1970s. Although federal and state regulatory statutes facilitated some of the shift from traditional, fee-for-service “indemnity” insurance to pre-paid managed care coverage, economic conditions and competition have driven the movement toward more cost-conscious care. As these changes have played out in California, consumer interest in and concern about the health care system has escalated. Significant public concern has emerged on topics such as how to appropriately limit the proportion of national resources devoted to health care, how and by whom decisions about treatment are being made and how health care organizations are spending the public’s premium dollars.

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, and discusses industry trends. This analysis focuses on managed care in California but presents indemnity insurance and national information for context. This paper is not intended to be comprehensive, and more detailed descriptions of many issues can be found in separate Task Force papers.

II. Managed Care: Its Source and Growth
In its broadest definition, managed care is characterized by selective provider contracting and a defined list of benefits. The industry defines two general managed care categories: health maintenance organizations (HMOs) and preferred provider insurance PPI arrangements, commonly referred to as preferred provider organization (PPOs). While these two mature models of managed care are well established, many other innovative models are developing rapidly. California has one of the highest overall managed care penetration rates in the country, with nearly 14 million HMO enrollees in 1996. Of those Californians who receive insurance through employment, 63% are enrolled in HMOs, 7% in POS plans, 23% in PPI and 7% in indemnity plans. Thus, in the private sector, most insured Californians are enrolled in some form of a managed care plan.

A. Origins of Widespread Health Insurance
Although the antecedents to modern health insurance began in the nineteenth century, health insurance did not become a large-scale enterprise until World War II. During the war, when wages were frozen and employers sought ways to attract employees, the government permitted employer-paid health insurance to be excluded from the limits on wage increases and the taxable incomes of employees, effectively subsidizing employer-purchased 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 (Federal Employees Health Benefits Program, 1960), senior citizens (Title XVIII of the Social Security Act, 1965), and certain categories of “deserving poor” (aged, blind, disabled, families with dependent children) and poverty criteria (Title XIX of the Social Security Act, 1965). From 1940 to 1970, the number of Americans covered for at least hospital expenses rose from approximately 12 million to 159 million. (Over this same time period the U.S. population grew from approximately 132 million to approximately 203 million.)

1 Various sources rank California from first to fourth in the nation in managed care penetration.
2 California Association of HMOs, CAHMO, (now California Association of Health Plans, CAHP) 1996 Enrollment Survey of Plans.
3 Information provided by T Rice; based on KPMG data collected for the KPMG Survey of Employer Sponsored Health Benefits, 1996.
5 Statistical Abstract of the United States, 1996. Over this 30 year span, coverage percentages rose from approximately 9% to approximately 78%.
Widespread health insurance was welcomed by covered individuals, insurance companies, and providers. For covered individuals, insurance reduced the fiscal exposure of a serious medical incident. Insurers favored employer-sponsored coverage because the resulting grouping of employees resulted in a broader distribution of risk. Finally, providers welcomed insurance coverage because it resulted in an increased likelihood that they would be paid.

B. Economics of Health Insurance

From an economic perspective, however, insurance added complexity to a marketplace by distorting the fundamental laws of supply and demand. In the absence of health insurance, a patient would negotiate directly with the provider to determine the care plan, price and volume of services. In a “100% insured” situation—where the enrollee is not responsible for deductibles or copayments, he or she pays a fixed premium “up front” and does not face further cost decisions, distorting the “demand side” of the equation—the enrollee generally wants as much care as might help his or her condition even if its benefit does not outweigh the total cost of providing the care. This price insensitivity was further accelerated after World War II when employers routinely began to pay the premium on behalf of their employees, making the cost of care very distant from the consumer.6

Payment through insurance also renders the provider (supply side) price insensitive to the cost of care. Because unmanaged insurance assures that most or all services will be reimbursed, the provider no longer must negotiate directly with the patient and the economic process of balancing marginal benefit and marginal cost is eliminated.7 Theoretically, insurers might negotiate with providers to bring supply and demand into as close a balance as possible. However, until the early 1970s a power and information imbalance across the health care industry resulted in inevitable market failure. In addition, insurers had little motivation to negotiate, because they were able to pass cost increases through to employers. Employers were not very concerned with health cost increases, particularly because health benefits enjoyed tax-favored status and health care costs remained relatively low.

C. Health Insurance in the Indemnity Era

Prior to the 1970s, virtually all health insurance was based on the indemnity approach, which basically operated as a “cost-reimbursement” model under which providers were compensated based upon services delivered. This paper and all the Task Force papers use the term “indemnity” to describe all of the traditional, unmanaged fee for service, indemnity.

Under an indemnity arrangement, expenditures increase if: (1) providers’ fees increase, (2) more units of service are charged, or (3) more expensive services are substituted for less expensive ones. Providers were free—and encouraged by their training and societal norms—to determine treatment levels and standards of care without economic restraint. Under the indemnity system, individuals were responsible for choosing their own provider or providers, and often relied on a personal or family doctor to assist with referrals for specialty care. Two main types of health insurance characterized the indemnity era. Commercial insurance companies offered “indemnity” and “major medical insurance.” The more common indemnity insurance was modeled after casualty insurance, had no contractual link to providers, and based fee schedules on “usual, customary, and reasonable fees.” Under an indemnity plan, the insured party customarily contributed “coinsurance” representing a portion of the cost of services received in addition to a monthly or annual premium. Major medical insurance was frequently purchased as an “add-on” and typically covered most or all costs after a patient’s out-of-pocket expenses reached a certain limit.

The other insurance providers active during this period were the large, provider-sponsored non-profit Blue Cross and Blue Shield plans that were unified through the National Blue Cross and Blue Shield Association.

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6 Consumers’ premiums essentially reflect the average usage from the prior year’s risk pool, plus factors for inflation, overhead, profit and expected utilization.

tion (the “Blues”) and offered “service benefit” insurance. Regional Blue Cross plans contracted with hospitals, and Blue Shield contracted with physicians. Both insurance entities negotiated favorable reimbursement arrangements and enrolled as many providers as possible. The Blues maintained provider bargaining power against other insurance companies. By supporting freedom of choice of provider for enrollees, the Blues essentially made it impossible for commercial insurers to contract with providers selectively. Providers determined patients’ treatment options without oversight from insurers during the era in which most health insurance was provided through the indemnity model. Physicians predominately operated solo practices or were affiliated with academic medical centers and had little interaction with insurers; referrals were generated through professional relationships and reputation.

Despite the fact that the Blues had tremendous power in determining the costs and type of health care delivered during this time period, a few alternative organizational models had begun to provide health care with an emphasis on cost-effectiveness by the early 1970s. These organizations, known as prepaid group practices (“PGPs”) sought to band physicians together to provide coordinated care at a discounted, prepaid amount for individuals or employer groups who were willing to contract exclusively with them. What is broadly acknowledged as the first health maintenance organization (HMO) had its origins in the 1930’s in medical care programs designed to care for workers in Henry J. Kaiser’s industrial enterprises. This HMO and another early PGP plan combined multi-specialty group practice, per-capita prepayment, voluntary enrollment and physician responsibility for the management of care. The PGP concept became more popular as health care inflation continued to rise. Independent practice associations (IPAs) emerged in the late 1960s to compete against PGPs, which were beginning to capture significant business in select markets because of their cost-effectiveness and comprehensive coverage. (The characteristics of group, IPA and other health maintenance organization plan types are discussed in greater detail below.)

D. The Rise of Managed Care

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. The cornerstone of the strategy was the creation and fostering of competition among a group of HMOs, which he conceived of as non-governmental, comprehensive care organizations. These organizations would control spiraling health care costs through a range of management tools and techniques, such as emphasizing prevention and health promotion, coordinating the activities of a range of health care providers, and managing utilization of diagnostic tests, specialists and hospital beds. At a more conceptual level, the contrast between medicine practiced under an indemnity system and health care provided under an HMO would be a shift in the focus of the health care delivery system from episodic care for an individual to coordinated care for an individual.

In 1973 Congress passed the HMO Act which (1) defined HMOs as being either the group practice or the individual practice variety; (2) provided grants and loans to help start non-profit HMOs; (3) required that all employers with 25 or more employees that offered traditional indemnity insurance to offer employees the choice of one group practice and one individual practice HMO as alternatives to traditional health insurance if such HMOs served the areas where their employees lived and requested inclusion; and (4) over-ruled state laws that inhibited HMO growth. The Act passed despite the opposing interests of such groups as the “Blues” and the American Medical Association.

Although HMOs grew in number and power after 1973, traditional indemnity insurance still dominated the landscape. Health care costs during this period continued to dramatically outpace inflation. Seeking to bring escalating health care costs under control, some employers proposed to continue to offer employees the traditional fee for service coverage, but to do so with selective provider contracting. Under this modified fee for service scheme, employees would be encouraged to accept the narrower provider panel through financial incentives. Employers would be able to create economies by negotiating prices and utilization

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controls (discussed more below) with providers. But until 1982, compliance with principles of so-called "guild free choice" which was advocated by the Blues and medical associations, precluded development of this kind of insurance in most states. In 1982, in a major legislative battle in California, employers, insurers and labor unions worked together to secure the enactment of new legislation (AB 799 and AB 3480) permitting Medi-Cal and private insurers to contract selectively and pass the savings on to the purchasers. Most other states followed. This legislation authorized Preferred Provider Insurance (PPI), the other predominant form of managed care. While both of these laws were critical to the initial development of managed care, economic and competitive developments have been the primary driver of its growth.

It was not until the late 1980s that the cost pressures on employers and government really forced a proliferation of managed care across the nation. Figure 1 identifies the steady increase in the percentage of the gross domestic product spent on health care, illustrating why health care has become such a crucial area for reform. Figure 2 compares per capita health spending for California and US from 1984 to 1994. California fell below the national average in per capita spending on health in 1993 due to a lower rate of cost increase, which was largely attributable to higher managed care penetration level.\footnote{Congressional Budget Office, "Trends in Health Care Spending by the Private Sector," Washington, April 1997, p. 19; Welch WP, "HMO Market Share and Its Effect on Local Medicare Costs," HMOs and the Elderly, Health Administration Press, Ann Arbor, MI, 1994; Robinson JC, "HMO Market Penetration and Hospital Cost Inflation in California," JAMA, 266 (20 November, 1991): 2719-23; Zwanziger and Melnick, "Costs and Price Competition in California Hospitals, 1980-1990," Health Affairs, Fall 1994.}

![Figure 1: National Health Expenditures as a Percent of the Gross Domestic Product](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>NHE as %GDP</th>
<th>Avg Ann %Chg NHE</th>
<th>GDP ($ Billion)</th>
<th>Avg Ann %Chg GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>5.1%</td>
<td>–</td>
<td>$527</td>
<td>–</td>
</tr>
<tr>
<td>1970</td>
<td>7.1%</td>
<td>–</td>
<td>$1,036</td>
<td>–</td>
</tr>
<tr>
<td>1980</td>
<td>8.9%</td>
<td>–</td>
<td>$2,784</td>
<td>–</td>
</tr>
<tr>
<td>1990</td>
<td>12.1%</td>
<td>–</td>
<td>$5,744</td>
<td>–</td>
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<td>12.9%</td>
<td>–</td>
<td>$5,917</td>
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<tr>
<td>1992</td>
<td>13.4%</td>
<td>–</td>
<td>$6,244</td>
<td>–</td>
</tr>
<tr>
<td>1993</td>
<td>13.6%</td>
<td>9.5%</td>
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</tr>
<tr>
<td>1994</td>
<td>13.5%</td>
<td>6.3%</td>
<td>$6,936</td>
<td>5.2%</td>
</tr>
<tr>
<td>1995</td>
<td>13.6%</td>
<td>6.1%</td>
<td>$7,254</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

Source: HCFA Office of the Actuary: Data from Office of National Health Statistics

![Figure 2: Per Capita Health Spending in California and US: 1984–1994](image)

As managed care has expanded and become a fact of life for a large percentage of the population, regulatory interest and activity have intensified. Following is an overview of the regulatory environment of health care in California. (See the Task Force report Government Regulation and Oversight of Managed Health Care.)
A. Current Regulation in California
The operations of health care service plans and other managed care organizations are regulated and 
overseen by a broad range of entities, both governmental and private.

- The Department of Health Services (DHS) contracts with some health care service plans 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 
  used by managed care organizations.

- The Department of Industrial Relations (DIR) oversees managed care organizations offering man-
  aged care services for work-related injuries and illnesses.

- The Medical Board of California, under the Department of Consumer Affairs (DCA), licenses health 
  professionals who work for managed care.

- The Managed Risk Medical Insurance Board (MRMIB) contracts with many managed care organiza-
  tions involved in Access for Infants and Mothers and The Health Insurance Plan of California (HIPC).9

- The single largest customer for many health care service plans (i.e. HMOs regulated by the DOC) 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 health professionals, facilities, and non Knox-Keene 
regulated 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 by the Knox-Keene plans with which they contract as a requirement of the health care service 
plan’s licensure. Medical groups wishing to accept fully capitated contracts, must receive “limited licen-
sure” 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.10

The private sector supplements these state and federal regulatory functions through a variety of quality 
measurement and accreditation mechanisms and organizations that assist employers and consumers in 
evaluating their purchases by providing information. Their products, as well as the products of managed 
care organizations’ internal quality programs are also 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 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.

1. Government Regulation
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 Health Care Service Plan Act of 1975 (“the Knox-
Keene Act”), a portion of the Health and Safety Code, governs health care service plans and is enforced by

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9 MRMIB will also have oversight responsibility for the state’s “Healthy Families” program.
10 For example, one California hospital provided the Managed Care Improvement Task Force a list of 17 federal and 27 state agencies and 
organizations that have some regulatory or oversight authority over it.
the Department of Corporations (DOC). These two bodies of law, which contain many similar provisions denote financial standards, contractual requirements, quality assurance programs, required grievance and appeals processes, oversight of soliciting and marketing practices, and mandatory basic benefits.

The Knox-Keene Act contains specific requirements for health care services plans in numerous areas. For example, the Act requires health plans to file extensive documentation on their proposed health care delivery systems prior to licensure. Health care service plans must file copies of their contracts with network providers, and must include maps illustrating where provider facilities and offices are located to ensure that licensed facilities and professionals are within 30 minutes or 15 miles of the enrollees' workplace or residence. They must provide documentation regarding the ratio of full-time equivalent physicians to anticipated enrollees to demonstrate that the number of specialists will be adequate to serve the expected population of enrollees; provide descriptions of the plan's quality assurance program, grievance and appeals processes; and delineate provisions for continuity of care as a patient moves through the health care delivery system. The licensing application also requires detailed financial information to ensure regulators that the health plan's management has realistic projections about costs and revenues and to ensure that the plan has enough reserves to cover all claims costs.

Once a health plan is licensed, the Knox-Keene Act requires the plan to submit quarterly and annual financial statements and to maintain reserves or “tangible net equity,” sufficient to cover outstanding claims. Plans also undergo regular financial audits, and may be placed under closer examination if their financial reports indicate problems.

2. Regulation Through Consumer Protection Legislation
One of the most fundamental tasks of government is to create the conditions for markets to serve consumers well. These conditions include the rule of law, including securing property rights and defining liability, licensing facilities and professionals, contract enforcement, anti-trust enforcement and a regulatory scheme that fits the needs of each market. Government has been active in defining, and to a much more limited extent securing, patients' rights under health care coverage contracts. Examples include free expression of medical judgments by doctors (“anti-gag clauses”), information about how plans operate, timely payment for care for emergencies, and confidentiality of personal medical records.

The Knox-Keene Act contains extensive requirements in the areas of consumer protection relating to patient care. The Act requires all health care service plans to have grievance and appeals processes that allow enrollees to submit disputes to the plan and receive a timely response, including expedited review of grievances involving serious conditions. The Act also allows enrollees to seek assistance from the DOC if they are unsatisfied with the plan's response. When a plan denies coverage for care, the Act requires that the plan must disclose to patients and providers the criteria or clinical basis for the decision upon request. The Act also contains requirements for an outside, independent review process for terminally ill patients who have been denied coverage for experimental treatments. Finally, the Act seeks to protect consumers by prohibiting unethical marketing and solicitation practices, such as using statements in advertising that are false, deceptive or misleading. All advertising and marketing materials must be submitted to the DOC for review prior to use.

3. Regulation Through Insurance Contracts
The Knox-Keene Act and its underlying regulations, which govern HMOs in California, sets comprehensive standards for the contracts between health care service plans and consumers. All contracts between plans and enrollees, plans and employers, and plans and providers must be filed with the DOC for review and approval, and must meet the statutory “fair and reasonable” requirement that is imposed. Specific requirements are spelled out. Health care service plans, for example, must cover all medically necessary basic health care services, which are defined to include care provided by physicians or other appropriately licensed health professionals operating within their scope of practice (hereafter “providers”), hospital care, emergency care in and out of the network (in accordance with a “prudent layperson” standard), urgent care in and out of the network, home health care, diagnostic tests, laboratory tests, preventive care, physical
therapy, speech therapy and occupational therapy. Other statutory mandates address preventive care for children, reconstructive surgery and prosthetics for mastectomy patients, medical transportation, screening and diagnostic tests for cervical cancer and osteoporosis, and medically necessary surgery for temporal mandibular joint disorder. These benefits are not subject to negotiation between plans and employers; they must be provided in any benefit package. There are also many mandatory “offers” requiring plans to offer to employers coverage for services such as diabetes education, acupuncture, special footwear, substance abuse treatment, infertility coverage and orthotics and prosthetics.

The Act also sets out specific disclosure requirements pertaining to these benefit mandates and includes additional disclosure requirements regarding exclusions, limitations and copayments, and provider payment arrangements. There are also specific contractual requirements for plan contracts with employers of fewer than 50 employees (small employers) prohibiting plans from refusing coverage or refusing to renew existing coverage.

Access
The Knox-Keene Act also addresses access to health care coverage. For example, the Act prohibits the use of genetic information in underwriting so that individuals with genetic predispositions to certain diseases cannot be denied coverage simply because of that predisposition. The Act also prohibits plans from denying coverage or services to individuals who are blind, who are physically or mentally impaired, who have conditions related to diethylstilbestrol, or for reasons related to the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age of an individual.

Quality Assurance
The Knox-Keene Act requires that every health care service plan have in place a quality assurance program that is designed to continuously review the quality of care provided, review problems and complaints, and design corrective action plans that prevent future problems. In addition, health care service plans undergo a medical audit every three years to determine whether they are meeting the requirements of the law regarding quality assurance as well as access to care, continuity of care, and provision of benefits. These audits include examinations of patient records and documents from quality assurance committee meetings to ensure that problems have been corrected in a systematic way.

The Knox-Keene Act prohibits any contractual requirements that would inhibit a provider from discussing treatment options with his or her patient and also prohibits incentive arrangements that would induce the delay, denial or reduction of medical necessary and appropriate care. State law also prohibits any termination or disciplinary action against a provider for advocating appropriate health care on behalf of a patient. The Knox-Keene Act and its underlying regulations also require that medical decision-making be separated from fiscal and administrative functions so that these functions do not hinder the medical decision-making process. When a claim is denied for clinical reasons and appealed, for example, it must be reviewed by a licensed professional with competency in the clinical area in question. And individuals who are hired to review claims may not be compensated on the basis of the number of claims denied or the dollar amount of the claims involved.

4. “Regulation” by Public and Private Purchasers
Large purchasers (such as the Health Care Financing Administration (HCFA), the California Department of Health Services (DHS), the California Public Employees Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), the Health Insurance Plan of California (HIP), and the University of California (UC)) are able to use their substantial expertise and negotiating power to deal effectively with some of the major concerns in our health care system for their populations. Cost and access to primary care providers and specialists of one’s choice are two examples of where large purchasers have had some success in making plans more responsive to consumer concerns. For example, managed care organizations have been innovating with new products that offer wider access to specialists, or point-of-service options for access to doctors outside a managed care network that are more acceptable to many consum-
ers. Well-organized, large purchasers have significant tools to make the market work better for consumers—tools that they have used only to a limited degree so far. The list includes:

- Creating equitable rules within which health plans\(^{11}\) must compete;
- Expanding the choice of plan at the individual level;
- Providing an incentive for health plans to offer value-for-money by (1) standardization of coverage contracts, significant reduction of market segmenting variation within sponsored groups to combat segmentation and to lower switching costs, (2) allowances for individuals to keep the full savings when they choose a plan with a lower premium, (3) creation of a “Super Directory” of doctors and hospitals so people can easily look up their preferred doctors and pick from among the HMOs with which they contract;
- Obtaining and publishing quality-related information that consumers can use to make better decisions and that clinical providers can use to improve their medical results; and
- Risk-adjusting premiums (e.g., as currently practiced by the HIPC) so that plans and providers have financial incentives to enroll and develop expertise in caring for even the most sick among us, reducing risk-skimming behavior.

Governments are also major purchasers of health care coverage. In 1995, government paid for 46% of health care services in the US. Its purchasing power—as well as its obligation to beneficiaries and taxpayers—is significant. In 1995, approximately 40 million Americans received Medicare benefits, 10% through managed care programs, and 14.3 million received Medicaid benefits, 32% under managed care.\(^ {12}\) About 3.5 million Californians are enrolled in Medicare, of whom about 30% were enrolled in HMOs in 1994.\(^ {13}\) About five million are enrolled in Medi-Cal of whom 23% were enrolled in HMOs in 1995.\(^ {14}\) In addition, the State of California created the HIPC to improve the market for small employment groups in the private sector, and is now creating a new program, with Federal support, to cover 580,000 children of low-income families.\(^ {15}\)

5. Industry “Self-Regulation”

In addition to the government and private sector regulations highlighted above, the health care industry has developed some “self regulation” mechanisms. For example, the American Association of Health Plans (AAHP) has developed a standards initiative called “Patients First” for AAHP member plans. A cooperative group consisting of the American Association of Retired Persons, Families USA (a consumer advocacy group), and several non-profit HMOs have proposed “Principles for Consumer Protection.” This alliance might help to create new standards for industry practice, which might eventually be ratified by legislation or regulation to make them applicable to all health plans.

B. The Regulatory Oversight Structure

The current regulatory picture of health care in California reflects both the broad range of entities with regulatory or oversight involvement in health care and the fact that legislation affecting health care has occurred over a long time frame.

Several specific elements of this regulatory picture should be highlighted to elaborate on the general industry profile. First, different state bodies regulate different types of health plans: the Department of Insurance (DOI) monitors all indemnity plans and insured PPOs, other than employer self-funded plans; the Department of Corporations (DOC) regulates all HMOs under California’s Knox-Keene Act of 1975;

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\(^{11}\) Throughout this document, “health plan” is used to describe health insurance arrangements, also known as health benefits financial intermediaries.


\(^{13}\) Health Care Financing Review, Medicare and Medicaid Statistical Supplement, Table 21, 1996, 225-226.

\(^{14}\) Interview, California DHS, Managed Care Division, 1997.

\(^{15}\) California DHS, Healthy Families Plan, August 1997.
Federal Regulatory Structure
(Federal HMO Act, Health Care Financing Administration, Department of Labor, Etc.)

California Regulatory Structure

Models of Health Care Delivery
HMO POS PPO FFS

Hybrids

Key Regulatory Agencies
1. Department of Corporations
2. Department of Insurance
3. Department of Health Services

Risk Taking Medical Groups

Financing
Health Coverage Companies

Risk Bearing Medical Groups

Providers
Physicians, Nurses, etc.

Facilities
Hospitals, Clinics, etc.

and the Department of Health Services (DHS) oversees Medi-Cal (state version of Medicaid) plans. Under the Federal Employee Retirement Income Security Act of 1974 ("ERISA"), the federal government preempted state regulation of employee benefits. Plans exempted from state regulation under ERISA are subject to federal regulation under the Department of Labor (DOL) only. Under the current regulatory framework, employers, under ERISA, are always free to provide coverage to their employees through unregulated self-insured arrangements, likely based on PPI arrangements. Thus they can escape benefit mandates, state premium taxes and HMO regulations under Knox-Keene.

IV. Managed Care: Variety, Techniques, Players and Challenges
A. The Health Care Delivery System Continuum
The health care financing and delivery system covers a broad spectrum of health benefits and financial intermediaries, ranging from the essentially unmanaged traditional indemnity approach to the closely managed HMO.

Indemnity PPI POS HMO Hybrids

Less freedom of choice
Less expensive

Greater freedom of choice
More expensive

16 Under the 1965 law, Medicaid is a joint federal/state welfare program in which federal law defines benefit minimums and pays a portion of the costs (federal participation ranges from approximately 50-75% depending on the nature of the cost and the relative wealth of the state); states have the option to provide a range of additional benefits for which federal "matching funds" are available. Medicare is a national entitlement plan and an amendment to the original Social Security Act of 1935; it is regulated and funded at the federal level, but state provision alterations can be requested through various codes.
• **Indemnity.** Under this traditional health insurance arrangement, a provider, hospital or clinic bills for each encounter or service rendered and the insurer reimburses the provider. Patients are free to see any provider(s) they choose.

• **PPI (Preferred Provider Insurance).** Preferred provider insurers contract with a selected panel of providers, who agree to accept discounted fees as payment in full in exchange for a higher patient load and to comply with reporting and utilization management. In this model, consumers have a choice of using participating (i.e. contracting) or non-participating providers; however, financial incentives are built into benefit structures to encourage customer utilization of participating providers. This control of patient populations gives the insurer negotiating power with providers while allowing consumers more personal control over provider choice and cost decisions.

• **POS (Point of Service).** Under the newest major type of health insurance, subscribers effectively enroll in an HMO, but preserve the option to seek care outside the network with a higher level of cost sharing. The costs of going “out of network” may be fairly substantial—deductibles of several hundred dollars and cost sharing of 20-30%. The popularity of these plans indicates that consumers are willing to pay to preserve the opportunity to exercise choice; experience to date has been that members of POS plans continue to receive the vast majority of their care from the HMO panel.17

• **HMO (Health Maintenance Organization).** An organized system that provides health care through participating providers in a geographic area and accepts the responsibility for providing or otherwise assuring the delivery of an agreed-upon set of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of persons. Providers or provider groups are reimbursed for services either through capitation—a predetermined, fixed, periodic payment made by, or on behalf of, each person or family enrolled regardless of the amount of care she or he actually receives—or through some variation on the indemnity arrangement. (See the Task Force “Provider Financial Incentives” paper.) Enrollees’ costs will be covered only if they stay within the HMO panel of providers and adhere to the plan’s referral and authorization rules. HMOs generally require copayments, a minimal payment made at the time of each visit, to help control utilization.18

• **Hybrids.** Any mix of provider practices, hospitals and/or health plans that competes for enrollees and uses some managed care techniques. New federal legislation is encouraging the formation of new models. One response from the DOC is to develop a “limited” Knox-Keene license with specific waivers. This “limited license” allows physicians and other providers to accept full risk from a licensed plan.

**B. Essential Managed Care Techniques**

Regardless of where they fall on the health care financing and delivery continuum, all managed care organizations employ techniques to control costs and quality. The descriptions below represent the “ideal” applications of these techniques; in practice, plans apply these tools with a wide variation in motivation, sophistication and success.

• **Utilization management/review,** which includes practice guidelines, gatekeepers and/or pre-authorization procedures, attempts to cut costs in the system through removal of unnecessary and ineffective resource consumption. It also seeks to identify and minimize practice variations through the description, communication and promulgation of best practices. Utilization management/review techniques and policies vary significantly across organizations, and are often at the heart of consumer concerns about and interest in the health care system.

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17 A 1994 study estimated that approximately 16% of enrollees in POS plans used the out-of-network option (Meyer and others, 1994, quoted in Zelman, The Changing Healthcare Marketplace, San Francisco: Jossey-Bass, 1996). Recent estimates of POS subscribers going out of network have been as low as 10%.

18 The Rand Health Insurance Experiment found that all types of service—physician visits, hospital admissions, prescriptions, dental visits and mental health service use—fell with cost-sharing. Adverse health consequences due to underutilization encouraged by cost-sharing requirements were concentrated among the sick poor. Newhouse J, et al., Free for All? Lessons from the RAND Health Insurance Experiment, Cambridge: Harvard University Press, 1993.
• Selective provider contracting by plans allows introduction of competition among providers and the ability to remove cost- or quality-ineffective providers and facilities.

• Negotiated fees contain costs through capitation payments, discounts (generally ranging from 20-40%), salaries or fee-for-service with “withholds” or bonuses (described in greater detail below). Currently, the federal government has legislated certain discounts for Medicare and Medicaid HMOs. Government attempts at “capping” payments in the 1970’s through price controls resulted in a higher service volume, which was then responded to with the development of the RBRVS.19

• Quality management refers to the use of process reviews, input selection, outcomes measures and patient satisfaction evaluations to improve the quality of care and create competitive advantages. It is a dynamic improvement process and is commonly known in health care and other industries as continuous quality improvement (CQI).

• Enrollee incentives can be negative or positive and range from not permitting any reimbursement for use of providers outside selected panels (as in HMOs) to encouraging preventive care. In the 1990s, many purchasers have reinforced payer plan incentives by making employees more responsible for premium differences, thus making the “end” health care consumer somewhat more price sensitive in his/her choice of plan. Proponents of enrollee incentives contend that the efficiency of the market could be significantly improved by aiming consumers with relevant information coupled with increased incentives to drive high quality, cost-sensitive choices.20

As evidenced above, managed care spans a broad range of coverage types and employs varied techniques to encourage cost-effectiveness. The variety of structure in delivery systems is explored more explicitly below and continues to evolve rapidly as economic, regulatory and market factors prompt differentiation and evolution.

19 The RBRVS, or “Resource Based Relative Value Scale” is a pricing system first instituted by the government under OBRA (1989). RBRVS was intended to reduce costs by putting in place a system more controlled than the “customary, prevailing and reasonable” fees convention of the Medicare payment system. RBRVS defined “relative” prices for physicians’ services as what would exist in an effective market system (i.e., where prices are proportional to marginal costs).


21 Although this table only lists use of principal managed care techniques, it should be noted that all health care financing and delivery systems may use the traditional FFS payment approach at times.
C. The Players: A Four-Tiered Structure for Analyzing Health Care Delivery

The four-tiered structure below 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 coverage for their enrollees, or "consumers"/patients, who ultimately receive care. The "payer" type determines how restrictive use of "providers" will be: indemnity has virtually no restrictions; PPI uses very limited constraints; POS encourages strong cost-consciousness and loyalty to an HMO panel of providers while retaining the "option" for choice; and HMOs restrict consumers' covered care to the specified and previously contracted providers.

**Figure 4: Four Tiers of Modern Health Care**

<table>
<thead>
<tr>
<th>Purchasers</th>
<th>Government, Employers, Purchasing Coalitions, Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payers</td>
<td>FFS, PPI, POS, HMO</td>
</tr>
<tr>
<td>Providers</td>
<td>Medical Groups, Independent Physician Associations (IPAs), Others</td>
</tr>
<tr>
<td></td>
<td>Primary Care, Specialty Care, Ancillary Care, Acute Care</td>
</tr>
<tr>
<td>Consumers</td>
<td>Patients</td>
</tr>
</tbody>
</table>

1. Purchasers

Traditionally, there have been three main purchasers of health care: the government, employers and individuals. In addition, purchasing coalitions have become significant players. Recent purchasing trends reveal that government has taken over a larger portion of responsibility for purchasing health insurance. Coverage by private employers has declined, as they have either stopped offering any health care benefits, stopped offering benefits to employees' dependents, or discovered other ways to minimize their portion of the health care burden (e.g. part-time workers, outsourcing). An increasing portion of the population is thus left potentially reliant on public funds—either through government-sponsored coverage or uncompensated care—for health care. Uninsured levels have steadily increased to over 15% nationally and nearly 20% in California despite cost containment and increasing government participation in health insurance through broader benefit range definitions for Medicaid.

Public Purchasers

Public sector expenditures include benefits for public employees and retirees (Federal Employees Health Benefits Program, FEHBP, and California Public Employee Retirement System, CalPERS), low-income Medicaid recipients (or Medi-Cal as it is termed in California), the Medicare population, the safety net (government reimbursement for care to uninsured, poor people), and other special populations such as veterans and native Americans. As mentioned above, the medical inflation rate for public sector care has outpaced that of private care in recent years.

**Figure 5: Public Expenditures, United States and CA, 1990 and 1994, $Billions**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>41.1</td>
<td>87.2</td>
<td>11.8</td>
<td>16.5</td>
</tr>
<tr>
<td>Medicare</td>
<td>109.6</td>
<td>168.1</td>
<td>10.6</td>
<td>10.7</td>
</tr>
</tbody>
</table>


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22 This structure is adapted from a flow chart in Rosenbluth JM, "Integrated Delivery Systems", Volpe, Welty & Company Equity Research (an industry report), March 3, 1995, p. 27. Changes made to it were independent of VW & Co.
As public expenditures have increased in California and across the nation (Figure 5), public purchasers have increasingly turned to managed care. California has encouraged government employees to use managed care through CalPERS, which offers state employees a variety of HMO and PPO options. While California is one of the national leaders in private managed care and Medicare penetration; the state’s Medi-Cal managed care coverage levels fall below those of several other states. (Figure 6).

Figure 6: Managed Care Penetration in Public Health Care Markets, 1992-1995

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>6.0%</td>
<td>7.0%</td>
<td>8.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>12.0%</td>
<td>14.0%</td>
<td>23.0%</td>
<td>32.0%</td>
</tr>
<tr>
<td>CA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>-(a)</td>
<td>-(a)</td>
<td>30.0%</td>
<td>-(a)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>11.6%</td>
<td>16.0%</td>
<td>17.2%</td>
<td>23.4%</td>
</tr>
</tbody>
</table>

(a) data not available

Sources: US figures: HCFA, Office of Managed Care (Dial, et al., 1996), HCFA, Statistical Supplement 1995, CA figures: CA DHS, Managed Care

Medi-Cal provides health insurance coverage to non-elderly, poor Californians and the disabled elderly. Non-elderly coverage rates have increased significantly in recent years. In 1993, one out of every seven non-elderly Californians and one out of every four California children was covered by Medi-Cal at some point during the year. Medi-Cal coverage is provided to a broad range of Californians, including many in working families. Though it is primarily targeted at non-working families with children, in California 32.2% of non-elderly Medi-Cal beneficiaries are children and adults in families headed by a full-time employee. California’s relatively broad Medicaid eligibility criteria have restrained further growth in the number of uninsured persons and the rate of uninsurance.

Employer Purchasers in the Private Sector

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 and a decrease in the overall percent of citizens receiving coverage through private sector work. The percent of the national employment pool being offered health care coverage dropped from 81% in 1995 to 78% in 1996.27 The lowest coverage percentage occurred in the Western region, where only 76% of workers were offered health insurance coverage in 1996. In addition, there has been a shift in the percentage of total employee compensation comprised by health benefits: between 1988 to 1993 in California, the average employee saw a shift from 90.9% to 89.4% of the portion of total compensation in the form of wages and salary and a shift from 5.6% to 6.7% in the form of health benefits.28 The national trend during this time was consistent with California’s.

Private employers provide health coverage under three primary arrangements:

• Through a third party payer, such as an insurance company or HMO. With traditional insurance, firms pay health plans (usually one or two per firm) a monthly or annual “premium” on behalf of each employee to insure and provide necessary care. After the premium has been paid to the plan, the employer’s risk is capped.

• Through “self-funding” coupled with the services of third party administrator (TPA). Under the self-funding scenario, firms pay for routine coverage for their employees, use TPAs to administer the plan and gain access to a provider panel, and cover costly events through the purchase of reinsurance and “stop loss”

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26 Ibid., p. 126.
29 Third party administrators (TPAs) are also known as Administrative Service Organizations (ASOs).
coverage. A major employer survey indicated that 46% of employees were enrolled in self-insured health plans in 1995.\textsuperscript{30} The move to self-insurance is particularly prevalent outside of HMOs, accounting for 63% of all indemnity enrollees, 60% of all PPO enrollees, 53% of all POS enrollees, and 11% of HMO enrollees. The rapid shift from indemnity to managed care over the past several years has resulted in a large percent of the population being covered by self-insured plans; 61% of all employees whose employers self-insure were in managed care plans in 1995, in contrast to 33% in 1993.\textsuperscript{31}

\begin{itemize}
  \item Through pooling their buying power with that of other firms by joining a purchasing coalition. California leads the country in this third, and new, type of coverage. With purchasing groups, employers pool their employee bases to exert buying power, provide wider choice, and/or pool risk, all of which leads to more affordable health coverage. Pacific Business Group on Health (PBGH), CalPERS, the Health Insurance Plan of California (HIPC) are purchasing groups in California. (See the Task Force report on Expanding Consumer Choice and Attachment II: Purchasers).

\end{itemize}

**Individual Purchasers**

The smallest group of purchasers is individuals who purchase insurance from a health plan because either they do not qualify for or do not use public or employment coverage. The number of individual purchasers is relatively small because the people who are not offered coverage through work and who do not qualify for public programs tend to be poor and unable to afford individual insurance.\textsuperscript{32} Although more health plans are now offering coverage to individuals, enrollment has not increased dramatically (Figures 8 and 9).

\begin{itemize}
  \item KPMG/Peat Marwick/Wayne State University Survey, 1996.
  \item An exception to this is seen in the Medicare program, where some wealthier retired individuals buy supplemental insurance.
\end{itemize}
A multi-year study of health insurance coverage trends in California supports these figures and elaborates on some of the causes and effects of the state's high uninsurance level.

An increasing number of working Californians are without insurance. Though expansions in Medi-Cal during the 1989-1993 time period resulted in basically flat uninsurance rates among poor Californians, the rate of uninsurance rose in the employed population—most notably from 33.5% to 43.3% among self-employed workers—during this time.

A combination of increasing poverty rates and rising insurance costs and rising costs in general have made it difficult for uninsured individuals to purchase coverage through employers or in the individual market. From 1989 to 1993, the proportion of California's non-elderly population living in poverty increased by one third. Forty percent of non-elderly Californians were living below 200% of the federal poverty level in 1993. Even among families with a full-time, full-year employee, 23% had family incomes below 200% of poverty.

Between 1989 and 1993, employment-based health insurance costs rose, on average, 13% per year in HMOs, 17% per year in PPOs, and 19% per year in indemnity plans. As previously stated, many firms have reacted to rising health care costs by purchasing less expensive plans, changing eligibility rules for employees or shifting a higher percentage of costs to employees. Consumers experienced 64% and 79% increases in their average monthly premium contributions for employee and family coverage, respectively, between 1988 and 1993, according to a Bureau of Labor Statistics study of employees in large firms. In 1997, employee

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**Figure 9: Californians’ Source of Health Insurance Coverage, 1988-1994**

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>1988</th>
<th>1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Coverage</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>


**Figure 10: Comparison of Californians with Private Insurance with Uninsured and Other Insurance Types, 1994**

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privately Insured</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Job-based</td>
<td>57%</td>
<td>66%</td>
</tr>
<tr>
<td>Medi-Cal (Medicaid)</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Other Public</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>


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34 Ibid., p. 126
35 Ibid.
contributions and deductibles were lower than the previous year, but HMO and POS copayments showed signs of increase from $0 to $5-$10 on average.\(^{37}\) These shifts resulted in many employees declining to participate in their employers' health plans. National figures show a decrease in full-time employee participation in employer-sponsored health plans from 92% in 1989 to 83% in 1993. National statistics from year end 1996 showed a change in this trend in response to the easing of health care inflation: between 1994 and 1997, the employee portion of the health benefits contribution declined.\(^{38}\)

The cost implications of increased voluntary participation in health insurance by the uninsured reveal a situation which is unlikely to be easily remedied; premium costs for a comprehensive health plan represent approximately 15% of the income of an individual at 200% of the poverty level, and over 60% of the uninsured in California have incomes below this level.\(^{39}\)

California recently established the Healthy Families Plan, which will extend coverage to approximately 580,000 children under the age of 19 from families with incomes below 200% of the poverty level. The state has modeled the plan after major purchasing coalitions such as CalPERS, PBGH and the HIPC, which offer consumers a choice of plans.\(^{40}\) Families will share in the costs of insuring children, providing approximately $8 per child per month toward the premium.\(^{41}\)

"Safety net" care provision, or care for the uninsured, has been funded in large part through cross-subsidization from the fees paid by insured patients. As premiums paid by both public and private insurers decrease, the opportunity to cross-subsidize care for the uninsured declines. Many are concerned that as managed care puts cost-containment pressure on health care providers, profit margins and thus the ability of treating institutions to "cost-shift" decreases substantially.\(^{42}\) (See the Task Force reports on Vulnerable Populations and Academic Medical Centers.)

The Task Force recognizes the serious problem of lack of any or sufficient health care insurance for many Californians. While it is deeply concerned about this issue, the Task Force acknowledges that the issue of health insurance coverage falls outside the scope of the mandate for the Managed Health Care Improvement Task Force.

2. Payers and Providers

Payers are the traditional indemnity insurers and newer managed care plans. Providers include physicians and other appropriately credentialed health professionals operating within the scope of their practice, and facilities, including hospitals, acute care centers, community health centers and clinics and ancillary service suppliers.

Figure 11 chronicles the popularity of various payer types over the past decade. As is evident, enrollment in pure indemnity insurance has decreased dramatically as managed care enrollment has made significant gains. The newest form of managed care, POS, is gaining in consumer popularity as it combines the cost-effective elements of HMOs with the flexibility and easier access to providers of PPI.

3. Payers

Differences among types of payers have been described above. The discussion below will focus on types of HMO plans or "plan models." There are five main HMO sub-categories: the payer/provider "group" model, the "staff", "independent physician association", "network" and "mixed" models. The HMO varieties can be categorized into two broad groups: integrated delivery system HMOs and "carrier" HMOs. Integrated delivery system HMOs feature a vertically integrated payer and provider organization with mutually exclusive contracting. In contrast, the more common "carrier" HMOs, with origins in the early IPA plans, feature selective provider contracting.


\(^{38}\) Ibid.


\(^{40}\) Healthy Families and the HIPC are both administered by the Managed Risk Medical Insurance Board (MRMIB).

\(^{41}\) California Children's Health Plan, "Healthy Families Plan" August, 1997.

\(^{42}\) Tranquada RE, "Emergency Medical Care and the Public Purse" JAMA, 276:12, September 25, 1996.
Integrated Delivery System HMOs

- **Group.** An HMO that contracts with one independent medical group practice to provide health services under a mutually exclusive contract. The plan (payer) level compensates the medical group (provider) (with or without an integrated hospital) with prepaid “capitation” payment. In the case of the original HMO, the provider level medical groups typically reimburse individual providers with salaries and modest bonuses based on hospital cost experience. Under this model type, the sole contracted medical group determines the formulary and utilization procedures for its provider members.

- **Staff.** A staff model HMO delivers health services through providers who are exclusively employed by the HMO. Typically, the providers are paid straight salaries. Currently, there are only two pure staff model HMOs in California, both small public or not-for-profit entities. The staff model is decreasing in popularity in California and elsewhere. For example, a non-CA based health plan which was the pioneer staff model non-profit in the 1970’s recently converted its staff model clinics to groups in order to get the providers more involved in cost management and patient satisfaction.

Carrier HMOs

- **Independent Physician Associations (IPAs).** The term IPA has two connotations: (1) an HMO that relies primarily on providers in independent or individual practices; and (2) an administrative organization that negotiates contracts with health plans and obligates its associated providers (in independent or group practices) to provide all necessary professional services to members of an HMO that contracts with them. While IPAs generally do not engage in exclusive contracting, there are no statutory prohibitions to their doing so.

There are myriad ways IPAs and medical groups pay providers, with the most typical arrangements being negotiated fee-for-service with withholds or salaries with bonuses based on quality and utilization measures, or capitation. Independent providers or medical groups often contract with multiple IPAs, and might see patients covered by several health plans with which these IPAs have contracts. Some authorities on medical groups suggest that some IPAs, particularly those oriented on primary care, have developed exclusive contracts with providers.

Like providers in other carrier HMO organizations, IPA providers face significant coordination issues as a result of the fact that they often contract with multiple plans whose medical directors or oversight committees determine the utilization controls and formularies. Providers often feel their opinions are not reflected in the formulary and as IPA medical groups contract with many HMOs, keeping formularies and utilization procedures straight is often complex and frustrating.
IPAs are best described as a “network” form of provider organization, performing many of the administrative and contractual functions pioneered by integrated groups, but without unified ownership and an internal group culture. IPAs can provide many of the scale economies and risk-spreading benefits of group practices.

- **Network.** A pure network model HMO contracts with two or more independent group practices, possibly including a staff group, to provide health services. While a network may contain a few solo practices, it is predominantly organized around groups. Like the IPA model, this format does not have exclusive contracts. * The main difference between the network and IPA models is that in the network model the independent medical groups (or more rarely providers in solo practice) do not have a regionally organized “IPA” intermediary as an administrative body to negotiate contracts with HMOs.

- **Mixed.** An HMO that uses any combination of the above models. For example, in recent years as a result of acquisitions, mergers and innovative adaptation to market conditions, HMO plans have simultaneously contracted with multi-specialty medical groups and IPAs. The term “mixed” can be somewhat ambiguous as an HMO carrier that contracts with medical groups and IPAs might be referred to as “mixed” or “network”. Mixed models are often HMOs with IPAs and a newly acquired staff form that are converting to a network form.

### 4. Providers

As managed care has become the norm in California, provider organizations, in the form of group practices and IPAs, are becoming more powerful. These groups are developing ownership and contractual relationships with hospitals and specialists, and increasingly bear risk in the system through capitation contracts with insurers. Because these groups are bearing financial risk, the insurers with which they contract are beginning to delegate much of the utilization and care management responsibility to them. To date this dynamic remains largely a California phenomenon; while provider groups and capitation contracts are becoming more widespread in other regions, providers across the country are still largely operating in small groups or solo practice under non-capitated contracts.

**Physician Group Practices and Organization Models**

The American Medical Association defines medical group practice as “the provision of health care services by three or more physicians who are formally organized as a legal entity in which business and clinical facilities, records and personnel are shared. Income from medical services provided by the group are treated as receipts of the group and distributed according to some prearranged plan.” The AMA estimates that the number of physician group practices in the US grew almost 20% between 1991 and 1995. There are about 20,000 physician groups in the US today and about one third of all physicians practice in these groups. California is the state with the largest number of medical groups. Most medical groups in the US are fairly small; approximately 19% of these groups have 10 or more physicians, and 46% have 3 or 4 physicians. Groups over 100 physicians in size make up only 1% of all groups, but include over 30% of all group physician positions. Seventy percent of these groups are single-speciality; the remainder are multi-speciality groups (22%) and family/general practice groups (8%).

Providers have been motivated to form groups by several industry factors: contracts with health plans are generally available only through group practices; economies of scale are becoming increasingly important as the market becomes more competitive; only as a member of a group is a physician able to spread the financial risk of capitation payment across a wide population of patients; transaction costs associated with negotiating, monitoring and enforcing agreements can be spread across a group; and a group creates an organizational context for the process innovation which is becoming important in managed care.

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44 Ibid., p. 7.
46 Robinson JC and Casalino LP, “Vertical Integration and Organizational Networks in Health Care,” Health Affairs, Spring, 1996.
medical groups and IPAs in California are aggressively growing by both bringing in small primary care practices and merging with other integrated groups.47

The basic group models, defined by ownership and organizational characteristics, include: tax-exempt, independent; tax-exempt, hospital or health system owned; tax-exempt, faculty practice plan; taxable, privately owned; taxable, investor owned; and taxable, partially owned by strategic investor. While there is not evidence that ownership status and organizational model impact many aspects of medical practice, these factors do play an important role in others, including access to capital for infrastructure and/or growth, ability to recruit new providers and the types of providers recruited, provider satisfaction and morale and provider incentives.

Medical Group Management Organizations
As “independent” medical groups have become a larger and more prevalent feature in the industry, management organizations designed to help providers deal with the complexity of the health care market have evolved. These organizations, known as physician practice management companies (PPMs) and management services organizations (MSOs) work with physician groups—either under contract or through ownership—to handle administrative functions, negotiate contracts and access capital. PPMs purchase the assets of a provider practice, while MSOs form contractual relationships with providers or groups, but the providers or groups retain their assets.

5. Consumers
Historically, consumers have had very limited direct influence on health plan or provider service structure. Enrollees trusted their providers to assert their interests in the indemnity structure, and uninsured people relied on charities or the government to represent their interests. With the introduction of broader plan choices as well as service and cost containment, consumers are being prompted to be more assertive. (See the Task Force report on the Physician-Patient Relationship.)

While consumer groups organized around particular health issues have begun to impact practices of plans and providers, the diversity of consumer interests in health care has made it difficult for consumers to organize effectively to influence the health care system. Under DOC regulation, plans are required to have member advisory committees. Many consumers and advocates assert that in the vast majority of plans, consumers have no formal, effective role in decisions about plan policy. Mechanisms to incorporate consumer feedback into the operations of health plans and provider groups are in their formative stages. Nationwide legislation designed to improve consumer access to health care system information and involvement in health care 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. (See the Task Force report on Consumer Involvement, Communication and Information.)

Consumer concern with managed care often revolves around the issue of accountability. The shift from indemnity to managed care has resulted in the “fragmentation” of accountability from the consumer’s perspective. Where historically consumers relied on providers to advise them on medical decisions and insurers to cover the costs of care, they now face a system and a series of organizational structures where decision making and financial responsibility may not clearly rest with easily identifiable or discrete parties. While proponents of managed care assert that the organizational arrangement improves accountability, (i.e. the plan is clearly accountable to members) many consumers are concerned that plans are not sufficiently responsive. A managed care organization contracting with a range of medical groups and “carving out” benefits such as mental health and pharmaceuticals (and likely employing a complex range of coverage and decision-making criteria) may appear quite confusing to a consumer who previously relied on his or her “own” physician as a point of accountability in the health care system.

Availability of consumer information in the health care system has been a topic of intense debate in recent years, and has led to substantial legislation across the country. Consumers and their advocates are pressing plans and state authorities, through legislative mandates, to make available and accessible more consumer-focused information on plan policies (e.g., referral and authorizations, after-hours care, out-of-area care), operations (e.g., consumer involvement in development of plan communications and policies), financial arrangements (e.g., provider incentive structures) and quality. A major criticism of health plans’ consumer information is the reading level at which it is written. A recent study of the “readability” of health insurance literature and contracts found that the average health plan document was written at the reading level of between third/fourth year college and first/second year graduate school. 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.

In addition to requiring and demanding access to better information about the health care system in the era of managed care, consumers are being made more aware of the cost implications of various plan types. At the time of enrollment, consumers in a workplace often face different contribution levels that correspond to the costs of the plans. A consumer enrolled in a PPI or POS plan also faces different costs based upon the type of provider he or she chooses to use. Employers and plans are using financial incentives directed at consumers to help reinforce other cost-controlling efforts of managed care.

D. Challenges Health Care Must Address to Create Cost-Effective Delivery

The primary challenges and objectives facing health care financing and delivery systems are to ensure cost-effective care while maintaining high quality standards. Organizations attempting to pursue this goal through managed care face the challenge of integrating a broad range of previously independent entities. Seven main types of integration are seen as desirable in the managed care system. Some plans have integrated more successfully than others have, and different plans may focus on different integrations.

1. Integration Between Financial Responsibility and Care Delivery

In this stage of integration, provider incentives to reduce unnecessary costs are aligned with patients’ interests in receiving high quality care. Before health care costs escalated to a point at which they became a major economic concern, providers were trained to provide care without regard to cost, and were supported by society in doing so. Incentives introduced under managed care include per capita prepayment or “capitation” which has providers sharing in the financial risk of the insurance arrangement to encourage them to deliver appropriate care in the most cost-effective manner.

2. Integration Between Providers and Enrolled Populations

The primary challenge the health care system faces is in meeting the health needs and improving the health status of the population. Elements include a greater emphasis on preventive medicine, health and safety education and advocacy, and a matching of appropriate numbers and types of providers to the needs of an enrolled population. Use of “segmentation” techniques to identify members of the enrollee population with common health status characteristics or behaviors and provide them with appropriate educational materials, care venues, screenings, etc. is an example of this type of integration.

3. Integration of the Full Spectrum of Health Care Services

By creating an integrated delivery system through contracts or ownership and structures that align incentives, this integration seeks to optimize the use of preventive services, education, doctors’ office, inpatient and outpatient services, home nursing, pharmaceuticals, and other resources. For example, doctors collaborate with pharmacists to choose therapies that produce the best outcomes and minimize total costs of care, rather than simply choosing drugs based on cost or supplier relationships in isolation. Care is delivered in the least costly, appropriate setting.

48 Hochhauser M, letter to the Editor, Health Affairs, September/October 1997, p. 220.
50 Integration need not mean common ownership. In fact, the trend is toward integration through contractual relationships.
4. Integration Among Physicians and Between Physicians and other Health Professionals
This level of integration assumes that an optimal team of physicians and other providers will be brought together to provide appropriate and cost-effective care. It depends upon plans’ contracting with the right numbers and types of providers and establishing the right specialty mix to assure patients good access to primary care and to ensure that proficient and qualified specialists are available when necessary. For example, many organizations, including health plans and medical groups, now use nurse practitioners to provide a great deal of primary care, including annual gynecological exams.

5. Integration Between Providers and Hospitals
This integration ensures that providers have an interest in efficient utilization of hospital resources. In a well-integrated system, providers develop practice patterns that facilitate efficient hospital operations; they work with hospitals to reduce unnecessary record keeping and advise on infrastructure investment decisions.

6. Horizontal Integration Among Hospitals
With this type of integration, hospitals in a region combine to share administrative support functions and to consolidate volume-sensitive clinical services such as open-heart surgery and neonatology. There are several prominent examples of horizontally integrated hospital systems in California. Horizontal integration also increasingly represents mergers of groups of hospitals across regions to gain buying power from national suppliers and to gain easier access to private capital markets.

7. Integration of Patient Information.
Managed care is encouraging the integration of patient information, including encounter, lab, pharmacy and other data. Ideally, each provider who has patient contact can have a complete picture of the patient’s medical history, which helps him/her to coordinate care with other providers and avoid duplicate tests and unfavorable drug interactions. This information, used anonymously, can also serve as a basis for research on the relationship among diagnoses, treatments and outcomes. It can also be used to provide feedback to providers for quality improvement purposes.

V. California’s Health Care Delivery System
As many organizations in the health care industry attempt to develop the integrations described above, the composition and demographics of health care delivery has begun to shift. Managed care organizations’ efforts to drive excess cost out of health care have affected, among other things, the utilization of hospital beds and the overall volume and composition of the physician supply. An overview of the changes in California’s health care delivery systems accompanying the proliferation of managed care follows. (See the Task Force report on Quality, Access and Cost.)

A. Physician and Hospital Bed Supply
Changes in hospital bed capacity and utilization rates and the composition and supply of the physician work force are relevant and easily measurable indicators of the impact of managed care on health care delivery. Because excess capacity uses resources inefficiently, because federal Medicare inpatient hospital compensation is now on a per case basis rather than cost reimbursement, and because managed care will not pay hospital overhead charges. Hospitals in the managed care era are reducing bed capacity.

<table>
<thead>
<tr>
<th>Year</th>
<th>CA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>2.65</td>
<td>3.69</td>
</tr>
<tr>
<td>1993</td>
<td>2.51</td>
<td>3.57</td>
</tr>
<tr>
<td>1995</td>
<td>2.39</td>
<td>3.34</td>
</tr>
</tbody>
</table>


A hospital bed at 80% occupancy produces 292 days per year. 2.39 beds/1000 population produces 698 days/1000 per year. California is using 523 days/1000 per year and could use fewer if it were at an efficient level. At current occupancy levels California needs only 75% of its hospital bed supply.
Figure 14: Distribution of Physicians in CA, 1994

33% Generalist
66% Specialist

Source: UCSF Center for the Health Professions, May, 1997.

Figure 12 shows how the reduction of hospital bed capacity in California has mirrored the national trend but well surpassed the national average. Although capacity has decreased, utilization figures show that the system is still facing an excess capacity (Figure 13).

In addition to prompting reduction of hospital beds and impacting hospital utilization, managed care will likely bring about a measurable effect on the composition and overall size of the physician work force. As managed care organizations have limited the number of providers they contract with, an oversupply of physicians, particularly specialists, has been revealed. The Council on Graduate Medical Education (COGME) recommends that the U.S. physician workforce be composed of 50% specialists and 50% generalists (family practitioners, general internists, general pediatrics and general practice).52 The Pew Health Professions Commission concurs with this, and additionally recommends that there be a 20% reduction in US medical graduates.53

As figure 14 indicates, CA was well off this mark in 1994, with only 33% of active non-federal physicians practicing as generalists. These percentages did not materially change from 1990 to 1994. From 1995 to 1996, changes in the market began to become apparent as trends in enrollment in residency programs showed a shift toward generalist fields. (See Task Force report on Academic Medical Centers.)

The state of California currently displays substantial regional variation in the supply of patient care physicians. Though statewide the specialist per 100,000 population ratio was 126, or 20-48% above COGME recommendations, and three regions had ratios that fell below the recommended level. The supply of generalists in most California regions is inadequate to barely adequate when measured against COGME standards, and is particularly low in inner cities and rural areas.54

As managed care has grown, imbalances in the physician supply have become more apparent. Federal and state legislation facilitating selective provider contracting enabled organizations to create competition among providers and reduce costs, and managed care organizations are beginning to use allied health professionals such as advanced practice nurses in primary care roles. The physician supply increased steadily through the 1980s to the mid 1990s (Figure 15).55 Figure 16 presents data from a study comparing GHAA (now AAHP) and four HMOs' estimates of needed staff with the number of available MDs, generalists, specialists, and allied health professionals (e.g. advanced practice nurses), illustrating projected industry trends.

54 Ibid.
55 Medical school enrollment and residency figures show the potential for a decrease in these figures early in the next century. See Task Force Report on Academic Medical Centers.
B. Composition of Health Care Personnel

Reductions in physician and hospital bed supplies represent just the surface of the health care transformation. Although it is difficult to determine to what degree these changes are attributable to managed care, demographic changes or regulatory developments, it is clear that evolving economic incentives have altered the composition of health care delivery. With the health care system's greater emphasis on prevention, an aging population, technology developments and financial incentives to move patients out of hospitals at the earliest appropriate time, expenses have been reallocated from specialists and acute hospital settings to PCPs, pharmaceuticals, out-patient care, and long-term care areas.

The composition of non-physician health care personnel has also changed to reflect managed care's effort to cut costs while continuing to meet patients' medical needs. 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 (Figure 17). Advocates for inclusion of advanced practice nurses in managed care contracts note that they have been excluded from

56 Interview, UCSF Center for the Health Professions.
participating in IPAs and group practices as primary care providers by Knox-Keene legislation that designates that patients must be assigned to a primary care physician.\textsuperscript{58}

Figure 17: Anticipated Growth in Annual Enrollment in Advanced Practice Nursing Programs, CA, 1994-1997

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1997 (est.)</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalist NP</td>
<td>542</td>
<td>658</td>
<td>21.4%</td>
</tr>
<tr>
<td>Specialist NP</td>
<td>128</td>
<td>152</td>
<td>18.8%</td>
</tr>
<tr>
<td>Nurse Midwife</td>
<td>88</td>
<td>102</td>
<td>15.9%</td>
</tr>
<tr>
<td>Nurse</td>
<td>41.0</td>
<td>58</td>
<td>41.5%</td>
</tr>
<tr>
<td>Clinical Nurse</td>
<td>377</td>
<td>396</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Source: UCSF Center for the Health Professions, California Needs Better Medicine, May 1997.

C. Covered Services
Mental illness and substance abuse are increasingly recognized as causal or compounding factors in poor health status. 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.\textsuperscript{59,60}

Many managed care organizations treat mental health services as “carve outs” and subcontract with specialty organizations to develop networks and administer benefits. Mental health advocates indicate that managed mental health care, particularly that provided under “carve outs,” presents particular obstacles and limitations to those seeking mental health services: the variation in subcontractors leads to problems with continuity of provider; the trend of lowering capitation rates may result in substandard treatment and care; potential compromising of the provider’s role as “patient advocate,” and pre-authorization rules which require “involuntary commitment” criteria to be met before inpatient care is allowed.\textsuperscript{61}

Mental health benefits provided under managed care often include services provided by a greater diversity of providers (social workers and nurses are often care providers along with the traditional psychologists and psychiatrists) than is customary under fee-for-service. In addition, the array of services and settings in which services are provided tend to be broader than those associated with mental health care provided under indemnity insurance. Some critics of managed mental health care assert that plans limit approvals to care, use non-psychiatric personnel to approve care and use less costly treatments and providers which they allege might harm the quality of care.\textsuperscript{62}

Behavioral health and health promotion activities are fundamental features of an optimal managed care system, but are only slowly being incorporated into standard medical training and practice. The clinical practice of these disciplines relies on multi-disciplinary teams, requiring physicians to work collaboratively with allied health professionals. (See the Task Force reports on Quality, Access and Cost and Integration and Coordination of Care.)

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

\textsuperscript{58} California Coalition of Nurse Practitioners, spoken and written testimony to the Managed Care Improvement Task Force, 1997.
\textsuperscript{59} Sturm R, “How Expensive is Unlimited Mental Health Coverage Under Managed Care,” RAND and National Institute of Mental Health, Fall 1997.
\textsuperscript{60} Institute for Mental Health Services Research, 1997, presentation to California Mental Health Directors Association.
\textsuperscript{61} California Psychiatric Association, Draft Presentation to the Managed Health Care Improvement Task Force, 1997.
\textsuperscript{62} Boyle P and Callahan D, "Managed Care and Mental Health: The Ethical Issues," Health Affairs, 14:3, Fall 1995, 7-22.
One measure of both California and national interest 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. While this measure is of obvious interest to insurers, providers, payers and consumers, it has come under significant criticism from many within and outside the industry. Observers note that in practice purchasers, providers, consumers, investors and regulators interpret and respond to the MLR in very different ways. Today’s health care delivery system is infinitely more complex from an accounting perspective than the historical indemnity system. The MLR measures the distribution of revenues among administrative and clinical functions that are organized very differently in different organizations, and will vary 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. Because there are no standard categorization of expenses or accounting practices under which plans must report medical loss ratios, MLRs are not comparable across plans and can be very misleading. Standardized accounting procedures for hospitals have been developed and mandated by the federal and state governments.

VI. Maturation and Consolidation of the Industry

A. Industry Maturation
Economic, regulatory, cultural and other effects all shape a state’s health industry profile. California is advanced in its managed care penetration, but it is not necessarily viewed as a “representative” state. For example, medical groups and IPAs are much more prevalent in California than in most other states, and are more likely to contract with plans under capitation arrangements than are groups in most other states. This fact, and others, shape the industry maturation and consolidation process. As the initial managed care plans met with success in various regions, new competitors, in the form of IPAs, began to enter to complement the initial firms’ ability to address a growing market need—cost-effective health care delivery.

B. Mergers and Consolidation in the Health Care Industry
In the managed care industry, expansion dominated until the late 1980’s and early 1990’s when widespread merger activity and industry consolidation began among the larger players. While payer/HMO and hospital consolidations have been attracting the most attention, mergers are occurring in all tiers of the health care industry.

1. HMO Consolidation
In the late 1980s, managed care coverage was fairly prevalent, and HMOs began to be concerned that growing competition would erode their profit margins. Large, publicly traded HMOs sought to assure earnings growth by cutting costs and entering less developed markets. As a result, HMOs have predominantly undertaken horizontal or market extending mergers.

Figure 18 illustrates HMO mergers by tracing the composition of the five largest HMOs in California in 1996. Government and private-sector analysts have conducted a great deal of research to determine potential effects of this consolidation on health care delivery. No proposed major California merger has been denied yet because of anti-trust concerns, but recent mergers have not been without controversy. Merger opponents, including providers, employers and consumer groups, who fear that consolidation will stifle competition, narrow consumer choice, increase costs and reduce quality, have urged federal and state

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64 Ibid., p. 176.
65 Ibid., p.179.
66 The first IPAs in CA were developed in the 1960’s.
67 Data presented is from July 1996. Some recent developments are not noted on this chart. Foundation and HIS merged to form FHS. PacifiCare and FHP completed a merger, and Blue Shield acquired two HMOs in Southern California, making them the fourth largest HMO in California in 1997.
officials to either disapprove health plan mergers on antitrust grounds, or condition such consolidations by outlawing exclusionary and anti-competitive contract provisions, such as exclusive dealing arrangements and “most favored nation” clauses, which inhibit competition. As managed care penetration and consolidation increase, antitrust concerns will likely become more of an issue. Some argue that the economy of scale argument for merging becomes less valid above a relatively small total HMO enrollment of 115,000.68 Others argue that consolidation may be acceptable if no firm or firms have the ability to dominate completely and cite that some of the largest firms are addressing consumers needs most creatively and efficiently (e.g. introduction of the POS plan).

2. Other Industry Tiers
Although some horizontal and market extending merger activity among other industry player levels may have occurred for efficiency reasons, HMO plan consolidation likely prompted a quicker and more extensive trend. As HMOs increased their buyer and seller power, hospitals, medical groups, IPAs and purchasers consolidated as a defensive measure so that larger HMOs could not easily claim their margins or exclude them from the managed care market.

Provider consolidations have become more prevalent at both the hospital and medical group level. Medical groups have merged to gain greater contracting leverage with health plans and hospitals, to build patient bases large enough to allow for effective capitation at the medical group level and to acquire the infrastructure necessary to effectively manage care. Hospital mergers have also become more prevalent, as hospitals seek to exploit economies of scale and scope in technology, to reduce administrative costs and realize purchasing economies, to gain marketing benefits (from the ability to offer “one stop shopping”) and to offer purchasers greater stability.69 Because they generally take place at a local level, these horizontal mergers have drawn a great deal of attention and have become a greater cause for consumer concern.

Vertical mergers combining hospital and medical groups have also become more common. These organizations are attempting to coordinate a range of services such that they could go directly to the purchaser and capture the profits currently being collected by HMOs.

C. For-Profit vs. Not-for-Profit Corporate Status

Legal and organizational scholars point to several historical precedents and ideals regarding profit status in the health care field. They assert that the non-profit organization theoretically helps to solve problems of distrust that arise in areas where purchasers lack the information needed to monitor or evaluate the services provided by sellers.\(^{70}\)

Historically, insurance plans and delivery system HMOs were non-profit for several reasons in addition to that noted above. Physician-driven organizations did not need access to private capital markets,\(^{71}\) 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 which has been seen, in accordance with the principles above, as appropriate to their charitable purpose. The majority have been 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, non-profit status has become increasingly difficult to maintain because they lack access to capital critical for growth.\(^{72}\) For-profit status is becoming increasingly more common in CA and across the nation. Figure 19 illustrates the shift in the profit status of HMOs in California from 1985-1996. The shift of enrollees from not-for-profit to for-profit HMOs has been dramatic: in 1985, 74% of HMO enrollees were members of not-for-profit plans; by 1994 only 42% of enrollees were in not-for-profits.\(^{73,74}\)

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72 Note: 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.


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 (who 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.75

The “community benefits” which are provided by both for-profit and non-profit health care organizations have been defined and measured in many different ways. They include, among other factors: charity care; losses from serving enrollees of public programs; the cost of research and education; lower prices; community needs assessments, education and service programs; community control and accountability; “trustworthiness”; and payment of taxes.76

A number of studies comparing performance of for-profit and not-for-profit organizations in health care have been conducted. While studies comparing non-profit and for-profit hospitals generally find that non-profit hospitals provide greater community benefit,77 studies comparing managed care plans are less definitive. Findings of studies comparing managed care organizations vary across types of organizations and comparison factors.78

Studies of private quality and satisfaction surveys of plans have found that non-profit plans been disproportionately represented at the top of HEDIS and independent publications’ rankings.79 A study conducted by the Kaiser Family Foundation 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.”80 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 all non-profit HMOs.81

As non-profit to for-profit “conversions” through merger or organizations’ decisions to change tax status continue, studies of the relative merits of the two types of health care organizations continue.82

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75 Hasan M in Gray BH, “Conversion of HMOs and Hospitals: What’s At Stake?” Health Affairs, March/April 1997, p. 34.
77 Ibid., p. 17.
80 Kaiser Family Foundation Survey, March and August 1997 as reported in Harvard Health News Index.
82 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
Background Paper

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. 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.” Some have focused on the service aspect of quality, stressing the need to satisfy patients and other customers. Managed care has had positive and negative impacts on quality. Though not current and not entirely specific to California, the best scientifically valid and available evidence suggests that HMOs have improved quality in several areas, but that there are also some areas of concern.

A. Quality Concerns of Patients and Providers
While perceptions do not constitute evidence in the same way as results of well designed, statistically valid, population-based studies; they are important, and they shape the policy debate. Below are generalizations about patient and provider concerns with the quality of the current health care delivery system (see also Task Force paper on Observations of Public Perceptions).

1. Patient Concerns
Patients want providers (i.e., doctors and other appropriately licensed health professionals operating within their scope of practice) to make decisions based on clinical rather than financial criteria. Some believe that HMOs reduce utilization by inappropriately discharging hospital patients early, and denying expensive tests and treatments. Same-day mastectomy patients may feel traumatized about emptying drain tubes at home, and new mothers discharged early may feel unequipped to care for their new baby while recovering from childbirth. While there is little evidence demonstrating any compromise to medical quality in these cases, patients perceive a decline in service quality as a result of these early discharges. The popular press reports that mental health patients are approved for fewer visits in less aggressive settings without regard to quality in a managed care environment, and that some patients committed suicide after a health plan denied inpatient care. This is not an exhaustive list.

2. Provider Concerns
Some providers are concerned that HMOs sacrifice quality to reduce costs. Some believe that HMOs and providers in managed care operate under perverse incentives that result in denial of care. Providers are also concerned about low medical loss ratios (the proportion of revenue spent on medical care relative to other costs).

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3 Same-day mastectomies are not mainly an HMO invention; they were developed and introduced in an indemnity, academic setting at Johns Hopkins University. Miller S, “Johns Hopkins offers outpatient mastectomies, hysterectomies,” Warfield’s Business Record, 8:40:1, October 1, 1993, p.16.
5 Boyle P and Callahan D, “Managed Care and Mental Health: The Ethical Issues,” Health Affairs, 14:3, Fall 1995, 7-22.
6 Throughout this paper, the term “health plan” refers to any health insurance arrangement or health benefits financial intermediary, unless otherwise specified (e.g., Knox-Keene regulated health plan).
that spent on overhead, administration and profits). Some providers believe that HMOs reduce access to expensive care so that more people can receive basic care. Some mental health professionals believe that non-psychiatric primary care providers lack mental health expertise, and non-clinicians should not manage mental health utilization. This is not an exhaustive list either.

B. Quality of Managed Care

While assessing quality of managed care against objective criteria (such as the Healthy People 2000 goals) is an appropriate evaluation for the health care system, it is less helpful in assessing the impact or change in quality due to managed care. To measure the change requires a baseline or point of comparison. Making a comparison between managed and unmanaged care is necessary because HMOs have been accused of compromising quality by reducing tests and procedures to enhance the bottom-line. The majority of research efforts designed to examine the impact of managed care on quality have compared managed care organizations (specifically HMOs) to unmanaged organizations (specifically traditional, unmanaged fee-for-service “indemnity” plans).

The most scientifically valid and available research on the impact of managed care on quality is often not current and often not specific to California. Interpretation of the results presented in this paper should recognize that significant change is likely to have had some affect on quality of care, including lower rates of premium and spending growth as well as major organizational and clinical practice changes. In addition, drawing conclusions for California based on national studies may not be appropriate.

According to available research, there is no “winner” between HMOs and 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. 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.

1. Medical Outcomes

Miller/Luft Literature Reviews. Professors Robert Miller and Harold Luft of UCSF concluded from an extensive literature review that there were equal numbers of statistically significant positive and negative “quality” results for HMO plans and non-HMO plans. The study found that HMOs produce better, the same or worse quality of care results depending on the particular organization and disease. The study compiled previous studies comparing HMOs to indemnity in peer-reviewed journals published after October 1993, with ending dates of 1985 or later and some attempt to risk-adjust. In a previous similar study, Miller and Luft also found roughly comparable quality; 14 of 17 observations showed better or equivalent quality in HMOs; however, two observations showed lower quality in HMOs for mental health problems. In addition, results varied widely among HMOs because each HMO is different. Industry-sponsored studies corroborate Miller and Luft’s results.

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12 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.
13 Op cit., Miller R and Luft H, “Does Managed Care Lead to Better or Worse Quality of Care?”
14 Ibid.
Other Outcomes Studies. Several other studies that have been published in peer reviewed journals or by a federal government agency show that some dimensions of quality of care for HMO patients are equal to or better than care given to indemnity patients. For example, results of various cancer studies suggest HMOs do more extensive cancer screening, detect cancer earlier, and have survival rates equal to or better than indemnity. Studies have similarly documented positive findings regarding heart disease, diabetes and hypertension, rheumatoid arthritis, and appendicitis, as well as among different settings and patient populations.

2. Areas of Quality Concern According to the Research Literature

Several studies point to specific areas of quality concern in HMOs.

Elderly and Poor Chronically Ill. The Medical Outcomes Study, conducted by John Ware and colleagues, suggests that while outcomes were the same on average for the average patient, the chronically ill elderly and chronically ill poor fare worse in HMOs than in indemnity plans. Elderly HMO patients had worse physical outcomes (54% declined in physical health versus 28% for indemnity) yet better mental health outcomes (26% improved versus 13% for indemnity). For non-elderly HMO patients, physical health was better. Poor HMO patients (at or below 200% of the poverty line) in poor health did worse than poor indemnity patients in poor health. However, non-poor HMO patients had better outcomes than non-poor indemnity patients did. In another outcomes study, based on HCFA Medicare data sets, results also indicate that for frail populations managed care poses particular challenges that require special attention from the policy community.

Shorter Lengths of Stays. Both the popular press and several peer-reviewed studies question whether shortened lengths of stay under managed care for certain procedures constitute appropriate quality. One recent industry-sponsored study, based on data provided by The MEDSTAT Group, found that approximately the same proportion of HMO and indemnity admissions had lengths of stays equal to or greater than both American College of Surgeons and Milliman & Robertson’s optimal recovery guidelines.


Maternity stays, however, have been an area of intense debate, and recently both federal and state legislation has mandated coverage of 48 hour maternity stays if needed. One study confirmed that HMOs discharge mothers one day after delivery more often than POS or indemnity, and that western HMOs discharge mothers one day after delivery more often than HMOs in other regions. Quality results, however, did not strictly suggest poorer quality with shorter stays. A recent study of Washington State vaginal deliveries from 1991 to 1994 suggested moderately increased risk of hospital readmissions for newborns related to shorter lengths of stay, at least in the absence of substitute services. However, the study does not suggest that newborns experienced worse outcomes due to readmissions. In addition, the authors suggested that outcomes may have had more to do with education of the mother and follow-up care than length of hospital stay.

Detection and Treatment of Mental Health. The Medical Outcomes Study suggests several areas of concern related to mental health in managed care, including the poorer detection of mental health problems and inappropriate use of antidepressants and tranquilizers, and counseling by generalists rather than specialists. However, despite lower detection and counseling rates, this study found no difference in overall outcomes between HMO and indemnity depressed patients. The study did find that HMO psychiatry patients had significantly worse functional outcomes than indemnity psychiatry patients did.

3. Customer Satisfaction Studies
In addition to objective measures of outcomes, customer satisfaction is a valuable indicator of the quality and perceived quality of care and service customers receive. According to several studies, satisfaction with various forms of managed and unmanaged care are mixed and often contradictory. Most studies 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. However, there is variation in satisfaction among plans within plan model types, and for some populations and some measures satisfaction is lower (for more detail, see Task Force paper on Public Perception and Experiences with Managed Care). In addition, there is some concern that many satisfaction surveys, by sampling a population that is mostly healthy and who use health services little, mask some dissatisfaction and problems in the population that needs and uses services most.

C. Trends in Quality Under 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 health promotion, early diagnosis, reduction in treatment variation, concentration of volume sensitive...
problems in high volume centers, and rewarding quality. Many of these activities have been driven by purchasers and not the managed care 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 work together with other elements to improve quality.

1. Quality Measurement

Historically, quality assurance activities in health care included Medical Board licensure for physicians, hospital audit committees, and efforts to take corrective actions after mistakes to reduce the likelihood of recurrence.42 Given the potential for under-utilization with some forms of financial arrangements that allow providers to assume financial risk for the cost of patient care (see Task Force paper on Provider Financial Incentives), such retrospective review may not be sufficient to assure quality. The quality measurement of process and outcomes data that is in use today stems largely from demand for more information from employers and consumer groups to prospectively evaluate health benefits coverage options. In addition, providers can use quality measures to improve quality. Many public and private organizations are active in the area of quality measurement, including the National Committee for Quality Assurance (NCQA) Foundation for Accountability (FACCT), and the Pacific Business Group on Health (PBGH).43 (see Task Force paper on Government Regulation and Oversight of Managed Health Care for information on current quality measurement and accreditation organizations and activities).

2. Quality Improvement

Providers' professional ethics have always driven them to want to improve. Because managed care organizations are responsible for both financial and clinical aspects of health care, many of these organizations have implemented quality improvement programs to improve quality systematically. One study showed that 72% of capitated network physician groups used continuous quality improvement tools to improve care.44 Groups that were older, more profitable or had a greater proportion of capitation contracts were more likely to use these tools. However, more groups focus on improvement activities related to overuse and preventive care compared to under-use and chronic disease care. As medical groups assume greater risk and work to improve cost and quality, their new practice patterns spill over to their indemnity patients as well.45,46

3. Process Improvement

HMOs and medical group/IPAs work to improve both administrative and clinical processes. For example, the cost of total hip replacements has declined while quality has improved due to both technological advances and process improvements.47 The average length of stay for hip replacements in the US, according to the study, decreased from 17 days to six days (three at some institutions) from 1983 to 1995, through practices including preoperative patient education, preoperative home visits by social workers, preoperative antibiotics, clinical guidelines, spinal anesthesia, earlier physical therapy, home care, nursing home care, and standardized prostheses.

One HMO that provided information to the Task Force reported improvement in annual sigmoidoscopy screening rates for colon cancer detection in 50 to 79 year olds (from 3.9% to 8.9% from 1993 to 1996), estimating prevention of 170 colon cancers.48 Another profiled providers by comparing 55 risk-adjusted measurements on clinical quality, utilization management, member satisfaction and administrative

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42 The federal HMO Act and the Knox-Keene Act (Section 1370) require quality assurance systems.
48 Public testimony presented to the Managed Health Care Improvement Task Force, Sacramento, CA, July 26, 1997.
efficiency for each medical group with national benchmarks. After they implemented the profile, the HMO's prenatal care increased by 35% to 90% of pregnant members receiving prenatal care (national benchmark status), and cervical cancer screening increased by 17% to national benchmark status of 75% of adult women screened.⁴⁹

4. Provider Profiling and Publishing Provider Outcomes Measures
Some HMOs evaluate provider performance and use peer group comparisons to encourage improvement. In addition, several HMOs and medical groups pay physicians at least in part on the basis of risk-adjusted quality report cards.⁵⁰

External pressure, through publishing provider performance measures, has also proven to be a valuable source of quality improvement, though not limited to managed care. New York State studied published risk-adjusted mortality outcomes for hospitals and surgeons performing coronary artery bypass grafts (CABGs).⁵¹ From 1989 to 1995, the years covered by the survey, risk-adjusted mortality rates declined from 3.52 to 2.52 per 100 patients from 1989 to 1995. Health care experts say the surveys themselves have contributed to the improved mortality rates because they give hospitals the opportunity to focus on the way they perform the operations.⁵²

5. Continuity and Coordination of Care
Many HMOs use primary care providers (PCPs) to coordinate patient and sometimes family care. PCPs are responsible for referring patients for specialty care, coordinating treatments, preventing duplicative testing, and reviewing drug prescriptions for contraindications. Where effective, PCPs may improve continuity, however the “gatekeeping” role provided by PCPs has also created tension (see discussion in Task Force paper on Physician-Patient Relationship).

6. Disease Management
A term invented by the Boston Consulting Group in 1993, disease management is a complete, systematic approach to treating chronic diseases to reduce complications, overall utilization, and cost which has been applied by HMOs and other managed care organizations.⁵³ Using the principles of disease management, some HMOs care for chronically ill by applying clinical guidelines, patient education, provider education, monitoring, prevention and outcomes measurement. Guidelines can contribute to quality of care by reducing unwarranted variation in clinical decision making and by providing practitioners with concise, practical advice on the diagnosis and treatment of illness.⁵⁴

One HMO that testified before the Task Force reported that just 16% of their members with several chronic conditions represented 67% of pharmacy costs and 50% of hospital costs. The HMO identified asthma care as a particular area for improvement. Upon finding that few asthmatics used peak flow meters, they sent peak flow meters and videos explaining their use directly to all their asthmatic members⁵⁵ (see also Task Force paper on the Physician-Patient Relationship).

Most HMOs use guidelines only as recommendations to accommodate differences among patients and their preferences as is appropriate since the individual needs of each patient should ultimately determine appropriate care. In practice, studies suggest that guidelines have limited ability to change practitioner behavior.⁵⁶ However, some providers may perceive guidelines as fixed constraints because they fear being an outlier.

7. Prevention and Health Promotion

One study presented to the Task Force found that managed care organizations provide more clinical preventive services than their indemnity counterparts. Another study found that HMOs are significantly more likely to offer health promotion programs to their members compared to indemnity plans, more likely to make their health promotion programs available to the general public, and more likely to evaluate the impact of their health promotion programs on medical costs and health status.

In addition, several HMOs that testified before or submitted information to the Task Force referenced their efforts in health promotion and prevention. One HMO surveyed its diabetic members and found that too few diabetics were getting annual retinopathy exams. In order to improve, the HMO sent a letter jointly with each medical group to remind patients to schedule this exam. Another HMO sent preventive health reminders on postcards to over 600,000 members in 1996, and additional follow up materials to groups with low screening rates. Screening rates subsequently improved by over 50%.

These efforts are often encouraged by purchasers. For example, PBGH adopted guidelines for appropriate preventive care, rewards health plans based on their performance with respect to the guidelines, and encourages employers and workers to choose health plans that excel in promoting health.

8. Early Diagnosis

Once at risk for the cost of care, managed care organizations have an incentive for early detection of illnesses for which early treatment can save lives and dollars. A Health Care Financing Administration (HCFA) study found that 58% of Medicare HMO patients were diagnosed at the earliest stage of cervical cancer versus 39% of indemnity patients.

9. Reduction in Treatment Variation

Studies show significant variations in practice patterns nationally. This is true across all models of care delivery. While some variation is inevitable, significant variation implies that some resources are being wasted and some patients are undergoing treatment unnecessarily, possibly dangerously (see Task Force paper on Improving the Delivery of Care and the Practice of Medicine). Some managed care organizations have identified reduction in practice variations as a goal and have designed studies to reduce variations among practitioners.

10. Concentration of Volume-Sensitive Procedures in High Volume Centers

Several studies of coronary artery bypass graft (CABG) surgery as well as angioplasty and percutaneous transluminal coronary revascularization (PTCR) show that outcomes improve with higher physician and/or hospital volumes. To improve quality, some HMOs consolidate these and other volume-sensitive

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59 Testimony submitted or presented to the Managed Health Care Improvement Task Force, Sacramento, July 26, 1997.
60 CalPERS press release, "New CalPERS Health Initiatives Target Wellness & Access", cooperative projects with one California health plan, September 17, 1996.
procedures in high volume centers and centers of excellence. One CABG study reported that 51% of patients at low volume hospitals in California are indemnity Medicare beneficiaries.68 In contrast, group and staff model HMOs contract only with high or intermediate volume facilities, and IPA HMOs use intermediate and high volume facilities slightly more often than indemnity.69 This may mean that all academic medical centers are not accessible to some HMO enrollees for all procedures.70 (see Task Force paper on Academic Medical Centers).

11. Rewarding Quality
HMOs create a structure that can be held accountable for the health of the populations they serve. Some purchasers are holding HMOs accountable by structuring HMO contracts with rewards for quality. HCFA is considering adjusting Medicare HMO payments for quality. Under the proposal HMOs with high HEDIS scores would receive higher premiums. Similarly, PBGH asked HMOs to risk 2% of their premiums on measures of customer service, quality and data provision.71 PBGH negotiates specific dollar amounts and targets based on past performance, the need for improvement and the ability to improve. PBGH asks HMOs with lower performance to improve more dramatically and to risk more.

HMOs can also put some of their providers' capitation payments at risk for meeting quality measures. One HMO told the Task Force that it links 1% of its capitation payments to medical groups with which it contracts to patient satisfaction, quality care processes, and data provision.72 Similarly, the HMO adjusts hospital payments on the basis of service and quality. Another HMO pays its providers bonuses for meeting certain targets for preventive screenings and immunizations.73

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. Barriers to access can be structural (e.g., availability, organization, transportation), financial (e.g., insurance coverage, reimbursement rates, out-of-pocket costs, public support) or personal (e.g., acceptability, confidentiality, cultural, language, attitudes, education, income).74 HMOs have generally improved financial access to insurance and care. Lower HMO premiums keep coverage more affordable for more people.75 Modest copayments and no deductibles make care at the point-of-service for those covered generally more affordable. However, HMO cost controls have also reduced the safety net's ability to shift costs in order to provide uncompensated care for the uninsured. HMOs provide access to certain benefits, such as prevention and health promotion, which were not typically covered benefits in unmanaged indemnity products. For example, a 1996 Mathematica study found costs were lower for Medicare HMO members than traditional Medicare beneficiaries: 76% paid no premium, and 83% had prescription benefits, while traditional Medicare recipients usually paid Medi-Gap premiums and had no pharmaceutical coverage.76

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.77 In fact, em-

69 Information submitted to the Managed Health Care Improvement Task Force by California HMOs, 1997.
70 Testimony to the Task Force at public hearings suggested that centers of excellence often have difficulty in obtaining contracts with health plans. However, this does not necessarily demonstrate that HMOs do not contract with other centers of excellence.
72 Testimony submitted to the Managed Health Care Improvement Task Force by a California HMO.
73 Testimony submitted to the Managed Health Care Improvement Task Force by a different California HMO.
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. Consumers experienced 64% and 79% increases in their average monthly premium contributions for employee and family coverage respectively between 1988 and 1993, according to a Bureau of Labor Statistics study of employees in large firms. In 1997, employee premium contributions and deductibles were lower than the previous year, but HMO and POS copayments showed signs of increase from $0 to $5-10 on average. Nevertheless, without cost-containment under managed care, these cost increases might have been greater.

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.

A. Access to Insurance
1. Lower Increase in Uninsured
Despite lower overall costs generally, the number of uninsured continues to be high. As a result of cost containment, managed care may have improved overall access by preventing even more people from becoming uninsured. Studies have shown that employer coverage is sensitive to the price of insurance.

The Lewin Group calculated that in 1996 three to five million additional Americans were insured due to managed care cost reductions, noting that because premiums were lower, more employers offered benefits. To develop this estimate, Lewin reviewed studies showing how the number of employers purchasing insurance changed at various price levels. Based upon these calculations they estimated that for every one percent increase in premiums, the number of employers purchasing health insurance would decline by 0.40 percent (i.e., the price elasticity of employer demand for health insurance is -0.40). An independent health economist at University of California at San Diego corroborated this estimate. In estimating the impact on the number of uninsured, Lewin assumed that about one-third of those who would have lost employer coverage would obtain coverage from some other source such as Medicaid, a spouse's employer plan or individually purchased non-group coverage.

The converse also appears to be true. That is, regulations that undermine cost containment efforts of managed care plans may increase uninsurance. In studies that examine the impact of benefit mandates

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84 Richard Kronick, personal communication based on research for a forthcoming publication.
and other requirements on health plans, the US Congressional Budget Office suggests that effects include both reductions in benefits and reduced coverage.86

2. Rural Areas
Access to insurance of all plan model types is a problem in rural areas. Rural HMOs have difficulties because of inadequate populations for risk distribution and too few providers.87 In addition, rural providers are often overworked, have little competition, charge high prices and have no incentive to join an HMO.88 To support rural HMOs, the Agency for Health Care Policy and Research (AHCPR) and HCFA have funded demonstration projects. Meanwhile, all 24 of California's rural counties have group or network HMOs in at least part of the county, 12 also have IPA models and nine also have mixed models. Furthermore, Knox-Keene rules requiring contiguous HMO expansion have helped to improve access in rural areas.

B. Access to Care
Studies of access suggest managed care's impact has been mixed.

1. Privately-Insured Population
The Robert Wood Johnson Foundation (RWJ) National Access Survey found HMOs had shorter waiting times and more and more widespread medical visits, but also longer travel distances and greater unmet medical needs.89 In their survey of 3,450 people with private insurance (HMO, PPO or indemnity), and additional samples of people reporting access barriers or certain serious illnesses, RWJ found that HMOs had the lowest office waiting time at the regular source of care: 13% of HMO enrollees reported waiting over 30 minutes, compared to 17% of PPO enrollees and 20% of indemnity enrollees. In addition, 85% of HMO enrollees reported a medical visit within the past year, compared to 80% of indemnity enrollees. HMO members with a visit averaged 4.8 per year, versus 4.0 for indemnity. However, 17% of HMO enrollees reported traveling over 30 minutes for that care compared to 12% of PPO enrollees.90 Additionally, 4.8% of HMO enrollees reported an unmet medical need, compared to 3.0% of indemnity enrollees. When sorted by income, low-income HMO enrollees (Medicaid and non-Medicaid) with at least one visit averaged 8.6 per year, versus 5.3 for low-income indemnity enrollees.

2. Non-Elderly Ill
Another RWJ-sponsored study conducted by the Harvard School of Public Health found that while nonelderly sick or individuals with disabilities in managed care plans report lower out-of-pocket expenses, they have more problems getting the health services or treatment they or their doctors think is necessary than their counterparts in indemnity plans (22% of sick people in managed care plans reported major or minor problems compared to 13% in indemnity plans).91 The study also found that managed care enrollees were more likely to report difficulty getting access to diagnostic tests (24% compared to 17% were unable to get the needed diagnostic tests in the past year) and waited longer for medical care (17 days compared to 12 days to get an appointment).

3. Medicare Managed Care Population
A 1996 Mathematica survey found lower costs for Medicare HMO members, greater access to prescription benefits, and more preventive care, but greater access problems, especially among vulnerable populations.92

90 In California, Knox-Keene regulated health plans are required in general by Rule 1300.51(H) to provide access to care within 30 minutes of 15 miles of members' home or work, so this problem may not apply in California.
Mathematica surveyed 3,080 Medicare HMO members and compared results to the 1994 Medicare Current Beneficiary Study for indemnity beneficiaries. Overall, HMO enrollees were satisfied with their access to care. However, 13% of HMO enrollees reported access problems compared to 4% of indemnity beneficiaries. HMO enrollees received more preventive care than indemnity beneficiaries did. However, vulnerable sub-populations (the non-elderly disabled, the oldest old, those with functional impairments and those in fair, poor or declining health) reported more access problems in HMOs than indemnity plans.

4. Uninsured Population and the Safety Net
The Task Force chose not to address some topics because they were considered outside the scope of the Task Force's charter. 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.

C. Access to Providers
Closed-end HMOs select medical groups, IPAs, and practitioners for their provider networks. Members' access to providers may be restricted to those providers participating in the network. The RWJ-Harvard School of Public Health study found that managed care enrollees were more likely to report difficulty getting access to specialist care than their counterparts in indemnity plans (21% compared to 15% were unable to see a specialist when they needed one in the past year).

A rapidly spreading innovation, point of service plans (POS) offer some coverage for care without a referral or outside the network for a deductible and higher cost-sharing. Many California HMOs now offer POS plans, though not all consumers have access to these plans. The 1995-96 AAHP annual industry census found that over 80% of HMOs currently offer POS products which offer access to providers outside the network at some additional cost. However, if these plans are not carefully constructed, POS can open certain vulnerable consumers to greater financial risk than is readily apparent in marketing and evidence of coverage materials.

Many HMOs require consumers to choose a primary care provider (PCP) to coordinate their care. Some HMOs allow family members to choose among different medical groups or IPAs so each can have his or her own personal provider. In general, patients who need care from another provider must obtain a referral from their PCP. This process is often a source of tension for providers and patients. Consumer Reports suggests that some referral processes are designed to make patients give up. For further discussion of the gatekeeper role of PCP and the potential impact of certain financial arrangements, see the Task Force papers on Physician-Patient Relationship and Provider Financial Incentives.

In response to consumer demand, many HMOs have developed new products with improved access. Some HMOs allow members to be referred to any network provider, regardless of medical group/IPA. Others do not restrict referrals to the PCP's medical group/IPA. Still more HMOs allow patients to visit specialists in their PCP's group without a referral for a higher copayment. In addition, access to specialists

for patients with chronic conditions is often more flexible. A 1994 Mathematica survey found that more than 75% of HMOs nationally allow specialists to serve as primary care providers for some patients.\textsuperscript{97} Testimony presented to the Task Force during public hearings, however, indicated continued problems with access for some to specialists in California (see Task Force paper on Improving the Delivery of Care and the Practice of Medicine).

D. Access to Hospitals
Historically, hospitals shifted uncompensated costs of government programs (e.g., Medicare and Medicaid) and other patients to private sector patients whose insurance covered the cost. With an increasing proportion of private patients in managed care plans, this practice is no longer possible and hospital reserves are being depleted.\textsuperscript{98} If these trends continue, hospitals in California may not have adequate reserves to enable them to comply with California law (SB 1953, 1994) that requires them to complete costly seismic safety upgrades by the year 2007. This is particularly a problem for hospitals in rural areas because they typically shoulder a greater burden of uncompensated care.

Hospital representatives have suggested that there is variation in hospital accessibility by geography, season, and class of service.\textsuperscript{99} Typically, rural and inner city hospitals have greater access problems than hospitals in other areas. The patient census at a typical hospital is higher during the winter months than in the summer, beginning in October and ending in March. This is because there is seasonal variation in some diseases, such as cardiac illness, which increases with stress and pressure associated with the holidays. There may also be more access problems in emergency rooms (ERs), intensive care units (ICUs), and critical care units (CCUs) than in other hospital units.\textsuperscript{100} Under current law Knox-Keene regulated health plans must have adequate ERs, ICUs and CCUs under contract to operate.\textsuperscript{101}

Access to hospital ERs is a complex issue. The ER is often a poor (and expensive) substitute for an office visit. Because ERs have been and continue to be abused and overused, HMOs have provided alternative services to help guide patients to the appropriate care setting. Some health plans now offer telephone advice from nurses 24 hours a day. Unless the need is urgent, patients and caregivers can call advice nurses first. When emergency care is necessary, HMOs are required by law to provide that coverage.

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that, when a patient presents in an ER, a physician must assess the patient prior to screening for insurance coverage. In addition, federal and state legislation has addressed complaints about overly restrictive access to ERs. With the passage of SB 1832 in 1994, HMOs are required to use a “prudent layperson’s” standard. That is, if a prudent layperson would believe his life or health was in danger and emergency care was needed, he may go to the ER without prior authorization from his HMO and the insurance must pay, even if subsequent investigation reveals no danger. Testimony submitted to the Task Force by the California Chapter of the American College of Emergency Physicians, however, suggested that greater enforcement of this provision is necessary. For Medicare and Medicaid HMOs, the federal Balanced Budget Act of 1997 requires the prudent layperson standard. For ERISA plans (those paid by self-insured employers), federal HR 815 proposes this standard.

E. Access to Pharmaceuticals
Most HMOs and other managed care organizations provide pharmaceuticals as a covered benefit. This represents an improvement in access for those whose coverage does not include outpatient drugs. HMOs created formularies (i.e., a pre-approved list of selected drugs, used to guide physician prescription decisions) to lower pharmaceutical costs and maintain affordable drug coverage. Without formularies,

\textsuperscript{97} Felt-Lisk S, “How HMOs Structure Primary Care Delivery,” Managed Care Quarterly, 4:4, Autumn 1996, 96-105.
\textsuperscript{98} Tranquada R, “Emergency Medical Care and the Public Purse,” JAMA, 276:12, September 25, 1996, 945-6.
\textsuperscript{99} Statement to the Managed Health Care Improvement Task Force by Task Force member, Nancy Farber, Washington Hospital, October 28, 1997, Sacramento, CA.
\textsuperscript{100} Stocking B, “Patient Influx Left Hospitals Scrambling”, San Jose Mercury News, October 19, 1997, 7B.
\textsuperscript{101} SB 1832 CA 1994, Chapter 614.
drug coverage could become more costly, and fewer Americans could afford it. Formularies have helped Medicare HMOs offer affordable pharmaceutical benefits, while indemnity Medicare does not cover outpatient drugs at all.

Formularies are an important tool because drug costs are rising rapidly. Prescription drug costs grew at 8% per year between 1990 and 1995. Spending growth was slower than total personal health care expenditures in 1993 and 1994, but jumped to 2% faster than personal health care expenditures in 1995, in part because switching to managed care increases the likelihood of prescription coverage.\(^\text{102}\) Drug costs rose 13% in 1996, largely due to the introduction of new, higher prices of older, and increased use of drugs.\(^\text{103}\) According to Hambrecht & Quist, while drugs accounted for 10% of HMOs' medical budgets in 1996, they accounted for 50% of their cost increases.\(^\text{104}\)

Formularies attempt to save money by directing patients to less expensive drugs when more costly alternatives provide little or no incremental benefit, allow managed care organizations to buy in large quantities, offer generics, and negotiate prices among similar drugs. Evidence suggests some formularies save money. For example, after the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) eliminated closed Medicaid formularies, Alabama drug costs increased by 62%.\(^\text{105}\)

Pharmaceutical manufacturers argue that many drugs offset their high costs by reducing other health care costs. One study, the Managed Care Outcomes Program, followed 13,000 patients with arthritis, asthma, ulcer, hypertension and otitis media for one year at five HMOs with closed formularies and one with an open formulary.\(^\text{106}\) After risk adjustments, the more limited the formulary, the higher the prescription count, number of office visits, emergency room visits and hospitalizations. This study, however, did not examine whether the patients' providers were responsible for total health care costs or for costs excluding pharmacy which could have affected the provider's behavior and potentially the outcomes examined in the study.

HMO formularies have been criticized because (1) prescription restrictions may not be adequately disclosed to enrollees, (2) formulary decisions may be based on drug discounts rather than rigorous analysis of comparative benefits and costs, and (3) continuity of prescriptions may be interrupted if health plans change formulary drugs or if an individual changes plans.\(^\text{107}\) Patients who changed drugs after joining new HMOs because their old drugs were not on the new plan's formulary have reportedly suffered side effects from the new drugs.\(^\text{108,109}\) HMOs have also been criticized for placing medical groups at risk for unrealistically low prescription drug budgets.\(^\text{110}\) This practice could be detrimental if groups select drugs without consideration of their impact on total costs (see Task Force paper on Improving the Delivery of Care and the Practice of Medicine).

In addition, formularies may cause an administrative burden for patients and providers if it is difficult to obtain approval for non-formulary drugs. Administration is especially complex for medical group/IPAs and other providers who may serve more than a dozen health plans, each with their own formulary with

\(^\text{104}\) Op cit., Johannes L, "Dose of Austerity: Some HMOs Now Put Doctors on a Budget for Prescription Drugs."
\(^\text{106}\) Horn S, et al., "Intended and Unintended Consequences of HMO Cost-Containment Strategies: Results from the Managed Care Outcomes Project," The American Journal of Managed Care, 1:3, March 1996, 253-64.
which the providers must comply. There is considerable debate about which is the most appropriate entity and which has the necessary resources and expertise to determine the formulary: the health plan, a pharmacy benefit manager (PBM), or the medical group/IPA.

**F. Access to Specific Types of Health Care**

1. **Reproductive Health Services**

Nationally, 81% of HMOs offer some direct access to obstetrician-gynecologists either by permitting selection of an obstetrician-gynecologist as a PCP or by allowing limited self referral to these specialists. In addition, according to the Alan Guttmacher Institute, HMOs nationally offer considerably more comprehensive coverage of the range of reproductive health services than does traditional indemnity insurance. For example, 99% of HMOs routinely cover annual gynecological exams compared to 88% of POS, 64% of PPOs, and 49% of indemnity. Similarly, virtually all HMOs and POS cover routine mammograms compared to 80% of PPOs and indemnity.

2. **Mental Health**

The impact of managed care on access to mental health services is mixed as is the impact on access to services generally. Lower costs for mental health services have increased access for some, but stricter limitations on benefits have decreased access as well. Some HMOs have lower copayments or fewer limits on mental health than PPO/indemnity plans. For example, HMO mental health benefits in CalPERS are more generous than their PPO competitor. Some, however, have criticized managed mental health plans for limiting approvals to care, using non-psychiatric personnel to approve care, and using less costly providers and treatments which they allege may harm the quality of care.

**IV. Impact of Managed Care on Cost**

A. **Cost of Insurance**

Driven by purchasers, competition and threat of legislation, managed care has slowed the rise in health insurance costs. In a recent study, the Congressional Budget Office (CBO) suggested that the steady shift of workers from indemnity plans to various forms of managed care plans and the consequent increase in competition in the health insurance market is a major factor in cutting employers' health care costs (for a discussion of employee's health care costs refer to Access section above). 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 uptick in 1997 to a 2.1% increase, about the rate of inflation. Recent reports suggest that premium prices are expected to increase more in 1998, though less so in California than elsewhere.

According to HMO self-reported data, average premiums in California increased for families by 17.3% and 6.6% for individuals in 1992. 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 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. As of 1995, more than 40% of insured Californians were enrolled in HMOs, the fourth highest penetration in the country.

111 California law, (AB 2493, 1994, Chapter 759) requires plans to offer obstetrician-gynecologists as PCPs if they meet certain criteria.
113 Op cit., Boyle P and Callahan D, “Managed Care and Mental Health: The Ethical Issues.”
117 Premiums are weighted by HMO size. Average premiums reported by HMOs include individuals and groups. California to national comparison does not account for differences in benefits packages, however, year to year changes provide some historical adjustment. Hoechst Marion Roussel, HMO-PPO Digest, 1992-1997.  
118 Hoechst Marion Roussel, HMO-PPO Digest, 1996.
Figure 1. Percent Change in Average Premiums, CA and US, (1991-1996)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent Change in CA</th>
<th>Percent Change in US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family</td>
<td>Individual</td>
</tr>
<tr>
<td>1991-92</td>
<td>17.3%</td>
<td>6.6%</td>
</tr>
<tr>
<td>1992-93</td>
<td>4.9%</td>
<td>5.9%</td>
</tr>
<tr>
<td>1993-94</td>
<td>-0.6%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>1994-95</td>
<td>3.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1995-96</td>
<td>-4.4%</td>
<td>-3.0%</td>
</tr>
</tbody>
</table>


1. Large purchasers

For large purchasers, net reductions in weighted average premiums since 1993 range between 1% and 20% before inflation, and managed care penetrations range between 57% and 100% (see Figures 2 and 3). Weighted average premium reductions translate into substantial savings. For example, CalPERS premiums doubled from 1987 to 1992. In 1991, the state had a fiscal crisis and froze its maximum contribution. At the same time, CalPERS demanded premium reductions, with threats to freeze membership in the health plan or drop it altogether. From 1992 to 1997, CalPERS premiums were approximately flat. If instead premiums had continued at the rate of growth of average US premiums, the 10 states with the lowest managed care penetration, or if premiums had continued at the pace they experienced during the five years prior to 1992, public employees and taxpayers would have paid substantially more. Under these assumptions respectively, cost avoidance was $570, $1,215, or $2,685 per employee or $250 million, $530 million, or $1.2 billion in 1996 alone.\(^{19}\)

Figure 2. California Weighted Average Health Care Premiums (1992-1998)

<table>
<thead>
<tr>
<th>Purchaser</th>
<th>Percent Change in Weighted Average Total Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97-98</td>
</tr>
<tr>
<td>CalPERS</td>
<td>3.20%</td>
</tr>
<tr>
<td>CalPERS (HMO only)</td>
<td>2.70%</td>
</tr>
<tr>
<td>FEHBP (HMO only)</td>
<td>N/A</td>
</tr>
<tr>
<td>PBGH(^{11})</td>
<td>1.00%</td>
</tr>
<tr>
<td>Stanford (b)</td>
<td>N/A</td>
</tr>
<tr>
<td>UC (b)</td>
<td>N/A</td>
</tr>
<tr>
<td>HIPC</td>
<td>3.87%</td>
</tr>
<tr>
<td>HIPC (HMO only)</td>
<td>3.30%</td>
</tr>
</tbody>
</table>

\(^{11}\) Calculation assumes 436,704 prime lives as of April 1997.

Figure 3: Proportion of Enrollees in HMO/POS, 1996

<table>
<thead>
<tr>
<th>Purchaser</th>
<th>Enrollees in HMO/POS</th>
<th>Percent in HMO/POS</th>
<th>1995-1996 % Increase for HMO/POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>13,393,100 (a)</td>
<td>42.40%</td>
<td>10.53%</td>
</tr>
<tr>
<td>CalPERS</td>
<td>810,110</td>
<td>80.79%</td>
<td>0.24%</td>
</tr>
<tr>
<td>FEHBP (CA)</td>
<td>493,075</td>
<td>57.41%</td>
<td>3.13%</td>
</tr>
<tr>
<td>PBH (b)</td>
<td>350,000</td>
<td>75.40%</td>
<td>9.28%</td>
</tr>
<tr>
<td>Stanford (est.)</td>
<td>25,000</td>
<td>100.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>UC (est.)</td>
<td>266,360</td>
<td>93.46%</td>
<td>3.63%</td>
</tr>
<tr>
<td>HIPC</td>
<td>126,692</td>
<td>98.80%</td>
<td>4.36%</td>
</tr>
</tbody>
</table>

a = 1995; b = negotiating alliance only.

2. Small Purchasers
In the small group market, HIPC rates have also declined since 1993, though its rates have increased in the last two years. A reasonable assumption would be to expect similar experience across the entire small group market, however, data on premiums in this market segment are not available. In addition, rates in the individual market are not documented in summary form.

3. Higher Managed Care Penetration Associated with Savings
According to an American Association of Health Plans-commissioned study, utilization review (i.e., case reviews of medical necessity issues), utilization management (i.e., incentive structures and other measures used to promote efficiency and quality), and provider discounts reduce managed care plan costs compared to traditional indemnity (see Figure 4).

Figure 4: Managed Care Health Plan Savings Relative to Indemnity Plans

<table>
<thead>
<tr>
<th></th>
<th>Utilization Review</th>
<th>Utilization Management</th>
<th>Discounts</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff &amp; Group HMOs</td>
<td>4%</td>
<td>18%</td>
<td>8%</td>
<td>30%</td>
</tr>
<tr>
<td>IPA HMOs</td>
<td>4%</td>
<td>4%</td>
<td>15%</td>
<td>23%</td>
</tr>
<tr>
<td>POS/PPOs</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>Managed indemnity (with utilization controls)</td>
<td>4%</td>
<td>–</td>
<td>–</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Congressional Budget Office, Lewin-VHI, Barents Group LLC

This and other studies suggest that much of the slow down in health care cost growth in California as elsewhere is attributable to the continued expansion of managed care enrollment.

121 Hoechst Marion Roussel, HMO-PPO Digest, 1996.
4. National Comparison
The higher penetration of managed care enrollees in California has resulted in lower premium increases in California than the US as a whole, as reflected in Figure 1 above. Using the Federal Employees Health Benefits Program which offers employees a relatively standardized benefits package nationwide, one can compare more precisely national HMO rates to California HMO rates. In comparing the weighted average individual monthly premiums, FEHBP HMO rates in California have declined more than the national average since 1994 (see Figure 5).

Figure 5: Health Care Marketplace Comparison: CA & US FEHBP HMO Weighted Average Individual Monthly Premiums and HMO Enrollment, 1997

<table>
<thead>
<tr>
<th></th>
<th>1997 WA Ind Monthly Premiums</th>
<th>% of Pop in HMOs 1997</th>
<th>% Chg 96-97</th>
<th>% Chg 95-96</th>
<th>% Chg 94-95</th>
<th>% Chg 93-94</th>
<th>% Chg 92-93</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>$158.25</td>
<td>57.41%</td>
<td>-2.16%</td>
<td>-3.94%</td>
<td>-7.25%</td>
<td>4.65%</td>
<td>7.33%</td>
</tr>
<tr>
<td>US average</td>
<td>$168.06</td>
<td>29.35%</td>
<td>1.08%</td>
<td>-1.93%</td>
<td>-3.85%</td>
<td>4.19%</td>
<td>8.11%</td>
</tr>
</tbody>
</table>

5. Impact of Savings on the Economy
A 1997 study by The Lewin Group estimated the amount of savings resulting from managed care. Based on their own and more conservative CBO 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.

According to the Lewin study, the reduction in health care costs due to managed care increased wage levels for covered workers above what wages would have been in the absence of managed care. The national average wage gain due to managed care savings for covered workers in 1996 was between $228 and $356, or between 0.7% and 1.0%. The average amount saved by households through managed care varied from $191 to $252 per single individual, $408 to $549 per married couple, and $375 to $500 per family.

B. Underlying Cost Structure
Information about the cost structure underlying insurance premiums suggests that California generally has a lower cost structure than the nation on average, including fewer hospital beds (though measurement of licensed beds potentially misses greater reductions in operating beds) and fewer hospital days per 1000 members (see Figure 6). While California has slightly more physicians per 100,000 population than the national average, this number has been increasing at a slower rate.

Variations in utilization of hospital days and visits among California medical groups may suggest continued room for improvement (see Figure 6). According to medical group data, the least efficient medical group typically uses twice the resources of the most efficient medical group. 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 HMO model types.

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124 Analysis did not control for patient populations or for outcomes. The term “efficient” is intended to describe a group’s use of resources, including number of days and office visits.
### Figure 6: Health System Utilization Statistics, California versus US

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>% Change per Year Since 1990</th>
<th>US</th>
<th>% Change per Year Since 1990</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHA (1996)(^{125})</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Stay Hospital Days/1000</td>
<td>523</td>
<td>(3.20%)</td>
<td>765</td>
<td>(2.84%)</td>
</tr>
<tr>
<td>Hospital Beds/1000</td>
<td>2.39</td>
<td>(2.18%)</td>
<td>3.34</td>
<td>(1.87%)</td>
</tr>
<tr>
<td><strong>Medicare (1993)(^{126})</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Stay Hospital Days/1000</td>
<td>1,656</td>
<td>(4.76%)</td>
<td>2,503</td>
<td>(3.50%)</td>
</tr>
<tr>
<td><strong>AMA (1995)(^{127})</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians/100,000</td>
<td>275</td>
<td>0.22%</td>
<td>264</td>
<td>2.35%</td>
</tr>
<tr>
<td>Percent Primary Care (a)</td>
<td>38.53%</td>
<td>N/A</td>
<td>38.77%</td>
<td>N/A</td>
</tr>
<tr>
<td>Physician Graduates /1000</td>
<td>324 (b)</td>
<td>(8.21%) (c)</td>
<td>605 (b)</td>
<td>(7.16%) (c)</td>
</tr>
<tr>
<td><strong>UMGA versus US (1995)(^{128})</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted total days/1000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial Days/1,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Medical Group</td>
<td>151</td>
<td>(7.99%) (d)</td>
<td>258.4 (e)</td>
<td>(5.31%)</td>
</tr>
<tr>
<td>Most Efficient Medical Group</td>
<td>96</td>
<td>(1.78%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Least Efficient Medical Group</td>
<td>201</td>
<td>(16.22%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Senior Days/1,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Medical Group</td>
<td>1066</td>
<td>(4.11%) (d)</td>
<td>1577.7 (e)</td>
<td>(0.63%) (f)</td>
</tr>
<tr>
<td>Most Efficient Medical Group</td>
<td>839</td>
<td>(2.72%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Least Efficient Medical Group</td>
<td>1623</td>
<td>(6.31%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Visits per member per month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Medical Group</td>
<td>3.84</td>
<td>(1.91%)</td>
<td>3.5</td>
<td>1.18%</td>
</tr>
<tr>
<td>Most Efficient Medical Group</td>
<td>2.25</td>
<td>7.19%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Least Efficient Medical Group</td>
<td>5.56</td>
<td>(3.46%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Senior Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Medical Group</td>
<td>8.54</td>
<td>(1.56%)</td>
<td>8.1</td>
<td>4.50%</td>
</tr>
<tr>
<td>Most Efficient Medical Group</td>
<td>6.01</td>
<td>4.77%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Least Efficient Medical Group</td>
<td>13.60</td>
<td>(2.11%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

N/A = Not Available

- \( a = \) Primary care includes family practice, general practice, internal medicine, obstetrics/gynecology, and pediatrics.
- \( b = 1990-1995 \) average.
- \( d = \) For California, total days include acute, skilled nursing and psychiatric facilities. Days are not adjusted for demographic characteristics, such as age (other than senior versus non-senior), sex or risk.
- \( e = \) For national data, hospital days include acute hospital days only.
- \( f = \) Note: The 1995 value represents a 6.20% decrease from 1994.

### C. Non-Economic Costs

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.

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\(^{125}\) American Hospital Association, 1996 AHA Hospital Statistics.


\(^{128}\) Unified Medical Group Association (now American Group Practice Association), data for California, and Hoechst Marion Roussel, HMO-PPO Digest, 1996, for national data.

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*Managed Health Care Improvement Task Force*
1. Uncompensated Care

Blumenthal, in a discussion of effects of market reforms, suggests that the “commodification” of the physician-patient relationship “will lead to a decline in physicians’ altruism and, particularly, reduced willingness to provide free care to uninsured and poor patients...Pro-market policy analysts who ignore this potential effect of competition are in danger of losing touch with the average citizen.”

According to a nationwide study on uncompensated care conducted by RAND, when measured in real terms, the level of uncompensated care grew by 150 percent from 1983 to 1995. However, the increase in levels of uncompensated care after 1988 appears not to have kept pace with the growth in hospital expenses or the number of uninsured. Although changes in uncompensated care have been modest in the aggregate, there have been significant shifts in the distribution of hospitals providing uncompensated care. The RAND study suggests that higher levels of managed care penetration are associated with lower levels of uncompensated care delivery.

2. Clinical Research

A Lewin-VHI study commissioned by the Department of Health and Human Services and the National Institutes of Health found that increased managed care penetration “has had a limited impact on clinical research to date, but that economic forces facing academic medical centers may substantially affect future clinical research” (see Task Force paper on Academic Medical Centers). Reductions in coverage for diagnostic procedures, denials for experimental treatment, and reduced patient flow are some of the variables that fuel these concerns (see Task Force paper on Improving the Delivery of Care and the Practice of Medicine).

In addition, two studies recently published in JAMA attempt to measure the impact of managed care on clinical research. The first study found that in competitive markets the rate of publication for clinical researchers decreased, the percentage of young faculty with patient care responsibilities was greater, and lower levels of departmental cooperation were perceived by faculty. However, the study also found that the percentage of senior faculty with patient care responsibilities remained the same and that there were no significant differences in the amount of faculty-student contact by market stage. The second study, provides evidence of an inverse relationship between growth in National Institutes of Health awards to clinical departments and managed care penetration among AMCs. Much of this revenue loss can be explained by the slower growth of research (RO1) awards to clinical departments in medical schools in high managed care markets. Whether this association is causal has not been determined. However, this study was criticized as being misleading by the American Association of Health Plans because the authors did not investigate whether the slowed growth reflects changing national research priorities or if awards were going to other institutions in those communities.

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Public Perceptions and Experiences with Managed Care

Appendix A: Literature Review Findings

I. Findings

The Task Force Survey was designed based on a careful review of existing research. This section is intended to place the results of that survey in context by reviewing the findings of other public opinion and plan member satisfaction and experience studies conducted from 1994-1997.

The impact of managed care on public satisfaction and experience with their health care system has been the subject of numerous studies, yet the existing body of research on this topic lacks consistent emphasis and methodology. Comparing the results of one survey to another is difficult because of different sample populations, questions, and varying levels of rigor in the analysis. Nevertheless, several themes emerge which are supported by the findings of the Task Force Survey.

A. Perceptions of Managed Care

A published review of six recent surveys stated that “most Americans are well satisfied with many aspects of their care, regardless of the type of coverage they have.”1 This review draws the same conclusion. However, many Americans’ attitudes toward the concept of managed care contain a level of mistrust and concern that lies in contrast to a high level of satisfaction with their individual experiences with the managed health care system.2,3,4

B. Overall Satisfaction

Despite the differences in focus and methodology, most studies 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. Typical results show that approximately four out of five people are satisfied with their plan, with over 50% highly satisfied.5,6,7,8

C. Preferred Plans

Several studies have measured satisfaction by type of managed care plan (HMO, PPO, POS) and compared these ratings to those observed in traditional unmanaged fee-for-service (“indemnity”) enrollees.9,10 The results of these surveys are mixed, and often contradictory. In the majority of surveys, managed care plans tend to score higher than indemnity plans overall, based on higher satisfaction with costs and paperwork loads. HMOs and PPOs tend to score higher than POS plans, largely based on the high dissatisfaction with POS procedures for seeing out-of-network physicians.11,12 Studies that show indemnity preference cite the importance of physician choice. In general, all types of plans produce satisfaction ratings consistent

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3 A similar poll by Louis Harris found that 51% of Americans say that managed care does a “good job” serving customers, compared to 83% for physicians, 79% for pharmaceutical companies and 77% for hospitals. In comparison, telephone companies received 80% favorable ratings and banks 75%. Louis Harris Associates, 1997, cited in Alex Pham, “HMOs Seek Cure to Image Malady,” Boston Globe, June 12, 1997, C1.
9 Pacific Business Group on Health (PBGH), Health Plan Value Check, 1996.
10 CareData Reports, Survey of Health Plan Members, 1996 & 1997.
12 CareData Reports, Inc., 1998 Novartis Report On Member Satisfaction With Managed Care.
with the overall average. Each option has its strengths and weaknesses, and no one approach emerges as
d the clear public preference.

D. Studies Comparing California to the Nation
The results for California do not vary significantly from those reported for the national population. Large
studies where intra-survey comparisons are possible show California near the national average in satisfaction.  

E. Areas of Dissatisfaction
While overall satisfaction is high, issues related to specialist care emerge as a common category of concern.
Managed care plans, compared to Medicare and unmanaged indemnity coverage, produce lower satisfaction
levels on the “quality of specialist care” and the “ease of getting referrals” to specialists.  Indemnity plans
suffer similar problems, although not to the same degree. Problems receiving the care a patient or the
patient’s physician believes is necessary is also an important source of frustration across all types of plans.

F. Trends
Studies that track satisfaction over time report a general stabilization in consumer attitudes over the past
two years. The researchers say these results suggest that managed care is achieving and maintaining high
levels of satisfaction, even as a larger percentage of the population is exposed to it. One possible explana-
tion for this trend is a growing familiarity of the general public with the concept of managed care, indicative
of a normal adoption process for any new product or service.

G. Satisfaction vs. Quality
The relationship between satisfaction and quality of care is complex and not definitively understood. In
general, satisfaction levels with health plans are higher than the perceptions of care quality, although
satisfaction with physician quality is consistently high. Plans that score well on objective measures of
quality do not necessarily perform well on member satisfaction surveys. The relative importance of the
care delivered in the clinic or the physician office and the administrative and operational processes as an
influence on member satisfaction is a point of ongoing study.

H. Medicare HMOs
The growth of managed care among Medicare populations has produced high satisfaction ratings. With few
exceptions, studies of this specific managed care population show that they are generally satisfied with their
care and that they compare favorably to the general population and traditional Medicare beneficiaries.

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14 Blendon RJ, et al., “Americans Compare Managed Care, Medicare, and Fee-for-Service,” Journal of American Health Policy, May/June 1994,
42-47.
15 PBGH, Health Plan Value Check, 1996.
16 “Consumer Satisfaction Surveys and Health Plans,” Research Highlights, American Association of Health Plans, July 14, 1997, based on
18 Stanley M, Testimony presented to the Managed Health Care Improvement Task Force, July 26, 1997 based on analysis of PBGH Health Plan
Value Check member satisfaction survey.
21 Riley GF, Ingher MJ, and Tudor GJ, “Disenrollment of Medicare Beneficiaries From HMOs”, Health Affairs, September/October 1997, pp. 117-
124.
I. Impact of Health Status on Satisfaction
Plan members who are in good health report significantly higher levels of satisfaction with their health plan than members who are in poor health. This finding is not unique to managed care, however, as indemnity patients who are in poor health also voice greater dissatisfaction with their care. Authors of these studies emphasize the importance of focusing not on the overall satisfaction levels of greater than 80%, but instead weighting more heavily the opinions of those with greater exposure to the health care system.24

J. Impact of Choice on Satisfaction
A widely cited study conducted by the Commonwealth Fund showed that managed care members whose employers offered no choice of plans were much more likely (22% vs. 14%) to be dissatisfied with the plan overall than those who were given a choice.25 A similar effect holds for employees who had indemnity coverage without and with options (14% vs. 8%).

K. Sources of Variation in Results Across Surveys
The news media have given managed care satisfaction studies significant coverage. In turn, the public has received a wide range of often contradictory reports about the ability of managed care plans to satisfy their needs. One major source of this variation is the definition of what constitutes a “satisfied” plan member. Depending on the study, “satisfaction” is defined as three or above on a five point scale, or limited to six or above on a seven point scale. This simple factor can produce satisfaction ratings that vary by over 30 percentage points, thereby painting very different pictures of the public’s perception.

Critics of many satisfaction studies point to the fact that plans tend to survey far more healthy people than those with actual experience with how the system treats patients. Healthy people are more numerous and likely to give high satisfaction ratings, and their opinions can mask real dissatisfaction by those who are heavy users of the health care system. Furthermore, those who are dissatisfied and leave plans are often not included in the sample pools. Rigorous studies oversample these populations to get a more balanced

Public Perceptions and Experiences with Managed Care
Appendix A: Literature Review
Background Paper

I. Introduction

The impact of managed care on public satisfaction and experience with their health care system has been the subject of numerous studies, yet the existing body of research on this topic lacks consistent emphasis and methodology. Comparing the results of one survey to another is difficult because of different sample populations, questions, and varying levels of rigor in the analysis. Nevertheless, several themes emerge. The purpose of this chapter is to provide an overview of other current research on public opinion and plan member satisfaction, and to place the findings of the Task Force Survey in context.

A. Perceptions of Managed Care

A published review of six recent surveys stated that “most Americans are well satisfied with many aspects of their care, regardless of the type of coverage they have.”26 This review draws the same conclusion. Despite many differences in methodology, objective, and target population, the majority of studies finds that most people are satisfied with their own health care coverage, whether that coverage is managed care or traditional unmanaged fee-for-service (“indemnity”).

Many Americans’ attitudes toward the concept of managed care contain a level of mistrust and concern that lies in contrast to a high level of satisfaction with their individual experiences with the managed health care system. A recently released national survey by the Kaiser Family Foundation and Harvard University found that only 34% of Americans think managed care health plans do a “good job” serving customers.27 This compares poorly to the 83% ratings achieved by nurses, 69% by doctors, 61% by hospitals, and 62% by pharmaceutical companies. Thirty-two percent, however, had no opinion about the kind of job managed care plans are doing.

While most insured Americans responding to the Kaiser/Harvard survey gave their own plan a letter grade of “B” or higher, the study found that consumers are anxious about whether their plans will pay for the care they need if they get sick. The survey authors offered some possible explanations for the discrepancy between consumers’ opinions about managed care in general and their own coverage. Harvard’s Blendon suggested that “members appear satisfied with their plans today, but are concerned about what might happen to them in the future.” In addition, while people say that their feelings about managed care, favorable as well as unfavorable, are more likely to be based on personal experiences and what they have heard from family members and friends than on media coverage, the survey found that people seem to generalize from anecdotal reports in the news about problems with managed care. When asked about specific examples taken from news stories about the problems some people have reported to have had with managed care, the public’s perception is that these are fairly common occurrences.

The California Chamber of Commerce and the California Business Roundtable recently conducted a

28 A similar poll by Louis Harris found that 51% of Americans say that managed care does a “good job” serving customers, compared to 83% for physicians, 79% for pharmaceutical companies and 77% for hospitals. In comparison, telephone companies received 80% favorable ratings and banks 75%. Louis Harris Associates, 1997, cited in Alex Pham, “HMOs Seek Cure to Image Malady,” Boston Globe, June 12, 1997, C1.
survey of business leader and voter views on managed care in general and found that 38% of voters and 47% of business leaders reported having a “somewhat negative” or “very negative” perception of managed care. \(^2^9\) When voters recently had the opportunity to change the managed care system by approving patient protection legislation (Propositions 214 and 216 of 1996), they voted not to do so by a margin of approximately 60% No to 40% Yes.

B. Overall Satisfaction

Of all issues related to the public’s perceptions of their health care coverage “overall satisfaction” scores are the most widely reported. Unfortunately, different survey methodologies make comparing these data across studies difficult. For example, in the same week in September 1997, two studies reported that American’s satisfaction with their managed health care plans was strong and growing. One reported a satisfaction level of 90%; the other 59%. \(^3^0\) Typical results show that approximately four out of five people are “satisfied” with their plan, with over 50% of them highly satisfied. Studies that focus on Californians reach similar conclusions, and find that California rates near the national average on overall satisfaction.

For example, the National Committee for Quality Assurance (NCQA) “Quality Compass 1997” gathered satisfaction data from 130,000 HMO members nationwide. Fifty-six percent said they were “completely or very satisfied” with their HMO, and another 25% said they were “somewhat satisfied.”

A 1997 ABC News/Washington Post survey found that nearly 90% of HMO and PPO members telephoned rated their coverage as “excellent” or “good.” \(^3^1\) These results are consistent with a 1995 Los Angeles Times survey of health care in California, which showed that 92% of HMO members rated their health care coverage “excellent” or “good.” Eighty-five percent of non-HMO managed care patients agreed, compared to 86% of traditional fee-for-service patients. \(^3^2\) Eighty-six percent of both fee-for-service and HMO members rated the quality of care “excellent” or “good.”

A 1996 study conducted by the Pacific Business Group on Health (PBGH) surveyed 15,000 Californians from 21 different HMOs. \(^3^3\) Across all the plans, 77% “responded favorably” about the health plan overall. There was significant variation among plans, however, ranging from a high of 85% to a low of 67%.

Together, these studies suggest that despite the negative perceptions of managed care in general, member’s ratings of their managed care plan are comparable to the high ratings achieved by the components of delivery. For example, a recent survey sponsored by the American Hospital Association reported that 78% of patients rated their hospital care either “very good” or “excellent.” \(^3^4\)

C. Preferred Type of Plan

Studies that have focused on the difference between types of health plans have come to different conclusions about which type of plan produces the highest level of satisfaction. In general, they find similar levels of satisfaction between managed care and indemnity plans, and only the rank order varies. Satisfaction with cost consistently favors managed care. One exception to the generally high levels of satisfaction is POS plans.

PBGH surveyed over 15,000 Californians on 10 major categories of satisfaction. HMOs and PPO/Indemnity plans achieved “satisfied or very satisfied” ratings from 80 and 82% of respondents, respectively. POS plans, by contrast, scored only 56%. \(^3^5\) The area of greatest dissatisfaction for POS plans was “time to approve care,” with only 44% of people satisfied. PBGH found that HMOs outperformed PPOs in willingness of members to recommend and continue with their plan, cost, administrative efficiency, and

\(^{3^3}\) PBGH, California Consumer HealthScope, 1997.
\(^{3^5}\) PBGH Health Plan Value Check, 1996.
medical benefits, while PPO/Indemnity received higher ratings for doctor seen most frequently, ease of referrals, quality of specialists, time to approve care, and time to reach a customer service representative.

A similar result was found by CareData Reports, Inc., an independent health care information company. Their 1996 and 1997 nationwide surveys showed POS plans scoring significantly below other types of plans. A primary area of dissatisfaction was the process of dealing with out-of-network providers. A CareData researcher explained the poor performance of POS plans as follows: “You would think that with more choice, as in a POS, satisfaction would skyrocket because of freedom of choice. But the fact that there is no satisfaction with the handling of out-of-network claims dilutes that appeal of POS plans.”

A different result was found by the 1996 Sachs/Scarborough HealthPlus Survey of 90,000 consumers, where adults in good-to-excellent health rated POS plans ahead of PPO and indemnity plans, and only slightly behind HMO plans (84% satisfaction level). Adults in poor-to-fair health, however, preferred PPOs (72%) to POSs (64%).

D. Studies Comparing California to the Nation
In national surveys of HMO satisfaction, California rates near the mean. A 1996 CareData survey reported that 58.3% of Northern Californians were “highly satisfied” with their HMOs, compared to a national average of 56%. This was, however, well below the 70.8% score seen in Boston. The 1997 version of the same study showed 54.7% of Southern Californians were “highly satisfied” with their HMOs, compared with a national average of 59% and a leading score of 69.6% (Cincinnati).

The higher level of managed care penetration in California appears to have neither a positive nor a negative impact on average overall satisfaction. The rapid growth of the market has supported some health plans that compare favorably to the best in the nation, while others fall well below the mean.

E. Areas of Dissatisfaction
Despite overall ratings that support the conclusion that Americans are quite satisfied with their health care and coverage, several studies suggest a lower level of satisfaction on several issues related to specialist care. A 1994 national telephone study found that “the major differences between managed care and these other plans occur in the area of specialty care.” The same study reported, however, that managed care patients were more satisfied than indemnity plan patients with the speed of referrals to specialists. A 1995 study of Californians who switched plans during the open enrollment period rated access to physicians as the number two reason for their switch, behind cost.

The “time required to approve care” is a consistent source of dissatisfaction across all types of plans. In one California study, HMOs, PPO/Indemnity plans, and POSs received satisfied or very satisfied ratings with time required to approve care from only 65%, 69%, and 44% of their members, respectively. In addition, only 57% of HMO members “responded favorably” about the ease of getting referrals.

Problems receiving the care a patient or the patient’s physician believes is necessary is also an important

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36 CareData Reports, Inc., 1998 Novartis Report On Member Satisfaction With Managed Care.
38 CareData Reports, 1996.
39 CareData Reports, 1997.
40 Blendon, et al., p.46.
42 PBGH Health Plan Value Check, 1996.
43 PBGH California Consumer HealthScope, 1997.
44 PBGH, Health Plan Value Check, 1996.
source of frustration. In the PBGH Health Plan Value Check Survey, 17% of members in all types of plans reported having such problems.44

F. Trends
Studies that track satisfaction over time report a general stabilization in consumer attitudes over the past two years.45 The researchers say these results suggest that managed care is achieving and maintaining high levels of satisfaction, even as a larger percentage of the population is exposed to it. One possible explanation for this trend is a growing familiarity of the general public with the concept of managed care, indicative of a normal adoption process for any new product or service.46 CareData found that between 1995 and 1997, the number of “highly satisfied” people rose from 56% to 59%.47 NRC, which has conducted a series of six studies beginning in 1987, found a slight increase of “completely or very satisfied” patients from 55.9% in 1994 to 56.3% in 1996.48 Medicare HMO plans showed the greatest increase in satisfaction, while HMO enrollees showed a decrease from 63.6% to 58.3%. In California, a CalPERS analysis of PBGH member satisfaction survey results during the period 1993 to 1995 revealed a small increase in satisfaction with both HMOs and PPOs, with 80% and 82% of members satisfied respectively.49 However, CalPERS also found that members’ satisfaction decreases if they experience administrative processes such as submitting a claim, seeking approval of care, and making a telephone call to their plan.

G. Satisfaction vs. Quality
The relationship between satisfaction and quality of care is complex and not definitively understood. In general, satisfaction levels with health plans are higher than the perceptions of care quality, although satisfaction with physician quality is consistently high. PBGH, in cooperation with The Medical Quality Commission, surveyed 60,000 patients in 58 physician groups and PPOs in California and the Northwest.50 Using a 100 point scale, the average score on “overall satisfaction with doctor” was 80.2 in Northern California and 77.8 in Southern California. Overall rating of the quality of care, however, was only 67 in Northern California and 63.5 in Southern California.

In other areas of the country, plans that score well on objective measures of quality do not necessarily perform well on member satisfaction surveys. A study by the Massachusetts Healthcare Purchasing Group, a coalition of government and corporations, found that some plans that scored high on quality indicators were below average in customer satisfaction.51 The relative importance of the care delivered in the clinic or the physician office and the administrative and operational processes that influence member satisfaction is a point of ongoing study.

H. Medicare Managed Care
The growth of managed care among the Medicare population has produced high satisfaction ratings. Evaluations of satisfaction and disenrollment rates indicate that Medicare HMO enrollees are generally satisfied with their care.52 Large studies conducted by NRC in 1994 and 1996 show that Medicare HMO patients are more satisfied than their younger counterparts of comparable health.53 A 1994 study spon-

49 Stanley M, Testimony presented to the Managed Health Care Improvement Task Force, July 26, 1997 based on analysis of PBGH Health Plan Value Check member satisfaction survey.
sored by the American Hospital Association found 93% of Medicare HMO patients rated their HMO good, very good, or excellent, which is equal to the ratings of fee-for-service Medicare beneficiaries.54

I. Impact of Health Status on Satisfaction

A common critique of many satisfaction studies in this field is that they emphasize the view of plan members who are healthy, and who therefore have minimal, if any, recent experience with the health care system. Several studies have attempted to eliminate this bias by focusing on the perceptions of those whose health status is poor.

A 1995 study compared the responses of managed care patients who had been sick in the past year to comparable indemnity plan patients in a number of areas.55 The study found that those who had been sick were more negative about their coverage than healthy plan members. Furthermore, the study found that:

“those in limited choice managed care plans were significantly more likely than those in fee-for-service plans to say that, on their most recent visit, they thought that the care was not appropriate or correct for their situation, the examination was not thorough enough, or the doctor did not spend enough time with them.”56

These findings are supported by several other studies, but it is important to note that the decrease in satisfaction is not unique to managed care. Indemnity plan members also report a lower satisfaction when their health status is fair-to-poor, though this group’s overall satisfaction level tends to be higher than those managed care plan members who are in fair-to-poor health. The authors’ conclusions from this research emphasize the importance of measuring customer satisfaction based on the opinions of those most familiar with the health care system, and not letting these views be masked by the vast majority of people who have favorable, but relatively uninformed views of the system.

In California, CalPERS analyzed results from the PBGH Health Plan Value Check and also found that, for members who were hospitalized or required more services, satisfaction with HMOs and PPOs were often lower than satisfaction of members in general.57 Seven plans had satisfaction levels for non-Medicare sick members (five plans for sick Medicare members) that were five or more percentage points below the satisfaction levels for those members who were not sick. For some plans, however, satisfaction increased for those who were sick.

J. Impact of Choice on Satisfaction

Two studies conducted by The Commonwealth Fund in 1994 and 1997 focus on how satisfaction with health plans is affected by the level of choice employees are given in selecting their own coverage. A 1997 study showed that while 17% of people “somewhat or very dissatisfied” with their managed care plan, dissatisfaction ranged from 22% among those with no choice to only 14% among those with a choice.58 The same effect held for indemnity plans, where a 12% overall dissatisfaction level is split 14% among those with no choice and only 8% among those with a choice.

A 1994 survey of 3000 workers in Los Angeles, Boston, and Miami showed similar results. Managed care members whose employers offered no choice were twice as likely (31% vs. 16%) to be dissatisfied with the plan overall as those who were given a choice.59 Particular areas of dissatisfaction included referrals to specialists, availability of emergency services, and waiting time for appointments.

K. Sources of Variation in Results across Surveys

56 Donelan, pp. 262-263.
57 Stanley M, Testimony presented to the Managed Health Care Improvement Task Force, July 26, 1997, based on analysis of PBGH Health Plan Value Check member satisfaction survey.
The news media have given managed care satisfaction studies significant coverage. In turn, the public has received a wide range of often contradictory reports about the ability of managed care plans to satisfy their needs. One major source of this variation is the choice of scale. Depending on the study, “satisfaction” is defined as three or above on a five point scale, or limited to six or above on a seven point scale. This simple factor can produce satisfaction ratings that vary by over 30 percentage points, thereby painting very different pictures of the public’s perception.

Critics of many satisfaction studies point to the fact that plans tend to survey far more healthy people than those with actual experience with how the system treats patients. Healthy people are more numerous and likely to give high satisfaction ratings, and their opinions can mask real dissatisfaction by those who are heavy users of the health care system. Furthermore, those who are dissatisfied and leave plans are often not included in the sample pools. Rigorous studies oversample these populations to get a more balanced view of member satisfaction.

II. Conclusion
The majority of recent research concludes that Americans and Californians, particularly those who are healthy, are generally satisfied with their health care coverage. Negative popular perceptions of managed care persist, but they are not necessarily consistent with individuals’ ratings of their own health care experience. HMOs and PPOs achieve satisfaction levels comparable, if not favorable to, indemnity plans on many satisfaction measures, and HMOs consistently score higher marks for their lower cost. POS plans are relatively new and have generated mixed results. Medicare beneficiaries are generally satisfied with their managed care experience. The common areas of dissatisfaction across managed care plans are in the areas of access to and quality of specialist care. Satisfaction is lower among populations with poor health status, and it is higher for people who are given a choice of health plans.
I. Call to Order [Chairman Alain Enthoven] - 1:10 P.M.

The first business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chair, Dr. Alain Enthoven, at the California Chamber of Commerce on Tuesday, April 22, 1997.

II. Opening Remarks - 1:15 P.M.

A. Welcoming Remarks by Governor Pete Wilson

Governor Pete Wilson was introduced by Chairman Enthoven. The Governor welcomed the Task Force and thanked them for taking part in "this most urgent of challenges facing California." The Governor cited that we are at a critical juncture in shaping the future of California's health care system. He said, "It is not enough that California has been a leader in managed care ... improving our health system by enhancing market incentives. We need to move forward...further streamlining and improving government's role in oversight and regulation, while preserving managed care's bests features: coordinated teams of highly-skilled professionals deserving cost-efficient, patient-sensitive care based on the best clinical information science has to offer:"

The Governor charged the Task Force with bringing a comprehensive, global perspective to the vexing issues facing Californians as we work as a community to bring excellent health care to our citizens. The Governor said that our goal is what's best, what's fair for all Californians: "a quality managed care in which all consumers and patients have the utmost confidence."

Governor Wilson also said that he trusted the Task Force will have answered two important questions once it has completed its report in January: 1) what is the appropriate role of government in monitoring and regulating managed care, particularly with regard to assuring quality; and 2) how should government be organized in order to maximize that goal?

The Governor also recognized the California HealthCare Foundation for generously contributing substantial resources to this project.

III. Roll Call and Declaration of a Quorum - 1:20 P.M.

Task Force Secretary, Ms. Jill McLaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Dr. Donna Conom, Ms. Barbara Decker, Mr. Alain Enthoven, Ph.D., Dr. Bradley Gilbert, Mr. Terry Hartshorn, Mr. William Hauck, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Ms. Kathryn Murrell, Mr. John Ramey, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ronald Williams, Mr. Alan Zaremberg, and Mr. Steven Zatkin.

The Secretary noted the following Task Force members were also present after roll call was taken: Assemblyman Martin Gallegos, Mr. Anthony Rodgers, Ms. Diane Griffiths, and Ms. Maryann O'Sullivan.
In addition, the following ex-officio members were present: Ms. Kim Belshe, Ms. Marjorie Berte, Mr. Keith Bishop, Dr. David Werdegar, Senator Herschel Rosenthal, and Mr. Michael Shapiro.

Chairman Enthoven declared a quorum was present.

II. Opening Remarks Continued

A. Chairman Alain Enthoven
Chairman Enthoven discussed his perspective on managed care in California's past and present. He believes, “the best interest of Californians will be served by a set of public and private policies and institutions that work together to encourage and support a process and continuous improvement: higher quality of customer satisfaction, greater accessibility, and lower costs.”

B. Assembly Member Richter, Author AB 2343 [ch. 815, stats. of 1996]
Assemblyman Richter said that it was his intent in his authorship of AB 2343 to create a group comprised of representatives from various groups affected by managed care for the purposes of reviewing and reporting on managed care in California. Specifically, the Assemblyman hoped that the Task Force would define “managed care”, discuss its evolution, and its impacts. The Assemblyman said that this report would be used to educate lawmakers who pursue legislative changes to managed health care.

IV. Introductions - 1:45 P.M.
Chairman Enthoven asked each Task Force member to introduce him or herself and to share their expectations of the Task Force. All present Task Force and Ex-officio Task Force members complied with the Chairman’s request.

Chairman Enthoven then introduced Dr. Mark Smith, President and CEO of California Health Foundation and invited him to address the Task Force. Dr. Smith encouraged the Task Force to “pass down a work order for the California Health Foundation” [as the foundation is currently in strategic planning mode]. Dr. Smith further suggested that the Task Force always ask the question “how do you know?” as it relates to comments it receives related to managed care and not to simply accept commonly held generalizations related to health care not borne out by facts.

Chairman Enthoven then introduced Executive Director Romero who then introduced Task Force staff before addressing several housekeeping issues — including a status report on the legislative appointments to the Task Force and member compliance with the Fair Political Practices Commission (FPPC). The FPPC is currently determining whether Task Force members will be subject to state disclosure laws, so until they so indicate, Task Force members need not complete the FPPC’s forms for the Task Force.

V. New Business - 2:20 P.M.
A. Adoption of the Task Force Bylaws and Rules
Chairman Enthoven briefly discussed the Task Force Bylaws and Rules and asked for a motion to adopt them. Mr. Kerr moved that the Task Force Bylaws and Rules be adopted, and Dr. Spurlock seconded the motion. After no discussion, the Bylaws and Rules were unanimously adopted.

B. Nomination and Election of a Task Force Vice-Chairman
Chairman Enthoven announced that the next order of business was to nominate a vice-chair for the Task Force. Mr. Zatkin moved to nominate Mr. Clark Kerr as Vice-Chair, and Ms. Decker seconded the motion. No other nominations were made, and Mr. Kerr was unanimously elected as Task Force Vice-Chair.
C. Discussion and Adoption of the Task Force Mission Statement and Discussion and Adoption of the Task Force Workplan Schedule
Chairman Enthoven announced the next order of business was to adopt the proposed mission statement for the Task Force. After much discussion, it was moved by Mr. Rodgers and seconded by Ms. Griffiths that the Task Force schedule a separate meeting on May 8, 1997 to take action on the proposed mission statement and the proposed workplan schedule. The premise for this motion was to allow the full compliment of Task Force members to vote on these issues [the Senate had not yet appointed its members to the Task Force]. The motion was unanimously adopted.

Chairman Enthoven then asked for a motion to defer the adoption of the proposed mission statement and the proposed workplan until the May 8, 1997 meeting. Mr. Lee moved for the referral of both items to the May 8, 1997 meeting and Ms. Severoni seconded it. The motion was unanimously adopted.

VI. Reports - 3:20 P.M.
A. Legislative Update [Alice Singh, Deputy Director for Legislation & Operations]
Deputy Director Singh gave a brief synopsis of the legislative process and discussed the parameters of AB 227 [Richter, currently pending before the legislature] which would, if enacted, authorize the Task Force members to receive financial reimbursement for travel costs associated with attending Task Force meetings.

B. California's regulation of managed care [representatives from the State Departments of Health Services, Insurance, and Corporations].
1. Mr. Keith Bishop, Commissioner, Department of Corporations, described the regulatory role of the Department of Corporations in managed care.
2. Ms. Ann Kuhns, Chief of the Medi-Cal Managed Care Division, Department of Health Services, discussed the Department of Health Services regulatory role in managed care.
3. Mr. David Knowles, Deputy Commissioner, Department of Insurance, discussed the regulation of health indemnity insurance and the departments relationship with health care.

C. A comparison of California's managed care regulation with other states [California Research Bureau]
Mr. Elias Lopez, Ph.D., California Research Bureau, discussed how health care coverage is regulated in California in relation to other states. [notes are available upon request]

D. Health Care Service Plans: Concerns Regarding California's Regulation of Managed Care
Ms. Myra Snyder, RN, President and CEO of California Association of Health Plans, illustrated the plans concerns regarding California's regulation of managed care. Specifically, Ms. Snyder discussed consumer protection, regulation options, and the Knox-Keene act in relation to managed care. [notes are available upon request]

E. Consumers: Concerns Regarding California's Regulation of Managed Care
Ms. Maryann O'Sullivan, Project Director for Health Access's Medi-Cal Community Assistance Project, and newly appointed Task Force member, briefed the Task Force on the consumers' perspective of California's managed care system.

F. Mr. Steve Thompson, California Medical Association [CMA]
Without objection, Chairman Enthoven invited Mr. Steve Thompson to speak on CMA’s perspective of California's regulation of its managed care system. Mr. Thompson cited an interim hearing conducted last year by the Assembly Insurance Committee which was held to address this and similar issues. He further encouraged the Task Force to define the function of managed care regulation. [notes are available upon request]
Chairman Enthoven thanked the speakers and announced that the Task Force had concluded its business and that the floor was then open for public comment. Seeing no public comment, Chairman Enthoven reminded Task Force members about the public hearing on May 1, 1997 in El Segundo and asked members to submit their names to Ms. Stephanie Kauss or Ms. Jill McLaughlin if they were planning to attend.

VII. Adjournment - 4:50 P.M.

Mr. Rodgers moved to adjourn the meeting and Mr. Lee seconded the motion. The meeting was adjourned by unanimous consent at 4:50 P.M.

Prepared by: Jill McLaughlin
Thursday, May 1, 1997 — 10:00 A.M.
350 Main Street
El Segundo City Hall - Council Chambers
El Segundo, California

Public Hearing Notice:
Ms. Alice M. Singh, Deputy Director of Legislation and Operations, read the Task Force public hearing notice as published and released in accordance with the Bagley Keene Open Meetings Act.

I. Call to Order and Open the Hearing [Chairman Alain Enthoven, Ph.D.] - 10:00 A.M.
The first public hearing of the Task Force was called to order by Chairman, Dr. Alain Enthoven, at El Segundo City Hall.

The following members were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Nancy Farber, Dr. Bradley Gilbert, Dr. J.D. Northway, Mr. Anthony Rodgers, and Ms. Ellen Severoni. The following Ex-Officio member were present: Mr. Michael Shapiro and Dr. David Werdegar.

Chairman Enthoven stated the May 1st hearing would be divided into two parts: presentations and public comment.

II. Presentations -10:07 A.M.
A. Impact Of Health Care Costs On California's Jobs [panel members: Mr. Stephen Lindsey, from Lindsey & Associates - a small business employee insurance broker and Mr. Steve Cummings, Vice President of Dalcin/Cummings & Associates, a civil engineering firm]

Chairman Enthoven introduced Mr. Stephen Lindsey of Lindsey & Associates who addressed the Task Force on the impacts of health care costs on businesses in the under-fifty employee marketplace. Mr. Lindsey noted certain trends in provider rate increases over the last five years. According to Mr. Lindsey, the typical criteria small employers use when deciding on coverage are the following, [in order of importance]: access to physicians, premiums, benefits, and providers. Mr. Lindsey referenced AB 1672 which allowed carriers to take less risk, initiated rate decreases, and brought stability to the market.

Task Force members and Mr. Lindsey engaged in healthy conversation regarding the HIPC, quality of care, and choice options available for enrollees.

Chairman Enthoven then introduced Mr. Cummings who spoke on behalf of the engineering firm Dalcin/Cummings & Associates. Mr. Cummings is also the immediate past chair of the Torrance Chamber of Commerce and addressed the concerns of the small business community. Mr. Cummings discussed the government’s role in managed care and the economic effects of managed care specifically in California. Mr. Cummings suggested that the Task Force look into quality of care, access, long-term care, emergency care, cost of care, and consumer choice as it relates to managed care.

The Task Force members and Mr. Cummings engaged in discussion regarding Mr. Cummings’ presentations and the issues he raised.
III. Public Comment - 11:20 A.M.
Chairman Enthoven opened the meeting to public comment.

1) Mr. Frank Pelcoffer - President of California Association of Managed Dental Care. Mr. Pelcoffer spoke about dental coverage and the various issues pertaining specifically to dental care. Mr. Pelcoffer said, “statistics show that 50% of the population of Californians do not have dental coverage. Managed care has made it more accessible and available to those who never had previous coverage.”

2) Ms. Cindy Dorn. Ms. Dorn spoke on behalf of maternal and child access for coverage relating to the transition of medi-cal to managed care specifically in L.A. County. Ms. Dorn has noticed many cases have consistent problems with access to providers, many enrollees do not understand choices of coverage, and some plans have not recognized the individual.

Lunch Break - 12:30 P.M.

IV. Presentation - 1:03 P.M.
A. Availability Of Quality Of Care And Quality Of Provider Related Data [Beth McGlynn, Ph.D., a health policy analyst with RAND Corporation]
Dr. McGlynn spoke on the availability of quality of care and quality of provider related data. The three main points of Dr. McGlynn’s testimony were: 1) information quality (as a multi-dimensional object), 2) multiple sources of information, and 3) transmitted ‘quality’ information. Dr. McGlynn began her discussion with ‘information quality’ and the elements of information needed to develop ‘quality of care’ standards. Dr. McGlynn then spoke on multiple sources of information and the specific demographics involved, such as social and economical qualities of life. Dr. McGlynn discussed patient confidentiality, certain linkages of information and timeliness of information shared. Her final point was geared towards the automation of data. Dr. McGlynn suggested that decisions need to be made for technical databases specifically, who will use the information received, and when, where, and why the data will be shared. Dr. McGlynn also shared that more data is not necessarily a better option, it may just create a higher volume of information than truly necessary.

The members discussed Dr. McGlynn’s testimony and asked specific questions pertaining to data retrieval and what to do with the information once it has been collected.

V. Public Comment - 2:05 P.M.
After much discussion, Ms. Severoni encouraged the members of the audience that were not in a health care related field to share their managed health care experiences with the Task Force. One gentleman, who wished to remain anonymous, discussed his difficulties in securing a commitment from his HMO to pay for name brand prescriptions. After much discussion about this issue, Task Force members cited the importance of providing the physician with the “last word” on a patient’s needs.

VI. Adjournment - 3:05 P.M.
Chairman Enthoven closed and adjourned the hearing at 3:05 P.M.

Prepared by: Jill McLaughlin
I. Call to Order [Chairman, Dr. Alain Enthoven] - 12:30 P.M.
The second business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce.

II. Roll Call and Declaration of a Quorum - 12:32 P.M.
Task Force Secretary, Ms. Jill Mclaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Nancy Farber, Ms. Jeanne Finberg, Hn. Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffiths, Mr. Terry Hartshorn, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Ms. Kathryn Murrell, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ronald Williams, Mr. Allan Zaremberg, and Mr. Steven Zatkin.

In addition, the following ex-officio members were present: Mr. Keith Bishop and Mr. Michael Shapiro.

III. Opening Remarks [Chairman] - 12:35 P.M.
Chairman Enthoven introduced newest Task Force Members appointed by the Legislature:
Members appointed by the Assembly Speaker:

- Assemblyman Martin Gallegos
- Dr. J.D. Northway with Valley Children’s Hospital
- Ms. Diane Griffiths with the Assembly Speaker’s office
- Ms. Maryann O’Sullivan with Health Access Foundation
- Mr. Anthony Rodgers with L.A. Care

Members appointed by the Senate Rules Committee:

- Dr. Rodney Armstead with United Health Plan/Watts Health Foundation, Inc.
- Ms. Nancy Farber with Washington Hospital
- Ms. Jeanne Finberg with the Consumers Union
- Mr. Mark Hiepler with the law firm Hiepler & Hiepler
- Mr. John Perez with UFCW Region and States Council

Senator Herschel Rosenthal and his Staff Director, Mr. Michael Shapiro were named as Senate Ex-officio members.
B. Brief explanation of Task Force rules and meeting protocol [Ms. Alice M. Singh, Deputy Director for Legislation and Operations] - 12:40 P.M.

Deputy Director Singh gave brief synopsis of the Bagley-Keene Open Meeting Act, Task Force Bylaws and Rules and Robert’s Rules of Order. The Bagley-Keene Open Meeting Act [Act] governs a State body, such as the Task Force, when it conducts its business [copies of Bagley-Keene Open Meeting Act were distributed to the Members]. According to the Attorney General, the purpose of the Act is to require that all aspects of the decision making process by multi-member state bodies be conducted in public. All deliberative processes such as, discussion, debates, and affirmation of information, must be made available for public scrutiny. The Act also requires that meetings be held in public, and the public must be permitted to attend any meeting of the Task Force. Further, the Act requires the Task Force to provide notice of its meetings [10 days prior] to any person that requests such notice in writing. The notice itself must include the day, time, location, and agenda of the meeting. The agenda must include the items listed to be transacted or discussed, and no item can be added to the agenda subsequent to the provision of this notice. [The Task Force may not act on an item unless it has been properly noticed.]

The Act prohibits what is referred to as serial, or rotating meetings by which a quorum of the Task Force becomes involved in the information acquisition or deliberation process, unless it has been noticed and public access provisions of the Act have been satisfied. The Act further states that some telephone communications where business is discussed or transactions between one Task Force member and more than two members occur can constitute a serial meeting and would be prohibited without satisfaction of the Open Meetings Act’s notice and public access provisions. Deputy Director Singh conveyed that the issue of serial and less than quorum meetings is a very complex issue and she is currently working with state counsel to better define these provisions for the Task Force. A defined summary will be provided for the members’ reference and until such time, Deputy Director Singh asks that the Task Force Members refrain from discussing Task Force agenda items with more than two other members of the Task Force unless it is within the guidelines noted in the Act.

Deputy Director Singh stated that the Task Force Bylaws were adopted at the April 22nd meeting.

Deputy Director Singh reiterated voting procedures for Task Force members, stating that the Bylaws specifically state only appointed Task Force members may make motions and vote on issues pending Task Force action. Ex-Officio members, alternates, and proxies are precluded from taking such action.

Deputy Director Singh also spoke about Robert’s Rules of Order, newly revised, indicating that this serves as the parliamentary law for the Task Force. Robert’s Rules are recognized and used by thousands of organizations world wide as the book of proper parliamentary procedure. Robert’s Rules require that each issue requiring action by the Task Force must be moved and seconded before it is discussed, amended, or voted on. Robert’s also states that members should seek recognition from the chair before moving or seconding a motion. This allows the Chair, Staff, Members, and the public to recognize who made the motion and seconded it. Please contact Deputy Director Singh for any clarification regarding any of these technical, procedural issues.

IV. Reports - 12:50 P.M.

Chairman Alain Enthoven thanked Deputy Director Singh for her summary, and then he briefly summarized the Task Force’s May 1 public hearing conducted in El Segundo. Chairman Enthoven indicated that there were three invited presenters at the hearing who addressed; 1) the impact of health care costs on California’s jobs, 2) the ability and willingness of California’s small business owners to offer and/or provide managed care to their employees, and 3) the availability of quality of care and quality of provider related data. Specifically, Mr. Steven Lindsey, who is in the business of selling or arranging health insurance for small employers, addressed the Task Force on the impact of health care costs and trends on small employers who employ predominately lower wage workers. Mr. Lindsey’s focus was that when health care
plan premiums rise in cost, small employers either drop plans, or offset these rising costs by passing them onto the health plan enrollees. The small group employment sector is very sensitive to health care costs. Mr. Lindsey also noted that very few small employers pay for dependents and very few have multiple choice health plans.

Ms. Cindy Doren spoke as an advocate for the poor and Medicaid beneficiaries.

Ms. Doren expressed concern of the multiple problems in Medicaid, including complex forms, language, and lack of education. Under questioning from Chairman Enthoven, she acknowledged that, (a) most complaints were associated with enrollment procedures, once enrolled, Medicaid recipients generally were satisfied with their care and; (b) the problems she described were mainly problems of public administration, not problems with managed care necessarily.

Dr. Beth McGlynn, Director of Quality Measurement for the RAND Corporation spoke before the Task Force stating that she feels a need for a coordinated strategy for collecting health care quality information. In response to this, Chairman Enthoven suggested the Task Force consider conducting a survey of provider and health plan reporting requirements. [NOTE: the May 1 public hearing was audio taped and hearing notes will be made available to Task Force members at a later date].

A. Executive Director's Report [Dr. Philip J. Romero, Executive Director]

Executive Director Romero welcomed new Task Force staff member, Attoney Dale Bonner, General Counsel for the California Business, Transportation, and Housing Agency. Mr. Bonner will assist the Task Force on a part-time basis. In addition, Executive Director Romero discussed marketing strategies for the Task Force. The Task Force has secured several press lists and will “broadcast fax” agendas for upcoming public hearing and meetings. In addition, Executive Director Romero indicated that staff plans to draft issues briefs that will include brief alternative structures for organizing the regulation of managed care in California, alternative products and models for providing greater customer choice, and finally economic impact of increased health care costs and savings. Executive Director Romero also noted the Task Force has obtained a research assistant.

Executive Director Romero also encouraged Task Force members to assist in the development of survey and research topics for the Task Force.

B. Presentations on managed care data and quality information availability and choice enhancing strategies, Mr. Greg Roth of the Office of Statewide Health Planning and Development [OSHPD] and Mr. Bob Crichlow of Benefits Alliance.

Vice Chairman Kerr introduced Mr. Roth, and briefed the Task Force on the role that OSHPD has in managed health care regulation. Mr. Roth reported on OSHPD’s various reports and projects and stated that it receives data from several sources, including licensed home health agencies, licensed clinics, licensed long term care facilities and licensed hospitals in California. Mr. Roth noted that the extensive data collected for its research purposes is the most comparable information available. Specifically, the type of data utilized in OSHPD’s reports originates from the aforementioned licensed facilities that report financial information, summary patient information, and provided patient treatment information. OSHPD’s reports include a patient discharge abstract summary addressing demographics, description, patient diagnosis, and patient treatment. OSHPD’s reports assist licensed health care facilities to gauge incident rates of certain accidents and ways to prevent them. OSHPD’s reports are also used to provide information to help individuals choose their health care plans with some degree of knowledge.

Mr. Roth recommended certain enhancements for OSHPD that include timeliness of abstracts, improving information technology, such as online services, and developing mandates for information collection. Mr. Roth finalized his report by requesting the Task Force to forward any recommendations it may have to improve OSHPD’s services or utilizing the information collected.
Mr. Roth provided Task Force members with a copy of the report entitled “Acute Myocardial Infarction – Volume One Study Overview and Results Summary”.

Mr. Bob Crichlow spoke on choice enhancing strategies related to the middle market using his marketing network, Benefits Alliance, as an example. About 30% of workers fall into the middle market category, and middle market employers are being forced to offer fewer and fewer health care plan options to employees. Mr. Crichlow raised the question as to whom will form future purchasing groups. He further stated that there needs to be work done to ease the regulatory process for purchase group participants.

Mr. Crichlow stated that Benefits Alliance’s package is derived from brokers specifically for the middle market. Specifically, Benefits Alliance serves as the administrative mediator between employers and eight managed care plans. Mr. Crichlow stated that Benefits Alliance has provided the employer a choice of the plan configuration, meaning the employer will determine what plan designs to offer its employees. The participating health plans offered are Blue Shield of California, Cigna HealthCare, PacificCare of California, and United Health Care. All health plans are fully regulated Knox-Keene plans, and the employer contracts directly with the health plan under the Benefits Alliance program. The employee will notice the various plan options, provider networks, costs and quality of services provided. As the program grows, member satisfaction surveys will be conducted for means of providing quality related information back to the employer and employees. The employees will be given the option annually to determine if they wish to stay with their current plan or to change plans according to their needs.

Executive Director Romero asked Mr. Crichlow for any potential “legislative fixes” to allow other groups like Benefits Alliance to exist. Mr. Crichlow did not have any concrete recommendations given the segregated regulation of managed health care plans.

Chairman Enthoven commented that programs such as Benefits Alliance are very important because normally small employers can only offer employees one health plan, and the employee not only has little to no choice of health plans, but he or she may also be unable to retain the physician of his or her choice.

At 2:15 P.M., Chairman Enthoven stated that without objection, the Task Force would recess for 20 minutes. Seeing no objection, Chairman Enthoven recessed the Task Force until 2:35 P.M.

After reconvening the, Chairman Enthoven opened the floor to public comment and encouraged Task Force members to discuss Mr. Crichlow’s presentation. Mr. Richard Spohn, an attorney representing the California Choice Program [a program similar to Benefits Alliance], stated that he has worked directly with the Department of Corporations, and found the department to be very helpful in getting his group “approved.”

Ms. Severoni indicated on her work with health care plan enrollees and said that one of the biggest problems she has seen is with regard to issues other than that of choice – claims and billing, for example.

Ms. Decker indicated that choice is important but that offering multiple plans does not always solve problems – it is important to look at plan specifics.

Ms. O’Sullivan stated that every health care plan should meet established standards before plan choice is studied.

Dr. Colin Cameron, UC Davis economist and a member of the public, felt that individuals are seeking choices in health care and will pay more if given best quality of care choices. Dr. Cameron discussed adverse selection and the limited options available. He suggested a point-of-service approach to health care.

V. Unfinished Business - 2:50 P.M.
A. Discussion and adoption of the Task Force Mission Statement
Chairman Enthoven announced that the next order of business was to adopt the proposed Mission Statement for the Task Force. The adoption of the Mission Statement was originally scheduled for the April 22nd meeting, and the Task Force voted to defer it to allow the most recent appointments to the Task
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Force an opportunity to review and vote on this item. Chairman Enthoven stated that the Governor and Legislature brought together a Task Force of distinguished citizens to try to develop a consensus on a point of view to make managed care more satisfactory to the citizens of California and that the proposed Mission Statement was the first step in this direction. Executive Director Romero reiterated Chairman Enthoven’s remarks. Mr. Kerr moved to adopt the proposed Mission Statement and the motion was seconded by Dr. Karpf. The floor was then opened for discussion on the Mission Statement.

Several members argued that the Mission Statement was “pre-loaded” with a particular expected outcome before the Task Force has had time to investigate the issues summarized in the statement and AB 2343 [Chapter 815, Statutes of 1996] other issues. Ms. Griffiths referenced that the Task Force is required to follow the mandates in AB 2343 [Chapter 815, Statutes of 1996] and that the Task Force should follow those mandates. Dr. Alpert stated his preference that the Task Force develop a strategy and to change the Mission Statement language to be more cohesive. Dr. Rodriguez-Trias felt the underlying issues are the values of the Task Force Members and that a Mission Statement is better served for a group with more common values. She also added, the role of the Government is to ensure accountability. Dr. Karpf stated that the Task Force needed a coherent strategy for the state to modify the existing health care system. Chairman Enthoven asked if there was consensus that it was the Task Force’s primary goal to determine the appropriate role for state government to regulate health care and how that regulatory structure should be organized to most effectively accomplish this.

Dr. Alpert then referenced Chairman Enthoven’s May 6, 1997 letter and recommended including a few key phrases from Chairman Enthoven’s letter in the Mission Statement. Specifically, Dr. Alpert suggested that the following be added to the Mission Statement “…making a series of specific recommendations to the Governor and legislature about how to improve California’s regulation of the industry. I believe our primary goal should be to determine what is the appropriate role of State government in California health care and how should the regulatory structure be organized to most effectively accomplish this role…” Dr. Alpert’s suggestion was not placed in the form of a motion and thus, was not considered a proposed amendment for vote by the Task Force.

Mr. Lee then asked that the Task Force to “call for the question” [stop all debate and take a vote on all outstanding motions], but before a motion was made, Mr. Knowles suggested that to simplify the Mission Statement, the proposed statement should be deleted and substituted with language requiring the Task Force to simply comply with the mandates of AB 2343. As a result, Mr. Perez moved to strike the proposed Mission Statement and to substitute it with “To fulfill the mandates of AB 2343 [Statutes of 1996]”. This motion was seconded by Ms. Decker. The motion was adopted by a simple majority of the total authorized number of Task Force members.

Chairman Enthoven then asked the Task Force if it wanted to be purely fact finding or did it want to make recommendations as well. He stressed that it was pretty elaborate to bring such a group of distinguished individuals together for a fact finding mission – he assumed that the Task Force would take the Governor’s charge seriously and want to make recommendations on how to improve the health care system [Please see the April 22nd Meeting Minutes for additional information regarding the Governor’s charge to the Task Force.]

Members then discussed the necessity of the Mission Statement to include some of the information included in the originally proposed statement. As a result, Mr. Kerr moved to amend the recently adopted Mission Statement by adding the following after “To fulfill the mandates of AB 2343 [Statutes of 1996]” – “and to provide significant public service by developing a coherent health care strategy for the State of California that enhances consumer health, choice and information, driven by incentive for improvement and supported by a legislative framework that defines and secures patients rights, that will continuously improve in all dimensions (quality, affordability, and access) and thereby build and aspire confidence in our overall health care system”. Ms. Farber seconded this motion and the vote was 12 in favor and 8 opposed. The motion to adopt failed because it did not obtain a simple majority of the total authorized
Chairman Enthoven then asked members to vote on the original motion to adopt the Mission Statement, as amended, and motion was adopted with only one dissenting vote.

B. Discussion and adoption of the Task Force Workplan Schedule
Chairman Enthoven announced the next order of business was to adopt the proposed Workplan Schedule. Like the Mission Statement, the proposed Workplan Schedule was originally schedule for adoption at the April 22nd meeting and be deferred until a meeting whereby all Task Force appointments could vote on the document. Chairman Enthoven opened the floor for discussion. After little discussion by members, Ms. Decker moved to adopt the Workplan Schedule as proposed. The motion was seconded by Dr. Rodriguez-Trias and unanimously adopted.

VI. New Business
A. Adoption of the April 22, 1997 meeting minutes - 3:30P.M.
Chairman Enthoven announced that the next order of business was to adopt the proposed Minutes from the April 22, 1997 business meeting and asked if there we any corrections. Seeing none, Ms. Severoni moved to adopt the April 22nd business meeting minutes and it was seconded by Mr. Kerr. The motion to adopt the minutes was unanimously adopted.

B. Adoption of amendments to Task Force Standing Rule Number 1 [Task Force Meeting/Hearing Schedule]
Ms. Decker moved to adopt the proposed amendments to Task Force Standing Rule Number 1 and it was seconded by Dr. Rodriguez-Trias. Mr. Lee suggested adding issues papers to public hearing schedules, and stated his preference for “theme” meetings. Ms. Bowne moved to amend the schedule to change the location of June 20th business/public hearing meeting from Redding to Fresno. The motion to amend was seconded by Mr. Perez and unanimously adopted. Mr. Lee then moved to amend the schedule by adding one “TBA” meeting to include a public hearing and have that meeting held in Los Angeles as the previously held public hearing conducted in El Segundo had a low public turnout. The motion to amend was seconded by Dr. Conom and was unanimously adopted. Mr. Perez then moved to amend the schedule by moving the Millbrae meeting on July 11 to San Francisco to better the opportunity for the public to attend. Mr. Lee seconded the motion and it was unanimously adopted. The amended Task Force Standing Rule Number 1 was adopted unanimously.

C. Discussion on a general framework for public hearings: questions to be posed to the public for response at the hearings
Chairman Enthoven stated that the next order of business was to discuss the general framework for public hearings. He indicated that since this was a non-binding document, no vote by Task Force members was necessary. Generally, members supported the document but suggested that Section I be amended to include more “layman’s” terms. Essentially, members wanted this section to inform the public that the Task Force members encourage public comment.

VII. Public Comment - 4:15 P.M.
Chairman Enthoven opened the floor to comments from the public. No public comments were received.

VIII. Adjournment - 4:20 P.M.
Chairman Enthoven said that without objection, the meeting would be adjourned. Seeing no objection, Chairman Enthoven declared that the meeting was hereby adjourned.

Prepared by: Jill Mclaughlin
Managed Health Care Improvement Task Force  
May 30, 1997 Study Session Notes

Friday, May 30, 1997 - 2P.M.-4:30P.M.  
Greater San Diego Chamber of Commerce  
402 W. Broadway, 10th Floor  
San Diego, California

I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 2:00 P.M.

The first study session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Greater San Diego Chamber of Commerce in San Diego, California.

II. Roll Call

Task Force Secretary, Ms. Jill McLaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Mr. Rodney Armstead, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Ms. Kathryn Murrell, Dr. J.D. Northway, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, and Mr. Ronald Williams.

The following ex-officio members were also present: Ms. Kim Belshe, Mr. Keith Bishop, and Mr. Michael Shapiro.

III. Opening Remarks

Chairman Enthoven announced that the focus of today's study session would be the roles, functions and organization of state government in regulating health care service plans. More specifically, to define what role government plays in regulating managed care, where its regulatory functions repose, how government exercises its regulating authority, and how efficient and effective is the regulatory function. Chairman Enthoven also announced that the last sixty minutes of today's session would be allocated to discuss the Task Force work plan schedule.

IV. Reports

A. The role of government and the organization of government's regulation of managed care [Ms. Hattie Skubik, Deputy Director for Policy and Research, Managed Health Care Improvement Task Force, and Mr. Elias Lopez, Ph.D., Economist/Demographer, California Research Bureau].

Deputy Director Skubik began the study session by distributing a handout that described the regulatory role of state government. Deputy Director Skubik described the spectrum of choice that consumers have regarding health care, ranging from closed panel HMOs to fee-for-service (FFS) health plans. HMOs are overseen by the Department of Corporations (DOC) while FFS plans are overseen by the Department of Insurance (DOI). She noted that the health care market is integrating vertically to include financing and delivery. Deputy Director Skubik also indicated the need to look at critical state government oversight functions, particularly the consumer grievance process.

Dr. Lopez distributed additional handouts and continued the discussion on state regulatory functions, focusing on the consumer grievance process. He described the three steps of the common grievance process. First, the consumer/patient registers a complaint with the health plan. Second, if the complaint
isn't resolved at that level, the consumer can call a state "1-800" hotline number. Third, the relevant state agency makes a decision about the complaint.

Dr. Lopez outlined more details of each agency's (DOC, DOI, and DHS) grievance process. He noted that both DOI and DOC require a written complaint, while DHS is able to take complaints by phone because they have Medi-Cal patient files on-line. He also noted that under DOC rules, the consumer must file their complaint with the health plan and allow the health plan 60 days to respond before the consumer can file a complaint with DOC. DHS requires a 30 day response period. DOI does not have a specific requirement. Dr. Lopez stated that the grievance process is not very consumer oriented because consumers can be “bounced around” from agency to agency. Task Force members discussed the possibility of establishing a single phone number that consumers could call to be referred to the proper oversight agency.

Mr. Lee pointed out that most complaints are resolved with the individual provider. He stated that some plans will not take a consumer's complaint until the consumer tries to resolve the complaint at the medical group level. He also noted several other sources of assistance, including the employer, group purchaser, insurance broker, or Medicare-specific groups. Mr. Lee also pointed out that complaints against self-insured plans are handled by the federal Department of Labor. Mr. Bishop later added that some complaints are handled by more than one agency at a time, and that arbitration or lawsuits might also be pursued simultaneously.

Mr. Shapiro commented on budget reductions that the Department of Insurance underwent and how these cuts have affected the efficiency of its consumer services division. As a result of these cuts, the DOI started to require consumers who called the consumer's hotline to submit a written request for assistance. If consumers did not follow through on that written request, they did not get the help that they might have needed. This procedure had a significant attrition rate which allowed DOI to become more efficient but at an expense.

Dr. Karpf then shifted the discussion towards the issue of complaints. He said that it is not only important to receive complaints but also to study any possible patterns and systemic issues that can be identified through the complaints.

Mr. Bishop, responding to the comment, said that DOC produces such complaint reports. He indicated that the report divides the complaints up into 32 different categories and lists by both full-service and specialized plans the number of complaints per 10,000 enrollees. He stated that many health plans are required to file reports on a quarterly basis regarding complaints that have been pending longer than 30 days. Those reports are filed with the department and are publicly available. Dr. Karpf then asked whether DOI and DHS had similar reports available.

Dr. Rodriguez-Trias asked Mr. Bishop to elaborate on the enforcement mechanism of DOC's oversight. Mr. Bishop said that enforcement action can happen in two ways. It may be dealt with administratively. That is, an order to cease and desist may be issued and/or a fine may be levied. Or it may be dealt with civilly. In this case a wide variety of remedies may occur such as fines, appointments of receivers, appointments of monitors, et cetera. He stated that the Knox-Keene act gives DOC a lot of different enforcement tools, but that the focus tends to be on fines. Mr. Bishop then discussed due process. He stated that DOC's grievance process does not afford all due process rights to either the person making the complaint or the plan.

Dr. Alpert stated that Task Force recommendations on this topic should focus on making sure that the regulating agency is staffed with people who have expertise "across the board" in financial and health-related aspects. Mr. Bishop stated that there are three types of professionals who work for the DOC: lawyers, health analysts, and financial examiners.

Dr. Spurlock commented on one of the possible causes of consumer dissatisfaction. He said that many consumers' complaints are a function of the relationship and the communication between consumers and health providers and not a function of the care. Dr. Karpf added that many consumers' complaints arise
from the disconnection between the levels of expectations and what is in fact available and appropriate. Mr. Williams stated that consumers feel that no matter where in the system the problem occurs, the health plan is responsible.

Ms. Finberg asked whether or not medical groups are regulated. Mr. Bishop stated that some large medical groups have limited Knox-Keene licenses and are directly regulated. He said that the other medical groups are indirectly regulated through plans that are held accountable and responsible for delivering services in compliance with the Knox-Keene Act.

Mr. Lee stated that there will always be some complaints and that the ultimate goal is to create health care systems that will minimize the need for sophisticated grievance processes. Good health plans resolve their complaints effectively and quickly so they rarely get to the regulatory point. Pointing out the lack of information that many consumers have about their health plans, Mr. Lee also said that an effective system is one that informs its customers about their coverage, their rights, and how to exercise them.

Agreeing with Mr. Lee, Dr. Rodriguez-Trias noted that complaints are indeed the tip of the iceberg. Complaints, many times, relate to human relations. Thus a health plan with very good public relations tends to receive low numbers of complaints. However, high or low numbers of consumer complaints are not indicators of quality care. That is, health plans may have very good public relations, but the quality of their health services may be very poor.

Mr. Williams outlined appropriate roles for government in the regulation of health care, including ensuring consumer protection; product adequacy; financial solvency at the health plan and medical group levels; a competitive marketplace; and expanding coverage as far as possible.

Ms. Belshé encouraged the Task Force to systematically identify the most problematic concerns in the current system and determine who has responsibility for addressing those problems: the private sector, government, or a partnership. She also encouraged the Task Force to think about how government should be organized to meet its responsibilities and form partnerships with the private sector.

**Break**

**Public Comment**

1) **Dr. Schumacher, former president of the Medical Board of California:** Dr. Schumacher stated that the Medical Board was only mentioned briefly in the earlier discussion, yet it is the main avenue in California for resolution of grievances concerning the quality of care. He also mentioned the role of county medical societies. He offered some reports and testimony on quality of care and the physician-patient relationship.

Dr. Schumacher also made some comments on regulation. He argued that the regulatory system is very fragmented. He stated that there is almost no regulation of medical groups. He concluded that there are two departments that currently have the expertise to deal with quality of care issues: the Medical Board and other associated departments in the Department of Consumer Affairs, and DHS. He stated that DOC and DOI do not have the required expertise to regulate the rapidly-changing managed care system.

2) **Dr. Robert C. Fellmeth, Director of the Center of Public Interest Law:** Dr. Fellmeth recommended that the Task Force avoid regulatory structures such as DOI, which he described as a single entity looking at thousands of consumer complaints without ever disciplining anybody. He recommended instead a board structure with the opportunity for public input and with representatives who are knowledgeable about quality of care.
Moreover, Dr. Fellmeth suggested that consumer grievances should be handled by the Office of Administrative Hearings (within the Department of General Services). OAH has a panel of administrative law judges to address medical matters.

B. The Scope of Work to Be Performed by the Task Force and Task Force Staff.
Chairman Enthoven introduced the concept of “expert resource groups” - small working groups on particular topics, composed of one or two Task Force members. Deputy Director Skubik asked if it would be possible to include particular experts who are not necessarily members of the Task Force but who have high levels of expertise on a particular matter.

Executive Director Romero then discussed possible topics for future Task Force meetings. He mentioned six topics (consumer protection, regulatory organization, quality of care, increasing choice among plans, increasing choice within plans, and industry restructuring) and asked the Task Force for their additions and priorities.

Mr. Williams stated that the Task Force should be sensitive to the fact that some reforms might lead to the unintended consequence of increasing the number of uninsured. Dr. Rodriguez-Trias said that the Task Force should take a more proactive stance and focus on increasing the effectiveness of managed care by increasing coverage. She suggested the Task Force discuss means of enhancing the ability of small businesses and employers to purchase insurance for their employees. Mr. Shapiro cautioned the Task Force against worrying about covering the uninsured at the expense of creating a second-class medical system. He stated that other groups were working on that issue.

Ms. Severoni suggested the Task Force consider the topic of consumer involvement. Mr. Lee asked that the topics of managed care’s impact on vulnerable populations, managed care’s impact on the physician-patient relationship, and improving information about quality be included.

Finally, through an informal poll of the members where each member could voice two preferences, Executive Director Romero prioritized future items of discussion. The priorities were quality of care (13 members), enhancing consumer protection (8 members), addressing the regulatory structure (3 members), increasing choice among plans (3 members), restructuring the health care industry (1 member), and increasing choice within plans (0 members). Ms. Alice Singh stated that absent members would also have an opportunity to voice their preferences through an anonymous Delphi questionnaire.

It was then agreed that staff would try to obtain some materials on what other states are doing with regards to managed care (e.g., Minnesota and Washington state).

V. Adjournment - 5:00 P.M.
Chairman Enthoven said that without objection, the study session would be adjourned. Hearing and seeing no objection, Chairman Enthoven declared the Study Session adjourned and announced that a public hearing would commence in the City of San Diego Council Chambers in 15 minutes.

Prepared by: Enrique J. Ramirez, Ph.D.
I. Call to Order and Open the Hearing [Chairman] - 5:30 P.M.

Dr. Alain Enthoven, Chairman, read the Task Force Notice as prepared and released pursuant to the Open Meetings Act.

The second public hearing of the Managed Health Care Improvement Task Force, [Task Force] was called to order by Chairman Enthoven, at the San Diego City Council Chambers.

The following members were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, and Mr. Ronald Williams.

The following Ex-Officio members were also present: Ms. Kim Belshe', Mr. Keith Bishop, Mr. Michael Shapiro, and Mr. David Knowles.

Chairman Enthoven informed the audience of the procedures for testifying before the Task Force. Specifically, he stated that the Task Force is interested in hearing the thoughts of the public regarding systemic changes in managed health care and any further comments or concerns related to health insurance in general.

II. Public Testimony - 5:45 P.M.

1. Dr. Rodrico Munoz - Vice President of the Mental Health Advisory Board of San Diego and President of the San Diego branch of the California Hispanic Medical Association. Dr. Munoz commented on the negative impact managed care has had on mental health care recipients who belong to HMOs. He expressed concerns about market consolidation, patient confidentiality, continuity of care, denial of care due to cost considerations, and other barriers to care. The doctor also expressed concerns about the Medicaid population under managed care.

   Chairman Enthoven thanked Dr. Munoz for his testimony. The Task Force members addressed Dr. Munoz's concerns with various questions and comments about physician supply, restricted mental health benefits, and funding pools for mental health care.

2. Dr. Larry Friedman - Chief of the Division of Primary Care Pediatrics and Adolescent Medicine at the University of California, San Diego. Dr. Friedman spoke about the relationship between academic medical centers and managed care. He stated that managed care has created a burden on medical outcomes studies. Dr. Friedman suggested that managed care companies begin funding these outcome studies because the study results form the basis of their medical treatment. Dr. Friedman also expressed concern about the profit motive in managed care.

   Chairman Enthoven thanked Dr. Friedman for his testimony. The Task Force members addressed Dr. Friedman's concerns with various questions and comments about data collection versus research; for-profit managed care versus fee-for-service; adverse selection and risk adjustment; the doctor-patient
relationship; the state regulatory role; the importance of outcomes studies; the positive effects of managed care on medical training; physician supply; and adolescent care.

3. **Dr. Don McCann** - a family physician from San Clemente, California. Dr. McCann stated that one of the most effective methods of managed care has been the introduction of physician risk sharing through capitation and reserve pools (withholds). Dr. McCann stated that managed care has decreased the rendering of both unnecessary and elective medical services. However, he noted that managed care has decreased the range of therapeutic intervention options that physicians discuss with patients, creating an adversarial doctor-patient relationship which affects quality. Dr. McCann called for the end of physician risk sharing and the introduction of global budgets.

Chairman Enthoven thanked Dr. McCann for his testimony. The Task Force members addressed Dr. McCann’s concerns with various questions and comments about incentives to provide preventive care under capitation; the necessary scope of a global budget; whether global budgets merely relocate the gatekeeper; quality under fee-for-service versus managed care arrangements; and performance-based physician compensation.

4. **Dr. Tom Houghton** - a children’s dental specialist. Dr. Houghton spoke on behalf of children dental patients. Dr. Houghton stated that in his experience over the last three years in Sacramento, the for-profit Denti-Cal plan is assigned more patients than the other plans. Dr. Houghton spoke about the special needs and circumstances of Denti-Cal children and expressed concern about the quality of care they receive. Dr. Houghton suggested improvements such as involving clinical practitioners in treatment authorization and emphasizing preventive measures.

Chairman Enthoven thanked Dr. Houghton for his testimony.

5. **Dr. A.D. Krems** - AARP. Dr. Krems addressed the Task Force on behalf of California’s seniors. He began his testimony by thanking the Task Force for their efforts and suggesting that future public hearings be held during the afternoon and not in the evenings or on Friday’s. Dr. Krems addressed the need for more outcome studies, particularly regarding preventive care. He stated that managed care doesn’t allow providers to spend enough time with their patients. He suggested that the Task Force study ombudsman programs and recommend a plan that could be used throughout health care.

Chairman Enthoven thanked Dr. Krems for his testimony. The Task Force members addressed his concerns with various questions and comments about the use of outcomes studies in medical education; training and payment for ombudsmen; and the relationship between long-term care and managed care.

6. **Dr. Stuart Scherr** - a retired doctor of internal medicine. Dr. Scherr contended that HMOs are contributing to the bankruptcy and for-profit takeover of many hospitals by forcing hospitals to accept contracts at reimbursement levels below costs. Dr. Scherr stated that the profits of organizations such as Columbia HCA come from inadequate staffing, deterioration in quality and quantity of supplies, and dirty hospitals. He supported these claims by reading from a letter written by a Columbia HCA hospital nurse. He suggested that HMO-hospital contracts be regulated and that inspections be unannounced.

Chairman Enthoven thanked Dr. Scherr for his testimony. Task Force Member Alpert reiterated and emphasized Dr. Scherr’s concerns.

7. **Ms. Ruth Rahenkamp** - an HMO enrollee. Ms. Rahenkamp discussed her personal experiences with managed care as a person with manic depressive illness. Ms. Rahenkamp described difficulties accessing needed care and receiving continuity of care under her managed care plan. She stated that when she needs care most, the barriers of managed care are at their highest. She stated that these difficulties have led to higher costs through lost work time and avoidable hospitalization.

Chairman Enthoven thanked Ms. Rahenkamp for her testimony. The Task Force members addressed her concerns with various questions and comments about receiving care outside of the plan and receiving assistance from family members or state regulatory agencies.

8. **Mr. Mark Jennings** - California Nurses Association, San Diego. Mr. Jennings represents nursing professionals from several hospitals in the San Diego area and addressed the Task Force about the
declining quality of patient care. He specifically raised concerns about decreased staffing as in-patient
acuity levels increase. He also discussed pressures on nurses to not deliver care.
Chairman Enthoven thanked Mr. Jennings for his testimony. The Task Force members addressed Mr.
Jenning’s concerns with various questions and comments about other payers’ impacts on hospitals and
a single-payer system.

9. **Dr. Fred Baughman** - a retired pediatric neurologist. Dr. Baughman discussed the history of physician
supply from the 1960’s to present day. He stated that rising costs and the increased numbers of unin-
sured persons are due to physician oversupply. Dr. Baughman stated, “the establishment of an appro-
priate physician supply appropriately distributed must be the primary plank of health care reform in
America”.
Chairman Enthoven thanked Dr. Baughman for his testimony. The Task Force members addressed his
concerns with various questions and comments.

10. **Ms. Joy Lynn** - an HMO enrollee. Ms. Lynn expressed her frustration with her HMO as it relates to
the chiropractic care she receives. Ms. Lynn described her difficulties obtaining referrals and authoriza-
tion for treatment and her need to pay for care out of her own pocket. She stated that this discontinu-
ity of care has a strong effect on her business, her employees, and her subcontractors. She suggested
“taking the insurance companies out of health care.”
Chairman Enthoven thanked Ms. Lynn for her testimony.

**III. Adjournment - 7:30 P.M.**
Chairman Enthoven said that without objection, the public hearing would be closed and adjourned.
Seeing no objection, Chairman Enthoven declared that the public hearing was hereby closed and ad-
journed.

*Prepared by: Jill McLaughlin*
I. Call to Order and Introduction

The third public hearing of the Managed Health Care Improvement Task Force (Task Force) was called to order by Chairman, Dr. Alain Enthoven. The hearing was called to order immediately proceeding the Task Force’s business meeting.

Chairman Enthoven presented Ms. Alice Singh, Task Force Deputy Director for Legislation & Operations, to the public to greet and announce the purpose of the meeting.

Deputy Director Singh discussed the charges brought upon the Task Force pursuant to AB 2343 [Chapter 815, statutes of 1996]. According to Deputy Director Singh, the Task force has been assigned the duty of reviewing and reporting on several aspects of managed care including, but not limited to the status quo of the health care service plans in California, its regulation, structure, operation, its trends & changes and how these changes have affected the health care economy.

Deputy Director Singh added that the Task Force will formulate and present its recommendations regarding the regulation of managed care in a published report due by January 1, 1998.

Chairman Enthoven thanked the public for coming and reminded them that the purpose for a public hearing, as such, is to listen to their ideas in order to understand better how the present system of managed care is working and how it might be modified to be satisfactory to all…health care providers & consumers. He reminded them that the Medi-Cal program is not a part of the Task Force charter or purpose.

Chairman Enthoven discussed the organization by which the hearing is to be run and introduced the first presenter.

II. Public Testimony and Comment

1. **Mr. Ray Ensher - Health Care for all CA.** Mr. Ensher presented to the Task Force the words of Congressman Radanovich of California’s 19th Congressional District on March 21, 1995. (Randanovich’s words called for effective health care reform, including insurance portability, medical savings accounts, and malpractice reform.) Mr. Ensher brought to the attention of the Task Force, however, that many of the goals of Randanovich to provide reform have not been met today. He notified the Task Force that we, as a society, must hold the medical providers accountable. He elaborated on several scenarios of abuse in the managed care system including the overpricing of a bottle of Tylenol in a hospital back in 1987. Mr. Ensher’s basic complaint was that most health care providers today over-treat their patients at too high a cost.

2. **Jim & Anna Euless - Patients at Kaiser Permanente.** Mr. Euless testified before the Task Force regarding the exceptional care he received from Kaiser Permanente. Mr. Euless told his story of being a five year survivor of a heart transplant performed while under the care of Kaiser. Despite his constant need for...
2. Kaiser has been and continues to be phenomenal every step of the way. His wife reaffirmed his statements.

3. **Dr. John Zweifler** - California Physicians Alliance. Dr. Zweifler addressed some of the issues related to managed care and the impact it has on providers. He blamed the managed care system as placing providers in an adversarial position with their patients, colleagues, and health care plans. (Testimonial stories were cited). Dr. Zweifler recommended streamlining the referral process; increasing consumer education about covered benefits and plan procedures; monitoring plans' medical loss ratio; and increasing managed care plans' liability for poor patient outcomes. He also urged the Task Force to consider the impacts of managed care on underserved populations and medical education.

4. **Don Albright** - Consumer of Health Services; Member of Local Health Care Coalition. Mr. Albright commented on his present medical coverage as supplied by Medicare and PERS care in saying that without it, he would have had to pay hundreds of thousands of dollars. He noted that some of the same arguments used to defeat single payer initiatives are now being raised against HMOs (destruction of physician-patient trust, high administrative costs, decreased quality of care). He complimented the Task Force and called for a continuous comprehensive study until one of the best possible health care situations exists in the state of California.

5. **Jeff Reed** - Fresno City Manager. Mr. Reed's comments were presented as his own opinion, not made in his official capacity. He discussed the federal tax code's role in health care price inflation. He suggested revising the tax code to allow individuals to deduct all health care expenses, including premiums. This reform would allow prices to drive decisions that would allocate scarce resources efficiently.

6. **Dr. Barbara Lundeen** - Health Educator. Dr. Lundeen spoke on behalf of seniors. She commented that HMOs benefit by keeping people well, and as a result are offering such benefits as prevention programs, wellness systems, and alternative healing methods. She suggested that instead of individual HMOs doing piecemeal education programs, a single comprehensive program would teach more people and save money. She recommended a single-payer system with 0.1% of total spending devoted to prevention and mass education.

7. **Rev. Walt Parry** - Local Health Care Coalition & Fresno Metro Ministry. Rev. Parry described the Medi-Cal Two-Plan Model's negative impact on safety net providers in Fresno, citing a flawed enrollment process, late and low payments, and lack of accountability. He recommended that the plans be placed on hold until the county's safety net is secure. Rev. Parry also criticized plans for diverting money from patient care to profits, denying patients choice of doctors and services, and leaving patients and doctors out of decisions.

Ms. Belshe discussed with Rev. Parry the “red teams” that bring together interested provider, plan, and consumer groups to discuss Fresno’s Medi-Cal managed care issues.

8. **Bo Carter** - Integrated Healthcare Association. Mr. Carter discussed three issues his organization has investigated: managed care's effects on graduate medical education, medical ethics, and regulatory reform. He offered to forward draft reports on these issues to the Task Force. He encouraged the Task Force to carefully distinguish between those items which need to be legislated versus those that can be incentivized. He cautioned that legislation and regulations might favor special interests over consumer interests.

9. **William S. Choate** - Fresno-Madera Area Agency on Aging & California Senior Legislature. Mr. Choate testified about physicians who resigned from managed care plans because they did not want to submit medical decisions for non-medical approval and did not like being required to limit the amount of time they spend with patients.

10. **Ezunial Burts** - Chamber of Commerce, Los Angeles - President & COO. Mr. Burts stated that the LA Chamber of Commerce has designated the provision of health care insurance to the uninsured as one of its six priorities for 1997: “The business community recognizes that a healthy population is in the best interests of business as well as society.” He applauded managed care for its cost effectiveness and integration of quality assurance. He discussed ways in which proposed mandates would increase costs.
and undermine managed care’s strengths. He presented recommendations on how to improve managed care: increase education on the advantages of managed care to all participants; encourage teamwork between providers and managed care professionals; emphasize preventative health measures; control the cost of health care; promote the use of community health centers, as opposed to hospitals; and allow market competition, not legislation, to be the regulator of managed care.

11. **Dr. Klaus Hoffman** - Medical Oncologist. Dr. Hoffman stated that managed care is reducing premiums for employers by impacting on the physician-patient relationship and decreasing access to care. Physicians are forced to accept greater financial risk, which leads to conflict of interest. He cited several specific examples from his practice.

12. **Don Fleming** - American Association of Retired Persons. Mr. Fielding expressed his concern regarding the ability of plans to circumvent the “gag rule” legislation by terminating physicians without cause, as allowed under their contracts. He stated that he does not believe consumers understand the managed care process and are overwhelmed by its bureaucracy.

13. **Dr. Alex Sheriff** - Family Physician. Dr. Sheriff spoke on the issue of Medi-Cal managed care. He stated that the rules, particularly regarding plan enrollment, are confusing for both patients and providers and result in reduced access to care. Doctors have to spend more time on administrative issues and less time caring for patients. He called for greater oversight, particularly concerning adherence to contracts.

14. **John Donaldson** - Local Health Care Coalition. Mr. Donaldson called for increased regulation of HMOs due to their incentives to underserve. He agreed with a previous speaker that consumers are already overloaded with information. He also stated that the patient-physician relationship is being replaced by the patient-insurance company relationship, which he described as unworkable.

15. **Dr. Linda Hewett** - Co-director, UCSF Fresno Alzheimer’s Disease Center. Dr. Hewett discussed a committee her organization established to monitor and identify problems of accessing care in managed care programs. She criticized managed care plans’ aggressive recruitment of cognitively compromised elders. She asserted that the state is underwriting managed care plans, because her state-funded center discounts prices to families who choose to pay out-of-pocket after their managed care plan refuses to give them a referral. Her complaints against managed care included lack of access to a diagnosis; lack of family education and support services; unwillingness to prescribe medications; and refusal to negotiate contracts to provide state-of-the-art care.

III. Adjournment

After seeing no additional speakers, Vice Chairman Clark Kerr closed the June 20, 1997 Public Hearing at 4:30 P.M.

Prepared by: F. Lottridge Neff
I. Call to Order [Chairman, Alain Enthoven, Ph.D.] - 10:00 A.M.
The third business meeting of the Managed Health Care Improvement Task Force [Task Force] was called
to order by Chairman, Dr. Alain Enthoven, at the State Office Building in Fresno, California.

II. Roll Call and Declaration of a Quorum - 10:02 A.M.
Task Force Secretary, Ms. Jill Mclaughlin, took roll. The following Task Force members declared they were
present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Jeanne
Finberg, Mr. Terry Hartshorn, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr.
Peter Lee, Mr. John Perez, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce
Spurlock, Mr. Ronald Williams, Mr. Alan Zaremberg, and Mr. Steven Zatkin.
The following Ex-Officio members were present: Ms. Kim Belshe’, Mr. Keith Bishop, and Mr. David
Knowles.

III. Opening Remarks - 10:10 A.M.
Chairman Enthoven began the meeting by announcing, that the day's program was about consumer
protection as implemented by managed health care plans and would focus on two issues: the managed
care environment around 1975 when the Knox-Keene Act was enacted, and a discussion of the Act’s
objectives and how it’s been progressing; and then the second part would be a discussion on consumer
involvement communication and information. Chairman Enthoven announced that forty-five minutes
had been allocated for each topic.

IV. Reports - 10:20 A.M.
A. Presentations on Consumer Protection as Implemented by Managed Care Health Plans - Warren
   Barnes and Keith Bishop with the Department of Corporations.
Mr. Warren Barnes and Mr. Keith Bishop, with the Department of Corporations [DOC], presented back-
ground information about the history of managed care regulation in California and about the Knox-Keene
Act.

Mr. Barnes began by noting that concerns about changes in financial incentives run throughout the history
of managed care in California. He described the origins of managed care [then known as prepaid care]
during the 1930’s in California; some of those early plans are still operating today. Mr. Barnes stated that
in the 1960’s, there was a resurgence of interest in managed care, with a number of new entrants into the
market. The more established companies were concerned that problems with these new plans might
tarnish the entire industry’s image; they therefore sought legislation to regulate the managed care industry.
The resulting legislation, the 1965 Knox-Mills Health Plan Act, provided for registration of health care
service plans. The Attorney General administrated the Knox-Mills Act. Mr. Barnes noted that during the
late 1960's, then-Governor Reagan encouraged the use of prepayment for delivery of medical services to the Medi-Cal population. The ensuing problems with marketing, quality of care, administration, etc., resulted in the Waxman-Duffy Health Plan Act of 1972. This Act gave the Department of Health Services formal authority to contract for Medi-Cal services on a prepaid basis and to monitor those contracts. Mr. Barnes stated that neither the Knox-Mills nor Waxman-Duffy Acts were able to contain the "entrepreneurial ferment" associated with prepaid health care, particularly for the Medi-Cal plans.

As a consequence, Mr. Barnes stated, the Legislature enacted the Knox-Keene Health Service Plan Act of 1975. Because the Attorney General no longer wanted to regulate managed care, the Legislature considered other options. Though the Department of Insurance [DOI] regulates managed care in many states, it was rejected in California on the grounds that managed care is primarily a service, not insurance, industry. The Department of Health Services [DHS] was rejected because of its role as a health services purchaser. Ultimately, the DOC was chosen for two reasons: it had a long history of successful regulation of a large variety of different types of businesses, and it had its own enforcement capability. Mr. Barnes summarized by saying that, in many respects, the regulatory emphasis has come full circle, transitioning from financial and to quality of care concerns.

Mr. Keith Bishop next summarized today's Knox-Keene Act [Act].

Mr. Bishop stated that the four main purposes of the Act were to ensure: 1) the continued role of the professional as the determiner of the patient's health care needs; 2) the best quality of care at the lowest cost by transferring financial risk from patients to providers; 3) the financial stability of plans; and 4) that enrollees receive available and accessible health care services, maintaining continuity of care. He stated that the Act applies only to health care service plans, which are characterized by prepayment or periodic charges for direct or contracted delivery of health care services. Mr. Bishop described the documentation requirements for licensing, the material modifications process, and standards for marketing, contracting, grievance processes, disclosures, and other business operations. Mr. Barnes emphasized that the Act has very specific licensing requirements in a wide variety of areas. Mr. Barnes went on to describe the oversight and enforcement authority granted by the Act. DOC conducts periodic and non-routine medical surveys and financial examinations. It also has the authority to issue cease and desist orders, institute civil injunctive actions, seek appointment of a receiver, seize the business, freeze new enrollment, and issue civil penalties. Mr. Bishop concluded by noting that the Act contains both specificity and broad principles and encouraged people who are considering regulation to become familiar with its operation, philosophy, and requirements.

Chairman Enthoven thanked Mr. Barnes and Mr. Bishop for their presentations. He reiterated that the Task Force members received a copy of the Knox-Keene Act and that he hoped that members have reviewed the document. A discussion on the following topics ensued: further details about implementation of the Act; DOC's recent budget augmentation; whether PPO and POS plans should be regulated by DOC or DOI; DOC and DHS regulatory overlap on quality issues; regulation of medical groups; physician compensation and financial pressure; streamlining auditing efforts between DHS, DOC, and the private sector; collection and tracking of complaint data; potential costs of outcomes evaluation; and the apparent incompatibility in the Act between transferring the assumption of financial risk to providers and requiring the delivery of care without the hindrance of financial concerns. A five minute recess was taken during this discussion.

B. Presentations on Consumer Protection as Implemented by Managed Care Health Plans - Ms. Ellen Severoni, Executive Director of California Health Decisions.

Ms. Severoni was called upon to discuss consumer information and involvement. Ms. Severoni presented information about the history of California Health Decisions and its mission of educating and involving the public on issues relevant to individual and societal health choices. She described five consistent areas of concern in health care: cost, waste/fraud/abuse, technology, aging, and values. Ms. Severoni next
outlined the member advisory committee of the CalOPTIMA program in Orange County, emphasizing its central role in defining and carrying out the program's mission. She then discussed the consumer feedback loop that is a model for improving health care quality and that involves patients, providers, purchasers, and health plans in a consumer-driven process of research, solutions, change, and evaluation. Ms. Severoni described the findings of her work, including a joint project between Chevron, Health Net, and Hill Physicians Medical Group. Chairman Enthoven thanked Ms. Severoni on her insightful and interesting presentation.

C. Presentations on Consumer Protection as Implemented by Managed Care Health Plans - Ms. Jeanne Finberg, Consumers Union.

Ms. Finberg began her presentation by describing the role of the Consumers Union and the findings of the research done regarding managed health care. Ms. Finberg spoke of a current project involving the Medi-Cal managed care program in California, working with the consumer representatives who are supposed to sit on advisory committees of both plans in each Two-Plan county. She is having difficulty identifying these representatives, either because the plans do not actually have any or because the plans will not release the representatives' names for confidentiality reasons. Ms. Finberg described the Consumers Union survey research, published in two issues of Consumer Reports, that presented comparisons of health plan quality. She discussed the limitations of HEDIS data as a basis for selecting a health plan. These limitations included inconsistent measurement methodology, inadequate data systems, high costs of participating in HEDIS and collecting the data, lack of benchmarks for appropriate utilization, and unwillingness of plans to report results due to adverse selection issues. She also identified a need for quality measures at the medical group and physician level. Ms. Finberg summarized that there is a need for standardization of information and more cooperation or required disclosure from the plans. Chairman Enthoven thanked Ms. Finberg for her presentation.

Ms. Estella Martinez of the CalOPTIMA program offered further testimony about member involvement with CalOPTIMA. Mr. Steve McDermott of Hill Physicians Medical Group spoke about his positive experiences with the consumer feedback loops and his organization's payment structures. Mr. Beau Carter of Integrated Healthcare Associations testified about creating enrollee-driven models that will increase the responsiveness, accountability, and performance of managed care.

A discussion on the following topics ensued: CalOPTIMA's progress in meeting its goals; the kinds of information that are most useful to consumers; incentives for primary care providers to see patients and communicate effectively; how to institutionalize consumer participation; distinctions between payment structures for plans, medical groups, and physicians; utilization and disease management in fee for service versus managed care systems; outcome data as a basis for comparing plans; whether patients are aware of or understand how their doctor is paid; the role of government versus market drivers; the need for a context for the large amounts of data about quality that are available.

Chairman Enthoven suggested he forego his summarization on the May 30th study session and the executive director's report and proceed to the New Business as reflected on the meeting agenda. Receiving no objection, Chairman Enthoven proceeded to New Business.

V. New Business - 11:30 A.M.

A. Adoption of the May 8th, 1997 minutes

Chairman Enthoven asked for a motion to adopt the May 8th, 1997 Task Force business meeting minutes. Mr. Perez made the motion to adopt the minutes and it was seconded by Mr. Kerr. The motion to adopt the minutes was adopted unanimously.

B. Adoption of the amendments to the Task Force Bylaws and Standing Rules

Chairman Enthoven stated that the next order of business was to adopt the amendments to the Task Force
Deputy Director Singh stated that the first proposed amendment authorized the Task Force Chairman to create expert resource groups and to appoint members thereto. The second proposed amendment authorized the Assembly Speaker and Senate Rules Committee to appoint ex-officio members to the Task Force. The third and final amendment was a technical clarification to address the issue of persons voting on behalf of Task Force members.

Several of the Task Force members raised questions regarding the ERGs and their abilities to meet and distribute draft documents to other Task Force members for review. Specifically, Dr. Spurlock asked staff to clarify whether ERGs are subject to the Open Meetings Act. Deputy Director Singh indicated that she and legal staff were developing ERG Guidelines to address these and other issues regarding ERGs and ERG protocols. The Guidelines would be forwarded to Task Force members in the next few weeks.

Mr. Perez suggested that the proposed amendment to the Bylaws affecting ERGs be amended to strike “of no more than two” as it related to the number of Task Force members allowed to serve on an ERG. This language was further clarified by Chairman Enthoven to state:

If an expert resource groups is comprised of more than two Task Force members, meetings of that expert resource group shall be publicly noticed pursuant to Government Code section 11120 et. seq., the Bagley-Keene Open Meeting Act.

Chairman Enthoven then moved to adopt the above language as an amendment to the Bylaws, and it was seconded by Mr. Hauck. The motion to amend this section of the Bylaws was unanimously adopted.

Mr. Hauck then spoke to the second amendment stating that by allowing the Senate and the Assembly to appoint ex-officio members, thus adding more participants to the Task Force, would make the job of the Task Force more difficult. Mr. Perez and Executive Director Romero reminded members that the appointment authority was a technical amendment and that the Senate Rules Committee had already appointed two ex-officio members. After much discussion, Mr. Lee suggested an amendment to state that the Assembly Speaker and the Senate Rules Committee may appoint no more than a combined number of five ex-officio members [so that the Governor and the Legislature each had no more than five ex-officio members on the Task Force]. This amendment was unanimously adopted.

Mr. Perez then asked the Chairman if he could address a few additional issues with respect the Bylaws before the Task Force considered the adoption of the proposed amendment to the Standing Rules. Chairman Enthoven granted Mr. Perez the floor. Mr. Perez referenced page four, paragraph 1 of the Bylaws pertaining to the requirement that the Executive Director has final approval of documents before they are published or released or attributed. Mr. Perez did not find this to be an acceptable rule to govern the publication activities of a group this size, and asked to strike approval of the Executive Director and replace it with “approval of the Task Force”. Mr. Lee suggested a friendly amendment to state that materials distributed by the Task Force shall be approved by, and insert “a majority vote of the Task Force or the Task Force Executive Director”. Mr. Perez further clarified the wording in the next paragraph to state instead of using “exclusively”, to insert the word “necessarily”, so the disclaimer used with Task Force member writings [e.g., opinion/editorials] would read “views expressed herein aren’t of the author and do not necessarily represent the view or opinions of the Managed Health Care Improvement Task Force”. The motion to adopt the aforementioned amendments to the bylaws was moved by Mr. Perez, seconded by Mr. Rodgers and unanimously adopted.

Mr. Perez suggested one more amendment to the Bylaws with respect to items being placed on the Task Force meeting agenda. Specifically, Mr. Perez moved to adopt an amendment to allow Task Force mem-
bers to place items on an agenda by a simple majority of the total authorized membership of the Task Force. Mr. Lee seconded this motion and it was unanimously adopted.

Deputy Director Singh announced that a vote was still needed to adopt the staff proposed amendment to the Standing Rules prohibiting any person from voting on behalf of a Task Force member. Mr. Lee made a motion to adopt the proposed amendment and it was seconded by Mr. Perez. The motion was adopted unanimously.

VI. Public Comment - 1:15 P.M.
Chairman Enthoven asked if any members of the audience would like to give their testimony, and the audience declined. Chairman Enthoven mentioned to the Task Force members that a list of 14 expert resource groups [ERG] had been developed and would be soon forwarded to the full Task Force for review. Executive Director Romero mentioned that 14 groups will be a challenge to staff and that it may be appropriate to develop larger policy options work groups to encompass the work of several ERGs. Executive Director Romero also asked each ERG to address the following questions as they relate to their individual topic[s]: 1) What is the problem [real or perceived]? 2) What gaps or deficiencies exist in the market and/or state governing structure that may be causing, or failing to ameliorate, the problem? 3) What role should the various market participants [e.g., purchasers, plans, consumers, providers] and/or state government play in solving the problem? 4) Where there is a role for state government, how should state government be organized to best solve the problem?

VII. Adjournment - 1:30 P.M.
Chairman Enthoven said that without objection, the study session would be adjourned. Seeing no objection, Chairman Enthoven declared that the July 11th Study Session was hereby adjourned.
I. Call to Order [Chairman] - 10:00 A.M.

The second Study Session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman Alain Enthoven, at the South San Francisco Conference Center.

The following members were present: Dr. Bernard Alpert, Mr. Rodney Armstead, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Nancy Farber, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Mr. Terry Hartshom, Mr. Bill Hauck, Mr. Mark Hiepler, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Mr. Allan Zaremberg, Mr. Steve Zatkin.

The following Ex-Officio members were present: Mr. Keith Bishop, Ms. Marjorie Berte and Dr. David Werdegar

II. Opening Remarks [Chairman and Executive Director] - 10:10 A.M.

Chairman Enthoven stated the focus of today's Study Session was Quality of Medical Care. He introduced the five speakers for the Study Session: Dr. Arnold Milstein, Dr. Robert Miller and Dr. Joseph Aita, Dr. Zwerner and Dr. Madvig and gave a very brief synopsis of their backgrounds. He then turned the meeting over to Dr. Phil Romero, Executive Director of the Task Force, to discuss a few administrative issues.

Executive Director Romero discussed several administrative issues including Task Force member meeting materials, the Expert Resource Groups, the Task Force meeting schedule and Task Force meeting locations. The following are comments made by several Task Force members regarding Executive Director Romero's remarks.

Ms. O'Sullivan stated that she felt the San Francisco meeting location was very inaccessible to public transportation. She also brought up the topic of how the Task Force members need to decide on priorities such as spending money on a more convenient meeting location or using that same money for other items such as public polling.

Mr. Romero responded to Ms. O'Sullivan's remarks by stating that staff had made significant efforts to find a suitable and inexpensive meeting location. Further, he suggested that members notify staff of any prospective meeting locations for future meetings.

Mr. Lee asked Executive Director Romero as to whether the co-chairs of the Expert Resource Groups were being noted on the materials that were being sent to the public and the Task Force members. He also asked the status of the legislation that was going to reimburse the Task Force members for their travel costs. Deputy Director Alice Singh responded by stating that the language that would allow the members to be reimbursed for travel will be taken out of AB 227 (Richter), but that a budget trailer bill was going through the process that incorporated the removed language and nothing could be determined about this until after a budget is passed.

Ms. O'Sullivan continued the Opening Remarks portion of the meeting by asking about the potential for the Task Force to be used as a tool to kill certain pieces of legislation, a fact that Ms. O'Sullivan felt they had been assured as members would not happen. Both Dr. Enthoven and Executive Director Romero reiterated
to Ms. O’Sullivan that they both did not see any evidence of the Task Force being used for that purpose.

Ms. Finberg also spoke up on this subject asking if there was a way to reconfirm that indeed the Task Force would not be misused in regards to legislation. She felt strongly that policy and legislation go forward and that the recommendations from the Task Force be instrumental in shaping that policy.

Mr. Lee made the final suggestion that this issue be slated for discussion at the August 7 meeting in Los Angeles.

**III. Discussion - 10:25 A.M.**

A. Quality of Care in Managed Care vs. Fee for Service Care

1. **Arnie Milstein, MD - Medical Director, Pacific Business Group on Health (PBGH).** Dr. Milstein began by stating that the health care industry has neglected to measure quality of care until very recently. He asserted that while America’s best quality of care is probably second to none, our average quality of care is generally poor in relation to its cost. As managed care addresses costs by reducing service volume, we become more interested in measuring quality to assure ourselves that we are “only eliminating fat and not muscle.”

Dr. Milstein then reviewed the findings of research comparing quality of care under managed care versus fee-for-service (FFS) systems. He declared that this research is ambiguous as to whether quality of care is improving or declining under managed care. He cited research that found that while the average patient fared better under managed care, the sicker and older subset of patients fared better under FFS. PBGH’s research on quality at the medical group level found tremendous variation, with some capitated medical groups significantly outperforming FFS care and others performing significantly worse than FFS. He further described research by Dr. Eve Kerr that found that capitated medical groups 1) focused on detecting over-utilization rather than under-utilization of services and 2) emphasized preventive services rather than provision of services to the chronically ill.

Dr. Milstein recommended that we develop more comparative quality measures and quality accountability at each performance level (plan, hospital, medical group, and individual clinician). These quality measures need to be comprehensive, methodologically sound, user friendly, and public. The public and purchasers need to be educated in use of quality measures, and they need to incorporate the measures into their purchasing decisions. In the short term, we should expand the use of existing quality measures. In the longer term, we should build California’s information system infrastructure to enable better, quicker, and cheaper quality measurement and accountability.

(Dr. Milstein then took questions from the members)

Q: Allen Zaremberg asked Dr. Milstein: How do you measure quality? Whose standards should quality be measured by? And, once you establish the first two questions, do you have the ability to accumulate this kind of data from a FFS delivery system?

A: Dr. Milstein felt that there are a variety of choices for quality measurement, from customer surveys to longitudinal studies of global health status. He stated that over time there will begin to be different definitions of quality depending on your perspective - for example, employers might be more interested in work force absenteeism than consumers are. He felt that as people become less willing to pay the price of unmanaged, FFS care, comparisons will have to be made between degrees of managed care rather than between managed care and FFS.

2. **Robert Miller, PhD - Associate Professor of Health Economics, Institute for Health Policy Studies, UCSF.** Dr. Miller outlined findings from a study that will be published in an upcoming issue of *Health Affairs*. His group analyzed evidence from 15 quality of care studies. They found equal numbers of statistically significant better and worse quality of care results for HMOs compared to non-HMO plans.
He summarized this finding by stating that HMOs “produce better, same, and worse quality of care depending on the organization and the disease or condition.” He stated that there is no pattern of worse quality of care under HMOs, but that some results are unfavorable to HMOs, particularly concerning care for patients with chronic conditions. He stated that these ambiguous results are inevitable due to perverse payment incentives, inadequate information, and very slow change in clinical processes.

A panel discussion was held with Task Force members and the two speakers.

Q: Mr. Rodgers asked if either doctor has seen an increase in investment in quality improvement information and, if so, where is that money coming from? Does government have a role in creating investment in the infrastructure or should it be strictly driven by the market?

A: Dr. Milstein felt that the investment has been quite small relative to the need. Dr. Miller felt that government should coordinate with various stakeholders to assess the costs and benefits involved and reach an agreement to push ahead.

Q: Mr. Zatkin asked the panel about quality outcomes and their relationship to various physician financial incentive arrangements.

A: Dr. Milstein felt that there was not very good information available on this subject, but that an analysis was set for release in August that would shed some light on this issue. He suggested that incentives should be more contingent on quality.

Q: Dr. Rodriguez-Trias asked about HEDIS and its use as an information tool. She also asked about establishing cause and effect relationships in intervention and using that information to measure quality.

A: Dr. Miller felt that many of the measures being used now are still very crude. Dr. Milstein stated that HEDIS 3.0 is a tremendous step forward but small in comparison to where we ought to be. He outlined two problems: 1) Our information systems are very scanty. 2) For most of what we do in medicine, we don’t have good proof that it does improve health.

Q: Dr. Alpert asked the speakers how they reconciled their ambiguous results with the public outcry over managed care.

A: Dr. Miller responded that the “take-home message” of their presentations is that we currently have a fairly mediocre level of quality, with wide variation in that mediocrity. He stated that we have a duty to improve that quality and make it more uniform.

Q: Mr. Lee asked, given the decreasing enrollment in pure FFS plans, how useful the distinction is between HMOs and FFS.

A: Dr. Miller felt that the distinction is between capitated and non-capitated systems. He acknowledged that the distinction gets complicated because most medical groups are not completely capitated and do accept PPO enrollees.

Q: Mr. Hiepler asked if the panelists knew of any studies about patients’ knowledge of how their doctor is paid. He also asked if any of their studies distinguish between the types of capitation, or if they simply compared capitated to non-capitated arrangements.

A: Dr. Miller had no information that indicates patients know how their doctor is paid. Dr. Milstein added that there isn’t much information showing that doctors know whether any given patient is under a capitated arrangement. He referred to two studies that attempted to categorize medical groups by the types of capitation they received.
Q: Several Task Force members asked for clarification of the term “perverse incentives.”

A: Dr. Miller clarified that he was talking about payments to the physician organization. In the case of a physician organization that is paid essentially a finite amount of money, regardless of their patients’ characteristics: if the organization wants to do the right thing and improve care for people with particular (high cost) conditions, it runs the risk of attracting a disproportionate number of people with those conditions to the practice and thereby driving up costs. This could be “catastrophe for the organization.”

Q: Mr. Zaremberg asked if and how risk adjustment might be moved forward.

A: Dr. Miller stated that risk adjusted capitation payments to plans only make sense if plans also risk adjust their payments to the physician organization. He stated that many health economists believe there are currently available risk adjustment schemes that should be put into place.

Q: Mr. Hartshorn asked if either speaker could suggest Task Force recommendations that would address quality assessment and improvement.

A: Dr. Milstein suggested greater support for quality-based reimbursement from plans to physician groups and hospitals, and from physician groups to individual physicians. He was optimistic that the market would eventually solve the problem itself. However, he suggested that there be a legislative failsafe mechanism in the event that the industry is unwilling to sufficiently invest in the information infrastructure.

Break 11:40 A.M.

A: Dr. Miller had a chance to respond to Mr. Hartshorn’s question before the break as to what recommendations he would make to the Task Force. He stated that any recommendations should be made in consultation with the stakeholders. He indicated there should be targets for the kinds of quality outcome measurements. He also suggested that there should be information available at the medical group level.

3. Joseph Aita, MD - Executive Vice President and Medical Director, Lifeguard. Dr. Aita discussed the structure and business operations of Lifeguard, an open network model, not-for-profit HMO that uses FFS reimbursement rather than capitation. He stated that “value” should be defined as “the best achievable health of the community served for the cost.” He felt that detecting variation was crucial to enhancing quality and value. Dr. Aita stated that medical groups that bear risk act as insurance companies and should be regulated as such. He also felt that capitation impedes access. He stated that Lifeguard and other similar minded managed care plans can and do enhance the health and health outcomes of their members through prudent, consistent use of measurement tools.

B. Managed Care Efforts to Continuously Improve Quality of Health Care

1. Alan Zwerner, MD, JD - President and CEO, The Medical Quality Commission (TMQC). Dr. Zwerner discussed TMQC, their Workplan, products, and services, and the people who sit on the TMQC board. He then described three TMQC initiatives to improve quality in managed care: medical group and IPA accreditation; independent research, including cooperative efforts with PBGH and California Health Decisions; and education. He also discussed TMQC’s role in facilitating industry collaboration.

2. Phil Madvig, MD - Associate Executive Director, Permanente Medical Group. Dr. Madvig began by describing the Kaiser Permanente plan. He then discussed examples of quality improvement successes and failures. He also described the criteria his organization uses to target areas for quality improvement, and he described some of those quality improvement efforts. Dr. Madvig cautioned against over-emphasis on targeted quality outcomes because when you focus on those measures, you get improvement in those areas, but distract attention and resources from other areas.

A panel discussion was held with the members and the three panelists.
Q: Dr. Alpert asked Dr. Aita if Lifeguard had ever considered moving to for-profit status and if he thought the Task Force should make any recommendations regarding tax status. Dr. Alpert also asked Dr. Aita if he thought most pre-authorizations could be handled electronically.

A: Dr. Aita replied that about 7 years ago there were discussions about moving to for-profit status, but they dismissed the option because they felt it would not have been in keeping with the plan’s original mission. He felt that the Task Force should not address this issue because the public doesn’t have strong opinions about it. He noted that physicians, on the other hand, are very interested in Lifeguard as a non-profit.

Dr. Aita stated that electronic medical records are essential to further improvement in managed care processes and costs.

Q: Ms. Finberg asked if the TMQC data is available to the public and for details on the accreditation process.

A: Dr. Zwerner stated that public access to accreditation findings (including disclosure of who sought accreditation) will be available in the near future. He also gave some figures regarding the accreditation process. About half the groups pass the accreditation process, one quarter get provisional accreditation, and the last quarter are not accredited but revisited after six months. Approximately 3% fail.

Q: Mr. Hiepler asked Dr. Aita if capitation has an impact on the doctor/patient relationship and if it affects either party’s satisfaction levels. He also asked Dr. Zwerner to define the phrase “capitation done incorrectly.”

A: Dr. Aita responded that satisfaction rested more on the lack of access outside of the capitated group than any limitation of care within the group. Dr. Zwerner described “incorrect capitation” as capitation of the individual physician - “when capitation becomes compensation.”

Q: Mr. Zaremberg asked about process improvements plans have devised to achieve the goal of providing the right treatments as fast as possible in the best manner possible.

A: Dr. Aita described physician “gold carding” (physicians with a well-established history with the plan no longer need prior authorization) and use of physician practice pattern profiling.

Q: Ms. Severoni asked questions of each panelist: What tools would Dr. Madvig be using to bring his members’ voice into the quality improvement issues and changes? How does Dr. Aita help his members understand the authorization process? Does Dr. Zwerner think the accreditation process should be mandated instead of voluntary?

A: Dr. Madvig stated that they haven’t involved their patients enough. However, he stated that they use surveys and follow-up surveys to involve members in certain targeted areas. Dr. Aita replied that they do not intervene in the outpatient referral process at all. He stated that the authorization process is explained in a newsletter, in addition to the standard member materials. Dr. Zwerner stated that purchasers and enrollees should demand accreditation of provider organizations.

Q: Dr. Conom asked Dr. Madvig some questions regarding his presentation and some of his project results that he had shared. Dr. Madvig stated that he would need to get back to her with a response.

IV. Adjournment

Hearing no request for public comment, Chairman Enthoven adjourned the Study Session at 1:15pm. He also noted that a public hearing would be conducted at 2:00 P.M. today.

Prepared by: Stephanie Kuss
I. Call to Order [Chair] - 2:00 P.M.
The fourth Public Hearing of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman Alain Enthoven, at the South San Francisco Conference Center.

Dr. Enthoven asked Ms. Alice Singh, Deputy Director for Legislation and Operations for the Task Force, to read the Public Notice regarding the Public Hearing portion of the meeting.

Dr. Enthoven discussed the basic rules governing the Public Hearing process, how long it would run and how much time each member of the public would be granted to address the Task Force.

II. Public Testimony and Comment
1. **Dr. Krems, MD, PhD** - American Association of Retired Persons. Dr. Krems commented that recommendations should be made to the Department of Health Services and the HMOs to eliminate the inadequate care currently provided to chronically ill patients.

2. **Dr. Roland Lowe, MD** - President, California Medical Association. Dr. Lowe stated that the CMA is supportive of managed care, but wants to suggest improvements. He highlighted some of the key points in a paper that he distributed to the Task Force members. He stressed the need for more patient choice, especially educated choice; the concern that providers are given less money, yet are being asked to do more than ever before; the need for evaluation processes; and the role of government in health care.

3. **Lynnie Morgan.** Ms. Morgan talked about her daughter, Amy, who was born with a rare genetic disorder for which there is no cure and little treatment. Ms. Morgan relayed their experiences with Kaiser, which they have been members of since 1977. She expressed her distress and frustration with the quality of care her daughter was being given and the hassles she had to go through to have tests taken, to get referrals and for basic support. She and her husband have filed a grievance with Kaiser and a complaint against Kaiser with the Department of Corporations.

4. **Paula Campbell.** Ms. Campbell came to the hearing to speak as a consumer. She wanted to stress that she would like to have her health care managed by her physician and not by an insurance company. She cited problems with length of hospital stays, prescription drug services, and access to insurance for people with pre-existing conditions.

5. **Denise Gross,** Attorney. Ms. Gross came to testify both as a consumer and as an attorney advocate for persons who are being denied medical benefits pursuant to insurance company provisions. She brought forth examples of two cases, one involving her and one involving a client, in which she felt the insurance companies were attempting to manage the physicians and override their medical decisions.

6. **Catherine Dodd** - Executive Director, American Nurses Association of California. Ms. Dodd focused on three concerns. 1) She suggested the Task Force recommend that legislative barriers that impede licensed providers, particularly advanced practice nurses, from providing care to the full extent of their licensure be eliminated. 2) She suggested that outcome data be profession-specific. 3) Ms. Dodd felt
that pre-regulatory oversight is essential and that a proper balance between efficiency, quality, and consumer rights needs to be established.

7. **Kathleen Lynaugh** - United Health Care. She believes that in regards to quality, managed care provides excellent case management. She cited several cases where managed care provided case management that was both beneficial and comprehensive. Ms. Lynaugh stated that although managed care is not a perfect system, it does have the capability to do some things very well.

8. **Evelyn Rinzler** - Contra Costa Health Services Department. Ms. Rinzler spoke about the Ombudsman Program that was established by the Contra Costa Board of Supervisors for the Contra Costa Health Plan. This service was set up to be physically and functionally separate and independent from the plan. It is intended to provide information and support to the patients and to gather data on the HMO itself to be used to analyze the problems of managed care and to recommend solutions.

9. **Michael Van Duran, MD** - Medical Director, Contra Costa Health Plan. Dr. Van Duran cited an example of how managed care improved the coordination of care for a boy with ADHD.

Q: Mr. Lee asked whether Contra Costa County has a two-plan model and whether there had been any dialogue with the commercial plan to establish a single ombudsman program for all Medi-Cal recipients.

A: Ms. Rinzler answered that yes, Contra Costa is a two-plan model county and that they had tried to discuss that possibility with the other plan but they were turned down.

10. **Art Small, MD** - Medical Director, United Health Care. Dr. Small stated that managed care is the best hope for providing health care in the United States to the broadest array of people at the most affordable price and with the highest quality, especially in regards to prevention. He described ways in which managed care is superior to FFS.

Q: Dr. Alpert asked why there is such an outcry against managed care if everything is working so well.

A: Dr. Small felt that because health care is so personal, there is tremendous concern with the changes taking place. He stated that there is fear of change.

Q: Ms. O'Sullivan asked if the savings to employers were going into the wages of workers.

A: Dr. Small cited a study in which they observed a real wage increase and net savings to the average California family due to managed care.

11. **Kathy Schepple** - Alameda Alliance for Health. Ms. Schepple came to address the Task Force as a consumer. She discussed several access issues, including access to transitional coverage for Medicaid recipients, access to specialists under Medicaid, and access to insurance. She also discussed the need for better education about prescribed drugs.

12. **Howard Arkans, MD** - Medical Director, Aetna U.S. Health Care. Dr. Arkans spoke about several positive aspects of managed care, especially disease management. He felt that managed care provided the populations that are necessary to study outcomes, which can provide physicians with a better understanding of disease management. He went on to list several successful disease management cases.

Q: Dr. Alpert asked Dr. Arkans why people are so unhappy with today's health care environment.

A: Dr. Arkans stated that he thought a lack of education about how the managed care system works and how to use it was a big factor in people's dissatisfaction. He also felt there was a concerted publicity effort against managed care. He further stated that some bad plans give a bad name to all the plans.

Q: Ms. Severoni asked what Dr. Arkans felt was the most bothersome issue for Aetna members.

A: Dr. Arkans answered that most complaints have to do with lack of access to providers due to referral management processes.
13. Jane Jackson - Alameda Alliance for Health. Ms. Jackson specifically wanted to know who on the Task Force represented Medi-Cal recipients. Chairman Enthoven responded that six members were appointed to represent health plan enrollees and six to be consumer advocates, but that as far as he knew no welfare recipients were appointed. (A discussion between the Task Force members ensued as to whether Medi-Cal managed care administration is part of the Task Force’s charge.) Ms. Jackson felt that there are many problems with Medicare and Medi-Cal and that the Task Force should address those issues.

14. Greg Monando - President, Davies Medical Center. Mr. Monando believes that managed care companies are redlining his medical center because it serves San Francisco’s HIV+ populations. He feels that unless there are changes by a governmental oversight agency, inadequate reimbursement will force facilities like Davies to shut down. He felt that managed care has been a positive economic reward for insurance companies and their shareholders at the expense of patients, physicians, and hospitals.

Q: Ms. O’Sullivan asked for clarification as to what “redlining” meant.

A: Mr. Monando stated that the plans will not sign a contract with Davies or its physicians, thereby forcing people to go outside of the community to seek care.

15. Judith Mates, MD - San Francisco Medical Society. Dr. Mates wanted to introduce the concept of cooperative competition in managed care. First, she suggested that the Task Force agree to make access and quality the most important aspect of their deliberations. Second, she suggested encouraging the creation of centers of excellence that can concentrate on the detailed needs of patients with specific conditions.

Recess

16. William Goodson - University of California, San Francisco. Mr. Goodson discussed managed care’s impact on the physician/patient relationship. He felt that managed care is steadily increasing the workload of physicians by forcing the patient out of the hospital at a faster rate. Because the last thing to be compromised is patient care, this is causing extreme stress and burn out of the physician.

17. Ruth Clifford, MD - President, California Coalition for Ethical Mental Health Care. Dr. Clifford has resigned from all managed care plans because they were intruding on her treatment decisions. She cited problems with the pre-authorization process, utilization management practices, and restrictions on the number of covered mental health visits. She stated that managed care is a person-destructive system.

18. Frederick S. Mayer - Pharmacist Planning Services. Mr. Mayer first related a personal story about his difficulty accessing necessary care for his daughter under managed care. Second, he discussed the number of pharmacies in the Bay area that are shutting down because of pressures from managed care. He also discussed managed care’s high administrative overhead costs and high corporate profits. Mr. Mayer asked if there was a representative on the Task Force who would be willing to meet with the pharmacists to discuss their issues. He also requested that the Task Force adopt the standards for pharmaceutical services outlined in materials he handed out.

19. Laura Thomas - Public Policy Associate, San Francisco AIDS Foundation. Ms. Thomas discussed things that managed care must do to ensure that people with AIDS and other diseases are getting quality care. Managed care plans need to continually reevaluate and update their guidelines for treatment while maintaining treatment flexibility. There also needs to be an adequate capitation rate for diseases like HIV/AIDS, that are very expensive to treat. Finally, HMOs need to develop an extensive range of services within the community with a manageable referral system.

20. Rob Sabados - Act Up Golden Gate. Mr. Sabados is a Medi-Cal AIDS patient. He discussed Act Up’s efforts to draw attention to problems in managed care. He urged the Task Force to emphasize the adoption of quality assurance measures to insure that people in the population that cannot effectively represent themselves receive adequate health care. He also urged the Task Force to suggest that all Medi-Cal managed care plans be required to comply with federal guidelines for HIV care.
21. **Dr. Philip Alper** - California Society of Internal Medicine. Dr. Alper stated that the current system of competitive employment-based insurance carries an inherent risk of inadequate chronic care. He felt that capitation rate information should be available to the patient, that there should be actuarially sound reimbursement to the provider, and reimbursement based on geographic area. He suggested creating a way to develop new health care delivery entities, perhaps by relaxing the ban on the corporate practice of medicine.

22. **Gerda Miller** - Gray Panthers. Ms. Miller spoke about the eroding physician/patient relationship under managed care. She urged the Task Force to look at Medicare managed care and the problem of the number of uninsured in California.

23. **Dr. Bill Updike** - President, San Francisco Chiropractic Society. Dr. Updike spoke about quality of care and its relationship to the patients' continuity of care. He expressed concerns that the doctor/patient relationship and continuity of care is compromised when the health plan deselects a provider. He suggested that plans be required to provide a rationale for terminating a provider and that patients be allowed to switch to a plan that contracts with their terminated provider if such a plan is offered by the patient's employer.

24. **Oliver Baer** - Patient, Bay Valley Medical Group/Secure Horizons. Mr. Baer shared his experiences with FFS versus managed care Medicare. Under FFS Medicare he had to pay 80% of his substantial hospital bills, while under his HMO the health plan paid 100%. He is very happy with his health coverage and his plan.

25. **Dorothy Elward** - Patient, Bay Valley Medical Group. Ms. Elward stated that she is very happy with her Medicare HMO and the managed care system. She received a wide variety of services, all in a timely, caring manner. She stated that she is in favor of managed care “for all strata of our society.”

26. **Gladdy Cash** - Patient, Bay Valley Medical Group/Pacificare. Ms. Cash is a cancer survivor under managed care and satisfied with her plan. She felt that most people don't take the time to read and become knowledgeable about their managed care plan. It is a very confusing and complex system that takes some effort to understand.

27. **Daniel D. Morgan, MD** - Washington Hospital. Dr. Morgan discussed confidentiality and physician/patient relationship issues. He recommended depersonalizing coding systems in databases, allowing patients to review their records, purging information from databases after service is concluded, notifying patients when information from their records is released to government authorities, and holding plans liable if confidentiality guidelines are not met.

28. **Lucy Johns.** Ms. Johns suggested the Task Force recommend a prudent layperson standard for all emergency care, increased provider and consumer education regarding end of life care alternatives, and timely reporting of all test results. She also recommended that a standard definition of primary care practice be adopted.

29. **Jeff Wong.** Mr. Wong stated that it is increasingly difficult for pharmacists to get information from the plans about drug formularies. He suggested devising a Web page where all formularies are posted in order to distribute the information to physicians and pharmacists faster. He felt that health plans should be liable for side effects or problems that arise when they mandate a change within a drug classification. Mr. Wong also felt that many pharmacists are being excluded from health plans, which limits consumer choice. Finally, he stated that there should be continuity of care standards for people who switch plans.

30. **Dennis Wheeler** - Patient, Bay Valley Medical Center/FHP. Mr. Wheeler stated his satisfaction with managed care. He felt that the system can be improved, but that overall it works.

31. **Luella Penserga** - Asian and Pacific Islander American Health Forum. Ms. Penserga discussed the need for managed care systems to have interpretive services available for their members, and also to contract with or have providers who are multilingual themselves. She felt that one positive aspect of managed care was her interest in prevention and education.
32. Sherri Sager - Director of Governmental Relations, Packard Children’s Hospital. Ms. Sager stressed the issue of children’s care. She felt that there is a growing problem with children getting the kind of referrals to specialists that they need. Most physicians feel that any adult specialists can care for pediatric problems as well, but children have very special health care needs that need to be dealt with by a children’s specialist.

(Several of the members and the Chair spoke briefly about the subject of referrals and the importance of studying the issue closely)

33. Joe Keffer - California Nurses Association & Vote Health Coalition. Mr. Keffer stated that public hospitals have lost funding under the managed care system, burdening county governments. He felt that this funding problem will ultimately decrease access for the uninsured, because private insurers do not want to care for them and public hospitals will be unavailable.

34. Michael Popso. Mr. Popso stated as a consumer under managed care that he was extremely displeased with his plan. He needs some special treatment and therapy and is being continually denied that treatment even though several doctors stated that he was an excellent candidate for the procedures he needs. He was extremely frustrated and asked the Task Force to create a level playing field so that consumers have recourse if they are denied specific treatments they need.

35. Isaac Martin - Local 250, Service Employees International Union. Mr. Martin feels that managed care is an effective, affordable way to provide health care to people, but it requires regulation and enforcement. He feels that the regulatory agencies - the Department of Health Services and the Department of Corporations - are not keeping pace with the changes in health care delivery under managed care. These agencies also allow for very limited access to information and limited public input.

36. Dr. John Gilman - Legislative Chair, California Physicians Alliance. Dr. Gilman discussed capitation rates and incentives. He felt that because of perverse financial incentives, physicians will be providing lower quality care, less time with patients, and less care overall. He stated that the capitation system is transferring the financial risk from the insurance companies to individual providers, which ultimately means the patient is at risk. Dr. Gilman feels that the regulation of these issues is the way to control and improve managed care.

(Members asked Dr. Gilman for some clarification on his remarks, regarding capitation rates and the consumer's right to know)

37. Charla Cooper. Ms. Cooper has medical problems that she felt were heightened if not caused by her health plan. She was denied referrals for six months while her situation deteriorated. She presented documents showing that the Department of Corporations found her health plan, Kaiser, to be in violation of several provisions of the Knox-Keene Act, none of which have yet been corrected. Mr. Zatkin objected to Ms. Cooper’s characterization of Kaiser.

38. Bill Tarran, DPM. Dr. Tarran felt that managed care has failed to live up to acceptable standards of care and that it is basically “nickel and diming” consumers to death. He also discussed managed care’s negative impact on new physicians by restricting their freedom to practice where they choose.

Dr. Rodriguez-Trias requested that the Department of Corporations report referenced by Ms. Cooper be made available to the Task Force members.

III. Adjournment
Seeing no further speakers, Chairman Enthoven closed the public hearing at 6:15 P.M.
I. Call to Order [Chairman, Alain Enthoven, Ph.D.] - 9:40 A.M.
The fifth Study Session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Californian Chamber of Commerce building, Sacramento, California.

II. Roll Call - 9:42 A.M.
Task Force Secretary, Ms. Jill McLaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Barbara Decker, The Honorable Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffith, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Ronald Williams, Mr. Allan Zaremberg, and Mr. Steven Zatkin.

Ex Officio members Ms. Kim Belshe and Ms. Marjorie Berte were also present.

III. Opening Remarks - 9:45 A.M.
Chairman Enthoven outlined the study session schedule and introduced the first report. Dr. Philip Romero informed Task Force members of the recent Fair Political Practices Commission [FPPC] determination that at this time, Task Force members are not required to comply with the FPPC’s Form 700 requirement of economic disclosure. Executive Director Romero also reported that the issue of Task Force member reimbursement for travel costs associated with the attendance of Task Force meetings was tied up in the state budget process. Therefore, until further notice, the State is not authorized to reimburse members for any such travel costs. Finally, Executive Director Romero discussed a variety of policy approaches with respect to the implementation of Task Force recommendations.

IV. Discussion - 10:00 A.M.
A. Efforts to Continuously Improve the Quality of Health Care

1. Margaret Stanley [Assistant Executive Officer, Health Benefit Services, CalPERS]

Ms. Stanley outlined the benefits of the Californian Public Employees Retirement System [CalPERS], noting that “Employees’ satisfaction scores with their health plans are rising while health care costs remain stable.” She stated that CalPERS provides coverage to over one million employees of state and other public agencies and their dependents. Annual health care premiums total $1.5 billion. Ms. Stanley described four key elements of CalPERS’ success: the choice of plan and plan types; active purchasing management; the composition and leadership of the CalPERS board; and access to comprehensive, quality, and affordable benefits.

Ms. Stanley outlined CalPERS’ efforts to improve the quality of health care, including participating in the California Cooperative HEDIS Reporting Initiative [CCHRI], collaborating with the Pacifi Business Group...
on Health [PBGH] on customer satisfaction surveys, publishing an annual health plan quality and performance report, and partnering with health plans to develop best practice models, controlling costs.

Ms. Stanley stated that in the future CalPERS will focus on maintaining and increasing access, defining accountability, holding health-plans accountable, and encouraging plans to invest in information systems infrastructure. CalPERS is also considering risk adjustment.

Mr. Hauck asked several questions about costs and the seemingly incompatible aims of controlling cost while improving quality. Ms. Stanley responded that there is still a lot of fat in the system, including excess hospital beds, the number and distribution of physicians, inefficient organization and delivery of care, and administrative costs. She said that cost control and quality improvement can be complimentary: “There is still a long way to go in improving quality without cutting corners.”

Ms. Bowne asked if Ms. Stanley felt that the managed care industry consolidation is hurting the choice of plans for CalPERS members. She also asked how state mandates might affect CalPERS. Ms. Stanley responded that monopoly is a concern, so CalPERS is considering alternatives such as direct contracting with doctors and hospitals, POS options, and exclusive provider organizations. She also stated that the CalPERS board has a position against mandated benefits because such mandates limit flexibility.

In response to Dr. Alpert’s inquiry as to specific CalPERS recommendations for the Task Force, Ms. Stanley remarked that finding ways of making health-plans accountable for quality, access, and service should be the top priority. She also advocated a market rather than regulatory approach.

Ms. Decker asked about CalPERS’ dispute resolution system. Ms. Stanley responded that CalPERS has an ombudsman that is available to members once they have exhausted or failed to get a response from their plan’s appeal and grievance procedure. CalPERS contracts provide a right to an administrative hearing and hearing before the CalPERS board.

2. **Dr. Anthony Legoretta [Vice President of Quality Initiatives, Foundation Health Systems]**

Dr. Legoretta described some of the projects undertaken by his research and development group within the HMO. They have conducted member satisfaction surveys and presented the results, by medical group and by employer, to their medical groups, contracting employers, and members. Dr. Legoretta reviewed the results of a quality improvement program to increase the rate of annual eye exams for diabetic members. He also described the group’s efforts to develop specific interventions for patients with diabetes, asthma, high cholesterol, high blood pressure, or depression, by understanding the demographics of each population. Their goal is to improve the members’ quality of life, functional status, and work site absenteeism. He also presented the results of a mammography study.

Dr. Legoretta stated that “what I think we’ve been calling managed care for the past 15 [or] 20 years has been really managed utilization.” He felt that managed care organizations need to understand the populations they serve and adapt their systems around their members’ needs and wants.

Dr. Alpert asked Dr. Legoretta to identify physician incentive arrangements that he thought should be encouraged or discouraged. Dr. Legoretta responded that his plan is moving towards a performance-based physician contract structure, focusing on quality of care. They are developing similar programs for medical groups and hospitals. Dr. Legoretta also stated that dissemination of quality data to the public would be an even stronger incentive.

In response to a question from Dr. Rodriguez-Trias, Dr. Legoretta stated that there are a lot of databases that collect outcomes measures, but the timeliness of that data is “laughable.”

In response to a question from Dr. Spurlock, Dr. Legoretta stated that a way to disseminate clinical practice guidelines needs to be developed. He also felt those guidelines should be disseminated to plan members.
B. ERG Oral Report on New Quality Information Development [Members Clark Kerr and Dr. Rodney Armstead]

Mr. Kerr presented suggested Task Force recommendations about new quality information development. He first defined 5 audiences for health information: consumers, health providers, plan purchasers, health professionals and research efforts to improve evidence-based medicine, and policy makers.

Mr. Kerr stated that current information is inadequate. He suggested that California, in collaboration with other efforts:

- develop and implement risk adjusters, perhaps in a Medicaid demonstration project;
- establish a task force to develop a strategy to move towards electronic medical records;
- move from a statutory to a regulatory approach regarding which data elements are collected;
- collect and disseminate quality information at all treatment levels [plan, hospital, medical group, etc.];
- commission a series of specific and ongoing evaluative studies, including studies on who does the best job of involving and respecting the preferences of their patients.

Dr. Spurlock suggested that the cost and feasibility of these recommendations should be analyzed. Dr. Karpf echoed this concern, stating that recommendation should be pragmatic and appropriate. Dr. Kerr stated that the health care industry currently spends about 1% to 2% of the budget on information, while other service industries devote between 6% and 8%. He asked why the health industry is complaining about the cost of information when they are “so much farther behind the rest of society.”

Mr. Zatkin asked if everyone needs to move to electronic records, or if that would lead to costly data redundancies. Mr. Kerr responded that electronic records are useful for more than just outcomes studies. They can also be used for quality improvements, such as alert systems and decision assistance. In addition, he said that after an initial investment, electronic records actually save money.

C. ERG Oral Report on Managed Care’s impact upon vulnerable populations [Members Helen Rodriguez-Trias, MD and Anthony Rodgers].

Mr. Rodgers described several “vulnerable” groups, including the elderly; disabled children; the poor; people with long-term, chronic illnesses; “episodically vulnerable” people with serious, short-term illnesses; the working poor and medically indigent; and people who are illiterate. He questioned what proportion of the vulnerable population is in public programs such as Medicare and Medi-Cal. He also identified several roles for assisting vulnerable populations: administrative and financial intermediary, regulatory, market facilitation, and advocacy. He questioned how poor performers should be weeded out of the system.

D. Managed Care’s Impact on Women [Member Rodriguez-Trias, MD; Helen Schauffler, Ph.D., Associate Professor of Health Policy at UC Berkeley’s School of Public Health; Lucette DeCorde, MPP, MPH, Director of the California Women’s Health Project; and Debra Kelch, MPP].

Dr. Rodriguez-Trias outlined the importance of women’s issues in looking at managed care: women are the principle health care consumers in the country, for themselves and their families; they are the majority of the health care work force; they have been important in shaping the health care agenda through consumer groups; and they need frequent and regular care.

Dr. Schauffler described study results regarding primary and preventive care for women in California. She stated that the study set out to discover the extent the healthcare system and managed care plans in California were encouraging women to change their behaviors by offering them health advice or increasing access to health promotion programs. Dr. Schauffler described how she thought the incentives must be changed to increase counseling rates for women about their health behaviors when they visit their healthcare providers.
Dr. Schauffler stated that she would like to see the Task Force “work to begin to provide health insurance coverage and increased access to comprehensive quality managed care programs that promote health for all Californians.”

Ms. DeCorde stated that mental health benefits are “woefully inadequate” and called for parity with physical health benefits. She also stated that women have less access to health coverage, due mostly to employment issues.

Ms. Kelch had several recommendations regarding managed care and older women, including: strict guidelines and quality measurements for managed care plans serving elderly and disabled persons; objective consumer information; improved provider education and licensure standards; and scrutiny of health policies for their specific impacts on older women.

**Lunch at 1:10 P.M.**

E. **Task Force Public Survey [Helen Schauffler, Ph.D., Associate Professor of Health Policy, P.I., Health Insurance Policy Program, UC Berkeley School of Public Health]**

Dr. Schauffler described the goals of the Task Force’s survey: to conduct a statistically valid survey to supplement information from public hearings; to assess the problems consumers are having; to assess the characteristics of consumers who are having problems; to assess the extent to which consumers have been able to resolve their problems and how. All of this information should assist the Task Force in identifying the most important issues and targeting solutions to those issues.

She stated that the survey is being developed in conjunction with Task Force members and a national technical advisory group of experts. She described existing surveys that would be sources for questions on the Task Force’s survey. She recommended that the Consumer Assessment of Health Plans (CAHP) survey, developed by the Picker Institute and funded by the Agency for Health Care Policy and Research (AHCPR), be the core. She discussed the strengths and weaknesses of that survey. Dr. Schauffler also reviewed the proposed survey methodology and timeline. She asked Task Force to contact her with input on what topics are most important to include in the survey.

V. **Adjournment - 2:14 P.M.**

Chairman Enthoven indicated that without objection, the study session would be adjourned. Seeing no objection, the Chairman adjourned the meeting at 2:14 P.M.

Prepared by: Stuart McVernon
I. Call to Order and Open the Hearing [Chair] - 2:15 P.M.

The third public hearing of the Managed Health Care Improvement Task Force was called to order by the Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce Building in the California Room.

The following members were present: Dr. Bernard Alpert, M.D., Ms. Rebecca Bowne, Dr. Donna Conom, M.D., Ms. Barbara Decker, Honorable Martin Gallegos, Ms. Diane Griffiths, Dr. Bradley Gilbert, M.D., Ms. Diane Griffiths, Mr. Bill Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, M.D., Mr. Clark Kerr, Dr. J.D. Northway, M.D., Ms. Maryann O’Sullivan, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock M.D., Mr. Ron Williams, Mr. Allan Zaremberg, and Mr. Steven Zatkin.

The following Ex-officio members were present: Ms. Kim Belshé and Ms. Marjorie Berte.

Chairman Enthoven informed the audience of the procedures for testifying before the Task Force. He specifically stated that the Task Force is interested in hearing the thoughts of the public regarding systemic changes in managed health care.

II. Public Testimony - 2:22 P.M.

1. Ms. Kit Costello - President of the California Nurse’s Association. Ms. Costello stated that there is not a true health care marketplace for many people who receive their insurance through employment, because employers offer few plan choices. She cited her own employment with Kaiser as an example. Ms. Costello suggested numerous reforms, including mandating that at least 90% of premiums are spent on patient care; risk adjusting capitation payments; enacting whistle-blower protections for health care professionals; requiring the Department of Corporations [DOC] to publish a comparison of plan’s excluded benefits, treatments, etc.; and improving regulation of quality and staffing levels in health facilities. Written testimony was submitted.

Chairman Enthoven thanked Ms. Costello for her testimony. The Task Force members addressed Ms. Costello’s concerns with various questions and comments regarding disclosure of denial of care criteria, reporting of quality information, effects of managed care on nurses, and informed consent for hospital patient discharge.

2. Ms. Jane Parish - Advocate for Breast Cancer. Ms. Parish, who stated that she has been a nine year survivor of breast cancer, spoke about the shortcomings of managed care based on her personal experiences in 1988 and her experiences as an advocate for hundreds of other women since that time. She described concerns related to availability of patient information, options of care, and access to physicians, particularly regarding breast reconstruction. She also discussed the lack of accountability for managed care insurers under ERISA.

Chairman Enthoven thanked Ms. Parish for her testimony. The Task Force members addressed Ms. Parish’s concerns with various questions and comments concerning impediments to patient care, other sources of medical information for the public, hospital discharge policies, and reasons that plans are not providing information to patients.
3. **Dr. Loren Johnson** - California Chapter of the American College of Emergency Physicians. Dr. Johnson discussed the effects of managed care on the emergency room, especially in its role as part of the safety net. He stated that while the Emergency Medicine Treatment Labor Act strengthened the safety net by mandating emergency services, it did not mandate funding for those services. He stated that emergency specialists are “resigning in droves” as a result. He recommended that legislation allowing direct access to ER screening and evaluation, such as the Ferguson Act and Access to Emergency Medical Service Act, be passed.

Chairman Enthoven thanked Dr. Johnson for his testimony. The Task Force members addressed Dr. Johnson’s concerns with various questions and comments concerning appropriate versus inappropriate ER use, prior authorization for emergency care, and high charge versus high cost.

4. **Dr. Bill Weil** - Maxicare. Dr. Weil stated that he wanted to respond to an earlier question, “Does managed care suck?” Dr. Weil pointed out positive aspects of managed care including physician credentialing, utilization review, member services, health education and physician education.

Chairman Enthoven thanked Dr. Weil for his testimony. The Task Force members addressed his concerns with various questions and comments concerning high-quality physicians being denied access to panels, physicians treating patients with different types of insurance differently, disclosure of how physicians are paid, and his concerns with managed care.

5. **Lynnie Morgan** - Consumer from Concord, California and founder and Director of the Mitochondrial Disorders Foundation of America. Ms. Morgan suggested that if physician incentives and capitation are eliminated, doctors and plan administrations might refocus on caring for their patients. She also suggested developing centers of excellence. She expressed concerns about the Task Force survey, stating that surveys are only as good as the questions they ask.

6. **Mr. Warren Leach** - HMO enrollee. Mr. Leach testified about his personal experience with emergency cardiac care. He stated that many of his health problems might have been prevented with better management of his medical condition, specifically if he had received certain tests earlier and been given better after-care instructions.

Chairman Enthoven thanked Mr. Leach for his testimony. The Task Force members addressed his concerns with various questions and comments concerning what changes he would like to see in managed care.

**Ten minute recess**

7. **David Blackman** - President, Chief Operating Officer of Tower Health. Mr. Blackman stated that it is important to discuss both the positive and negative aspects of managed care. He stated that he has seen good quality care and access in the managed care industry. He also felt the biggest problem is the intangible and systemic forces in managed care, including political, environmental, and budgetary influences.

Chairman Enthoven thanked Mr. Blackman for his testimony. Task Force member Alpert asked Mr. Blackman if he had any specific recommendations regarding managed care. Mr. Blackman discussed risk adjusted premiums.

8. **Wilma Krebs** - California Senior Coalition. Ms. Krebs asked whether the survey discussed earlier in the day included the CalPERS PPO. Dr. Helen Schauffler responded that it was included. Chairman Enthoven pointed out that employers, like CalPERS, determine what coverage is included in the PPO and the PPO simply follows that direction. Some employers choose to offer much less expensive coverage.

9. **Mr. William Powers** - Congress of California Seniors. Mr. Powers discussed his views on the Patient Bill of Rights. He stated that it is a modest response to the rapid growth of the managed health care system and the problems for consumers which have resulted. He stated that we cannot depend on the
industry to police itself, we must look to government to protect our interests. He urged the Task Force 1) to address the needs of vulnerable groups such as the elderly, disabled, and low-income in its report and 2) to not allow its work to be a pretext for preventing current legislative reforms.

Vice Chairman Kerr thanked Mr. Powers for his testimony. The Task Force members addressed his concerns with various questions and comments concerning choice of fee for service versus managed care for Medicare beneficiaries.

10. Dr. Lisa Merritt - Multicultural Health Institute. Dr. Merritt expressed concern with ten main areas of a multidisciplinary team model that she feels could benefit managed care. These areas include issues of access; the need for cultural competence and multicultural curriculum training; the need for research and useful data on outcomes; the need for collaboration; the need for greater training of community health care workers and coordinators, as well as minority/under-served health care providers for under-served populations; an effective plan for California’s uninsured people; a way to target education for an early and aggressive intervention strategy for high risk populations; the greater use of information technology; and the greater need to bridge the gap between allopathic and complementary, traditional, and/or spiritual medical belief systems.

Vice Chairman Kerr thanked Dr. Merritt for her testimony. The Task Force members addressed her concerns with questions and comments concerning choice of fee for service versus managed care to address her concerns.

11. Ms. Betty Perry - Older Women’s League. Ms. Perry spoke about support for the Patient Bill of Rights, particularly the portions pertaining to second opinions and denial of care by non-physicians. She noted that many doctors and plans are not aware of or following through on current mandates.

12. Dr. Barbara Arnold - California Association of Ophthalmologists. Dr. Arnold stated that access doesn’t mean having a health plan, it means being able to see a doctor in your neighborhood. She criticized managed care for interfering with long-standing doctor-patient relationships, making people wait too long to get an appointment, restricting access to physicians, and having inefficient authorization processes. She suggested that many people would be willing to pay a little more for a PPO plan if they had the choice. She stated that instead many people are using their managed care plan as catastrophic coverage and paying for other services out of their own pocket.

13. Dr. Margaret Parsons - the California Dermatology Society. Ms. Parsons pointed out positive aspects of managed care, including the cost-effectiveness for seniors with limited incomes and the coordination of care through the primary care physician. She also described some concerns with managed care, including the need for an appropriate specialist referral process.

Vice Chairman Kerr thanked Dr. Parsons for her testimony. The Task Force members addressed her concerns with various questions and comments about appropriate referrals versus the referral process. The Medi-Cal authorization process was also discussed. Dr. Merritt (previous testifier) added her comments about chronic conditions and Dr. Arnold stated the common problems with dermatology and ophthalmology.

III. Adjournment - 4:46 P.M.

Vice Chairman Kerr asked if there were any further questions and announced that anybody wanting to submit written testimony should please contact one of the Task Force members. He also stated the next meeting would be in Los Angeles, Thursday, August 7. He thanked everyone for their time and showing up on a Saturday, and officially closed the hearing.

Prepared by: Spencer Mendez
I. Call to Order [Chairman, Alain Enthoven, Ph.D.] - 9:30 A.M.
The sixth meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the First Floor Auditorium, Junipero Serra State Building in Los Angeles.

II. Roll Call and Declaration of a Quorum - 9:32 A.M.
Mr. Stuart McVernon of the Task Force staff took roll. The following Task Force members were present: Dr. Bernard Alpert, Mr. Rodney C. Armstead, Ms. Rebecca Bowne, Ms. Barbara Decker, Hon. Martin Gallegos, Dr. Bradley Gilbert, Mr. Terry Hartshom, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodríguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ron Williams, and Mr. Steve Zatkin.

The following Ex-Officio members were present: Ms. Marjorie Berte, Mr. Keith Bishop, Mr. Michael Shaperio, Ms. Kim Belshe, and Dr. David Werdegar.

Once roll was called, Chairman Enthoven declared a quorum was present.

III. Opening Remarks
Chairman Enthoven opened the session by stating that Task Force has been asked to review the existing regulatory framework for the managed care industry of California, and if deemed appropriate, to make recommendations so that any regulatory framework [existing or new] can function effectively, satisfy patients, and control costs. Chairman Enthoven suggested that in thinking through this issue, members might be interested in the article: “Making Health Plans Accountable for the Quality of Care” by Clark Havighurst, a distinguished professor of law at Duke University.

Chairman Enthoven stated that given the high interest in this issue, without objection, the discussion of the Task Force’s role on legislation scheduled for later in the day would be moved so that it immediately proceeds New Business. Seeing and hearing no objection, the item was moved.

PUBLIC COMMENT:
Mr. Jamie Court, Director of Consumers for Quality Care Consumers Advocate - asked the Task Force to send a message to the Governor stating that it [Task Force] does not legislate and that Governor Wilson should not veto health reform bills solely on the basis that the Task Force is reviewing managed care and will come out with recommendations in January 1998. Mr. Court stated that patients benefiting from such reform [as proposed in the patients bill of rights bill package] cannot wait another year for such changes to occur.

IV. Consent Calendar
Chairman Enthoven said that the next order of business was the adoption of the Consent Calendar, which contained two items: the proposed June 20, 1997 business meeting minutes and an amendment to the
Task Force meeting and hearing schedule to add additional meetings. Mr. Hauck then moved that the Consent Calendar be adopted. Mr. Perez seconded the motion and it was adopted unanimously.

V. New Business
Chairman Enthoven and Task Force Deputy Director Alice Singh to introduce the next item of business. Deputy Director Singh stated that the next item before the Task Force was the adoption of an amendment to the Task Force Bylaws to allow for the creation of Policy Options Work Groups [POWG]. Mr. Hauck moved to adopt the proposed amendment. Mr. Perez seconded the motion and it was adopted unanimously.

VI. Task Force Discussion
A. Discussion Of The Task Force’s Role Regarding On Going Legislation
Chairman Enthoven then moved to Task Force Discussion and said that the Task Force has not been asked, not does it intend, to review and comment on specific bills because the Task Force is not a legislative body. Instead, the Task Force has been asked to provide a “coherent overall recommended framework for how this industry [health care] should be regulated.”

He then invited Assemblywomen Susan Davis and Liz Figueroa to address the Task Force on managed care legislation. Specifically, Ms. Davis discussed her bill [AB 1354] which was recently vetoed by Governor Wilson. The Governor cited the Task Force in his veto message of the bill, which would have allowed a woman direct access to an OBGYN, stating that he [the Governor] wanted to refrain from signing any managed care legislation until the Task Force publishes its findings and recommendations in January 1998. Both Ms. Davis and Ms. Figueroa expressed their concern that the Task Force is being used as a rationale to veto legislation and urged the Task Force to clarify its role with regard to legislation. Ms. Figueroa further suggested that some managed health care legislation be allowed to move forward this year without objection by the Task Force.

Mr. Shapiro urged the Task Force to encourage the Governor to reverse his decision to veto any more HMO bills until the Task Force has made it's final report in January.

Ms. Bowne asked the Task Force not to let individual incidents and circumstances influence the creation of “bad policy”, while Mr. Lee pointed out that reviewing legislation would be a distraction for the Task Force. He further argued that the Task Force needs to be a complementary entity of the legislative process.

Dr. Rodriguez-Trias proposed that the Task Force make a clear statement regarding our role to make recommendations, not specifics.

Ms. O’Sullivan recommended that the Task Force send a delegation to the Governor [including the Chairman] to ask him to consider bills based on their merits.

Mr. Hiepler said that he wanted the Task Force to make a statement that its role is not to impede the process of legislation and that bills should be judged on their own merit.

Mr. Kerr moved to adopt a statement that the Task Force “...strongly encourages the public, the legislature, and the governor to engage in an ongoing, constructive dialogue today, as well as tomorrow, about how best ensure our health care system meets the needs of Californians for high quality, accessible, affordable health care...”. The motion was seconded by Mr. Hauck and after a lengthy discussion amongst Task Force members, amended by a motion made by Mr. Kerr and seconded by Mr. Perez. The motion to adopt the following statement was passed unanimously:

The California Managed Health Care Improvement Task Force was established by the California Legislature to inform the public, the State Legislature and the Governor about managed health care...
and its impact, and to make recommendations on ways to improve managed health care for the benefit of the public.

The Task Force intends to provide the public, the Legislature and the Governor with a significant report that specifies recommended actions to improve the California health care system, including structural issues and accountability to the public, and improve the health of all Californians.

The Task Force informs the public, the Legislature and the Governor that we have not been asked and do not intend as a Task Force to comment on individual legislative bills, but rather to state our systemic findings and recommendations to help inform both private and public policy development.

Therefore, the Task Force strongly encourages the public, the Legislature and the Governor to engage in an ongoing, constructive dialogue today, as well as tomorrow, about how to best insure that our health care system meets the needs of Californians for high quality, accessible, affordable health care.

The Task Force supports that managed health care legislation be considered on its merits, and the Task Force process should not impede the legislative process.

**Short Recess**

Following the break, Ms. O'Sullivan made a motion that the Task Force send a delegation meet with Governor Wilson on this issue to express the statement just adopted by the Task Force. Mr. Perez seconded the motion, but after some discussion, the motion failed with 14 affirmative votes.

**VII. Oral Reports/Presentations**

A. Task Force Expert Resource Groups:

1. **Streamlining** [Members Ms. Kathryn Murrell and Mr. Ronald Williams].

   Mr. Williams addressed five topics relating to regulatory simplification:

   - **structural issues (oversight by Department of Corporations (DOC) versus Department of Insurance (DOI))** - Mr. Williams stated that DOC focuses on assessing service delivery and quality while DOI focuses on financial stability. He felt that this division works well.

   - **documentation that health plans are required to submit to regulators** - Mr. Williams recommended development of consistent criteria for amendments and material modifications so that both agency staff and health plans could apply the criteria accurately. He also made recommendations about procedural issues. He felt these changes would lead to continued innovation and increased market responsiveness.

   - **medical group oversight** - Mr. Williams recommended uniformity and equity in audit procedures for provider groups, recognizing that these groups are often actually managed by a third party such as a medical services organization.

   - **audit redundancy** - Mr. Williams stated that there are substantial opportunities for establishing audit standards across regulatory agencies. He also recommended that plans that have met national accreditation standards, such as the National Committee for Quality Assurance (NCQA) standard, should be approved for state regulatory purposes.

   - **agency resources** - In addition to enhanced DOC funding, Mr. Williams recommended that the DOC staff receive additional training to “ensure consistency and accuracy in the review process.”

   Task Force members asked Mr. Williams questions about regulating medical groups directly through an oversight agency versus indirectly through a health plan; financial solvency and risk issues for medical groups; appropriate kinds of staff for the regulatory agency; and how to address the needs of consumers who are in plans outside of current state regulation (e.g., self-funded plans).
2. **Practice of Medicine** [Members Dr. Bernard Alpert and Dr. Bruce Spurlock].

Dr. Spurlock stated that he and Dr. Alpert focused on the issue of how to decrease disagreement over medical necessity and improve decision quality. He described studies that show there is a lot of unwanted clinical practice variation in California and the US. To address this problem, he recommended increased use of evidence-based practice guidelines that incorporate patient preferences and values. He stated that individual patient variation and a thorough understanding of all relevant information should be considered when these guidelines are applied. Dr. Spurlock also recommended that disputes be resolved at the physician-patient level, but that patients should have recourse beyond their individual physician as well.

Dr. Alpert described two cases involving confusion over medical necessity and used them to illustrate the ERG’s recommendations on this topic. He first discussed an Arizona case in which a plan’s medical director reviewed a member’s medical record and determined that the member’s surgery was not medically necessary. The state’s Department of Insurance found that the medical director was not liable for the decision, while the state’s Board of Medical Examiners found that he was liable. Ultimately, the Court of Appeal determined that the medical director was liable. Dr. Alpert recommended that “all parties making medical decisions, whether by the traditional direct contact route or by other more removed methods... should be held accountable to the same standards.”

Dr. Alpert then discussed the pre-authorization or concurrent authorization process, stating that the insertion of this bureaucratic process can lead to poor medicine and bad outcomes. He recommended that the pre-authorization process be eliminated or modified with available electronic technology. He further recommended pre-credentialing providers, using post-utilization review of practice patterns, and using practice guidelines.

Task Force members discussed experimental therapies; referrals between primary care providers and specialists versus referrals between sub-specialists; population-based versus individual-based decisions; and how to align patient and physician expectations.

3. **Dispute Resolution Process** [Members Ms. Barbara Decker and Mr. Peter Lee].

Mr. Lee began by stating that disputes should be resolved at the lowest possible level (i.e., the doctor’s office) and that grievance data should inform quality improvement efforts. He then introduced two guests: Mr. Tom Guyser, Executive Vice President, General Counsel, Wellpoint; and Mr. Harry Christie, a Task Force alternate member.

Mr. Guyser described three elements of the dispute resolution process for Blue Cross of California: how the problems come to the plan’s attention, the plan’s method for third-party intervention, and the plan’s dispute resolution feedback loop.

Mr. Christie shared his family’s experience with the dispute resolution process when his daughter was diagnosed with a rare cancer. He reviewed the steps he went through with the medical group, health plan, arbitrator, and regulatory agency. He stated that the entire process took nearly three years. He recommended that HMO review processes be open to outside medical scrutiny.

Task Force members discussed the high consumer costs of arbitration and asked for clarification from the two speakers.

Mr. Lee outlined some “essential elements” of dispute resolution for the Task Force to consider: disputes should be resolved at the lowest possible level; consumers need to understand their rights, responsibilities, and the plan’s dispute resolution process; some consumers will need assistance to navigate the process; the processes need to be perceived as fair; the findings need to be communicated to the consumer; the
process needs to treat like consumers alike and must be efficient from both the plan's and consumer's perspective; the process must have appropriate finality and it must help improve system-wide problems.

Ms. Decker described potential recommendations, including:

- all enrollees in managed care plans should have the same procedural rights and protections regardless of the plan type or the purchaser;
- all consumers should be informed of their rights and responsibilities, including avenues for pursuing complaints, upon enrollment and whenever a potential misunderstanding arises;
- some consumers may need access to an independent external source of assistance in the dispute resolution process;
- regardless of plan type, plans' internal processes should have common standards, including time frames;
- the basis for decisions should be shared with consumers, while maintaining patient confidentiality, to establish precedents;
- there should be an independent third-party review available to all consumers at some point in the process;
- the state should establish arbitration standards; and
- the efficacy of a full range of dispute resolution mechanisms should be explored.

Mr. Lee circulated to the Task Force as a public document a list of fifteen questions regarding potential recommendations.

The Task Force members discussed the importance of this issue; barriers to early compromise; and financial incentives.

Lunch

B. Managed Health Care Oversight
1. Private Sector Efforts in Managed Care [David Hopkins, Ph.D., Director of Health Information Improvement, Pacific Business Group on Health]

Dr. Hopkins described PBGH and its efforts to improve quality. The organization measures quality by conducting member satisfaction surveys at the health plan and medical group levels. The results are used to produce report cards that are distributed to consumers. PBGH also builds performance measures into their health plan contracts. They put 2% of the premiums at risk for certain measures.

Dr. Hopkins also discussed data issues. He recommended implementing electronic medical records, electronic data interchange, making data available in real time to providers, universal patient and provider identifiers. He also recommended that the Task Force support private sector initiatives and encourage public-private partnerships. Finally, he recommended that the state use its purchasing clout to advance data and quality improvement initiatives.

2. The State’s licensure and certification of hospitals and facilities [Mary Retzer, MD, Licensing and Certification Division, Department of Health Services]

Dr. Retzer described Licensing and Certification (L&C) Division’s staffing and basic functions, which include licensing 30 types of facilities and providers so they can do business in California; certifying facilities and providers as eligible for payment under the federal Medicare and Medicaid programs; certifying certain types of health care professionals; educating consumers and providers; and investigating complaints.

Task Force members asked Dr. Retzer about the quality of care in California facilities; certification of specialized centers of excellence; nursing skill levels in acute care settings; and reducing audit redundancies.
3. **The State's licensure and regulation of medical doctors** [CA Medical Board - Stewart Hsieh, J.D., President of the Board, Karen McElliot, Secretary of the Board and Alan E. Shumacher, M.D.]

Dr. McElliot gave an overview of the Medical Board's structure and purpose. She stated that the Board has created a Quality of Care in a Managed Care Environment committee that is similar to the Task Force. She stated that there is a breakdown of the public's trust due to managed care and recommended that the Task Force devise a regulatory mechanism that has the interest of the consumer as its primary mission. She suggested that the "regulation of the managed care facilities should be in the hands of the Medical Board."

The Task Force members asked the panelists questions about outcomes of the Board's oversight efforts; necessary functions of an oversight agency; whether any other state uses its Medical Board to oversee managed care; how many physicians have actually been disciplined by the Board; clarification on the scope of regulatory activity they are recommending; and conflict of interest issues.

4. **The State's licensure and regulation of nurses** [Ms. Geri Nibbs, Supervising Educational Consultant for the CA Board of Registered Nursing]

Ms. Nibbs described issues that were brought up in four forums the Board of Registered Nursing convened. The nurses at the forums were most concerned with the substitution of unlicensed assistance personnel for registered nurses. She stated that these unqualified individuals were assessing, triaging, and providing care to patients at a level they were not prepared to do. The nurses were concerned that patients would be harmed as a result.

Ms. Nibbs recommended that consumers and all health care professionals be represented in any oversight agency the Task Force might recommend and that practice barriers for advanced practice nurses be removed.

Task Force members asked for more details about the substitution of unlicensed personnel.

5. **Managed Health Care Oversight** [Ms. Chris Selecky, former president of a major managed care organization in California].

Ms. Selecky described the evolution of the managed care system from one "which was focusing on managing care to one that focused on managing costs." She stated that regulatory oversight does not focus on outcomes because there is insufficient data and instead focuses on processes. She felt that the regulatory process is fragmented and duplicative and leads to increased administrative costs without improving quality of care. She recommended that the Task Force look for a regulatory model that everyone can agree has worked well and use that model as a template.

**VIII. Public Comment**

Chairman Enthoven stated that without objection, public comment would be deferred until the public hearing which would be conducted in a matter of minutes. Seeing and hearing no objection from members or the public, the Chairman deferred public comment.

**IX. Adjournment [Chairman] - 4:04 P.M.**

Chairman Enthoven stated that without objection, the business meeting would be adjourned. Seeing and hearing no objection, the Chairman adjourned the meeting.

Prepared by Task Force Staff
I. Call to Order and Open The Hearing [Chairman Alain Enthoven, Ph.D.] - 3:30 P.M.

The sixth and final public hearing of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, immediately following the adjournment of the Task Force Business Meeting.

Chairman Enthoven thanked the public for attending today's hearing and encouraged people to target their comments at ways in which the managed health care system should be changed to better address the needs of all Californians. The Chairman also requested that members of the public keep their comments concise and non-duplicative. Chairman Enthoven then introduced the first speaker.

II. Public Testimony


Ms. Murray stated that the Governor should not use the Task Force as a reason for vetoing managed care bills. She stated that the AARP's constituents are concerned about lack of care coordination and the hampered ability of physicians to advocate on their patients' behalf under managed care. She felt government has a duty to protect consumers and counterbalance managed care's incentives to restrict care. She offered written testimony presenting ten areas for consumer protection, including the appeals process, disclosure of financial incentives, safe discharge, access to second opinions, response times, and disclosure of authorization criteria.

2. Joseph A. Cislowski - Executive Director of the Center for Health Care Rights.

Mr. Cislowski stated that there was widespread uncertainty about the impact of managed care reform, noting that the Center's studies suggest that “dramatic demographic shifts and volatile health policy environments are jeopardizing the safety net for health care consumers.”

In concluding his remarks, Mr. Cislowski asked the Task Force members to bear in mind the importance of consumer-empowering programs such as the health insurance counseling advocacy program when making their recommendations.


Mr. Miller argued that managed care's problems could be overcome by empowering the patient and institutionalizing the idea of consumer sovereignty. He stated that to empower consumers the financial intermediary roles of employers and governments must be minimized. He also stated that there are improper provider incentives under both managed care and fee for service arrangements. He felt that these problems could be addressed through risk adjustment, given the proper authority.


Dr. Cohen suggested that the Task Force ensure that vaccines are carved out of any capitated payments and...
5. Jamie Court - Consumers for Quality Care
Mr. Court expressed his desire to see the Task Force address the issue of capitation and at least make a recommendation about disclosure of capitation rates. Second, he urged the Task Force to recommend that only qualified physicians be able to deny care. Third, he recommended improvements in HMO accountability and liability. Finally, he urged the Task Force to consider the effects of the HMO industry's rapid consolidation.

6. Terry Johnson - HMO member.
As a bereaved parent, Mr. Johnson told of the “unfairness and injustice” he and his wife received from their HMO and the way in which the Department of Corporations handled their formal complaint. Mr. Johnson inquired as to where consumers should go when the Department of Corporations falls short of its responsibilities. He submitted written testimony to the Task Force.

7. Vince Riccardi, M.D. - President of the American Medical Consumers of California.
Mr. Riccardi made three recommendations to the Task Force members. First, he recommended that all managed care committees, including utilization review and credentialing committees, have consumer/patient participants. Second, he recommended that patients' personally maintained medical notes should be an equally important part of their medical record. Third, he recommended more reasonable utilization of the term “non-compliance.”

8. Paul Bronston M.D. - Chairman of the Ethics Committee of the American College of Medical Quality.
Dr. Bronston argued that whatever regulatory board the Task Force ultimately sanctioned, that board should have the expertise to evaluate the system, sufficient staff to ensure thorough investigation, and sufficient enforcement capabilities.

In illuminating his remarks, Dr. Bronston believed that there were three fundamental issues that have to be addressed: financial incentives, protection of the patient/physician relationship, and provider credentialing.

Following submission of material to the Task Force members, Ms. Mitchell stated that people with disabilities and chronic illnesses are often the first members of society to feel the repercussions of defective HMOs. Ms. Mitchell argued that the Task Force should level the playing field between health plans so that bad plans do not drive good plans out of business.

Ms. Strong stated that people with disabilities are a vulnerable population, often with multiple vulnerabilities. She noted that people with disabilities need rehabilitation to maintain functional status and independence, and that the need changes with age. She urged the Task Force to keep the aging, disabled population in mind when making recommendations.

Dr. Brewer remarked upon the similarities between medical groups and HMOs and questioned who regulates medical groups. She was concerned that medical decisions are being made at a distance, over the phone, without accountability, and for financial gain. Dr. Brewer argued that medical directors and partners in medical services organizations should be held accountable.
12. Claudia Jensen, M.D.
As a former employee of a managed care medical group, Dr. Jensen stated that medical groups strongly encourage physicians to be silent on perceived quality of care violations. She felt that medical groups should be liable and accountable for the decisions they make. She also recommended that the Task Force address financial incentives, encourage patient participation in the utilization review process, and encourage more factual marketing.

13. Maxine Stewart, R.N.
Ms. Stewart described difficulties obtaining care outside of her HMO for her spinal injuries. She stated she had sought outside help due to a lack of expertise within the HMO and she therefore requested that Task Force members make it mandatory for the industry to offer such specialized treatment.

14. Robert Peck, M.D.
Dr. Peck asked the Task Force to consider the needs of traditional Medicare providers who operate outside of Medicare managed care. He urged the Task Force to recommend that HMOs not fire physicians without cause and that they not deny care without stated reasons and second opinions.

15. Norman Shriter, M.D.
As a former medical director of an IPA, Dr. Shriter felt that managed care is “denigrating, insulting, demeaning, and... not good.” He also described being fired without cause.

16. Paul Carlson M.D.
Describing a study in the July 9, 1997 issue of the Journal of the American Medical Association entitled ‘Medical Record Abstraction Form and Guidelines for Assessing Quality of Care’, Dr. Carlson noted that the study concluded that patients in Medicare HMOs who experience strokes are more likely to be admitted to nursing homes than to rehabilitation centers. Dr. Carlson offered the article as evidence of the inadequacies of many HMOs and asked that the Task Force members take into account such practices when reaching their conclusions.

Citing his mother’s experience within an HMO, Mr. Park asked the Task Force to consider implementing mandatory second opinions.

18. Max Churchen - Chair of the Los Angeles Region of the Congress of Californian Seniors
Mr. Churchen submitted a fact sheet to the Task Force about a legislative package called the Patients’ Bill of Rights.

Ms. Palm urged the Task Force to find ways to improve rather than “delete” managed care. She gave an overview of the utilization management system at Blue Cross.

Dr. Wood felt that managed care has improved the delivery of health care in California and urged the Task Force to make recommendations that will allow the industry to continue to evolve and that will allow free market competition. She stated that Medi-Cal managed care has improved access to care, allowed broader selection of providers, and incorporated traditional and safety net providers.

Ms. Glenn felt that managed care has limited nurses’ ability to deliver necessary patient care and has restricted the time nurses can viably spend with patients. She stated that registered nurses are leaving the profession over quality of care issues.
22. Rhonda Goode, R.N.
Ms. Goode described quality of care issues and denounced the Governor’s plan to veto pending patient protection legislation. She also criticized the current private hospital accreditation organization and asked the Task Force to recommend a state agency accredit all hospitals within the state.

23. Matthew Margulies, M.D.
Dr. Margulies discussed provider termination without cause and the physician-patient relationship. He stated that health care decisions should not be based on cost containment.

24. Dr. Lloyd Friesen - Director of Government Affairs for the California Chiropractic Association.
Dr. Friesen discussed various bills currently being considered by the Legislature. He stated that the CCA was in favor of legislation changing the managed care system provided that legislation is provider-neutral and that the system is changed “in a cohesive manner rather than piecemeal.”

25. Bob McCloskey - HMO member and health professionals union representative
Mr. McCloskey described difficulties his physician experienced under managed care. He felt that the managed care system today is driven by profits, which is dramatically impacting hospital staffing and length of stay. He encouraged the Task Force to consider such issues.

Ms. Gilbert described her daughter’s difficulties in accessing services from her HMO. She stated that her experiences with managed care “greatly intensified anxiety, frustration and real suffering.”

27. Gordon Schaine, M.D.
Dr. Schaine advocated doctor-owned, doctor-supervised managed care medical groups. He praised managed care, stating that medical insurance costs in California had been reduced by some 25% in the last three years, that his HMO’s patient satisfaction rate is 95%, and that managed care groups have “layer upon layer” of quality control.

28. Mary Carr - Deputy Director of Ventura County Medical Society
Ms. Carr stated that IPAs and HMOs often do not adhere to their contracts with physicians and instead arbitrarily decrease benefits and co-pays and delay authorizations and payments.

29. Damiana Chavez - Kaiser Permanente member.
Mr. Chavez praised his experiences with his HMO.

Mr. Levy was concerned with state regulatory agencies’ failure to protect the public. He cited several examples from dental managed care organizations.

31. Nancy Greep, M.D.
Dr. Greep stated that her ability to deliver quality, comprehensive, sensitive care has been compromised by managed care and the invasion of corporate, for-profit medicine. She urged the Task Force members to support the Patient Bill of Rights and to recommend eliminating for-profit care or limiting the amount of profit managed care companies can take out of the health care system.

32. Virginia Whittig - former president of the California Association of Psychiatric Mental Health Nurses in Advanced Practice
Ms. Whittig noted that non-medical licensed health care providers are “underutilized sources of cost-effective care.” She stated that not all managed care plans accept such providers into their panels, not all list such providers in their provider directories, and some require higher member payments to see such providers. She asked the Task Force to broaden access to non-medical licensed providers.
33. **Jim Marx - patient.**
Mr. Marx detailed a personal experience of misinformation and misdiagnosis and simply asked the members to reform the health care system to prevent others from having similar experiences.

34. **John Bibb, M.D.**
Dr. Bibb complained that the reasonable person standard as outlined in SB-1832 (Bergson) only applies to out-of-plan emergency rooms and not in-plan emergency rooms or to ERISA plans. Dr. Bibb requested that the Task Force address the discrepancy.

35. **Robin Doroshow, M.D. - President-elect of California Chapter 2 of the American Academy of Pediatricians.**
Dr. Doroshow was concerned that many managed care plans do not offer access to pediatric subspecialists. She asked the Task Force to recommend requiring such access.

36. **Judith Porter - office manager for her husband’s practice.**
Ms. Porter described difficulties obtaining authorizations and payments for treatment. She stated that her husband often is not reimbursed for the care he gives. She also stated that patients who have difficulties navigating their plan’s system often turn to her for help.

37. **Ralph Reece - California Health Protection Fund.**
Mr. Reece called for policing of health care contracts at the state level. He criticized the state government and the Governor for failing to monitor the managed care system, concluding that the eyes of California were upon the Task Force.

38. **Kim Vuong.**
Ms. Vuong criticized Medi-Cal managed care. She recommended mandating that all managed care plans allow second opinions and precautionary exams after all accidents. She also recommended removal of the 15-day maximum physical therapy limit and advocated funding to support disabled persons’ ability to live independently and avoid institutionalization.

39. **Cy Cy Lambert.**
Ms. Lambert described her experiences as a mother of a spinal cord injured child and a volunteer caregiver. She wished the Task Force members luck in their endeavors. She provided written materials.

40. **Tracey Lovelace - pharmacist.**
Mr. Lovelace described the need for guidelines for HMOs preparing to serve Los Angeles County’s Medi-Cal population. Mr. Lovelace stated that HMOs are discriminating against independent pharmacies, even though independent pharmacies provide valuable services, such as delivery, counseling, and alternate languages, that chain pharmacies do not.

**III. Adjournment [Chairman Enthoven] - 7:00 P.M.**
Chairman Enthoven stated that without objection, the hearing would be closed. Seeing and hearing no objection, the Chairman closed and adjourned the hearing.

Prepared by: Stuart McVernon
I. Call to Order [Chairman, Alain Enthoven, Ph.D.] - 9:00 A.M.
The fifth study session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Oakland Scottish Rite Center in Oakland, California.

II. Roll Call
Task Force Secretary, Ms. Neff, took roll. The following Task Force members indicated that they were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Barbara Decker, Ms. Jeanne Finberg, Mr. Mark Hiepler, Mr. Bill Hauck, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Mr. John Ramey, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Allan Zaremberg and Mr. Steve Zatkin.

Ex Officio members Mr. Michael Shapiro and Mr. Keith Bishop ex-officio members, were also present.

III. Opening Remarks - 9:15 A.M.
Chairman Enthoven announced that today’s study session would focus mainly on options for organizing the government to regulate managed health care and to hear reports from several of the Expert Resource Groups. Chairman Enthoven then announced that Task Force member Ms. Kay Murrell has resigned her position with the Task Force as she has retired from her professional career and is moving out of the state.

A. Executive Director's Report [Phil Romero, Ph.D.] - 9:30 A.M.
Executive Director Romero said that Ms. Jill McLaughlin has left the Task Force staff to accept a job in the private sector and that Ms. Flo Neff has been hired to replace her as the Task Force secretary. He also introduced the new Task Force web page. The address is: http://www.chipp.cahwnet.gov/mctf/front.htm.

IV. Discussion - 9:35 A.M.
A. Managed Health Care Oversight [Rescheduled from the August 7, 1997 Business Meeting]
1. A status report of the Task Force's development of options for organizing Managed Health Care Regulatory Oversight [Executive Director Phil Romero, Ph.D.].

Chairman Enthoven started the session by introducing Task Force Executive Director Dr. Phil Romero who would be talking about Managed Health Care Oversight. Executive Director Romero then distributed two packets to Task Force members, entitled “Background and Organization of State Regulation of Managed Care” and “Managed Care Improvement Task Force Questionnaire.”

Executive Director Romero stated that one of the issues that catalyzed the creation of the Task Force was the question of which state organization should have responsibility for regulating managed care organizations. He felt that the issue of who should regulate (i.e., which organization should have oversight) was interdependent with the issues of what the scope of regulation should be and what the policy philosophy governing those regulations should be.
Executive Director Romero then presented a summary of the Delphi questionnaire administered to Task Force members in June 1997. Based on Task Force members' responses, seven out of eight members do not believe that the current regulatory structure is working optimally. Five out of six members think that HMO's should be regulated by the same agency as other managed care insurance entities. Five out of six members agree that the same regulatory authority should exercise oversight authority over the delivery system (i.e., medical groups) as well as health plans. A majority of Task Force members favored a new regulatory organization, while a minority was dispersed among several existing organizations. Executive Director Romero summarized that the Task Force members seemed to favor both horizontal regulatory consolidation across types of insurance entities and vertical integration among the health care delivery system.

Executive Director Romero then presented a matrix summarizing current state regulatory authority. He pointed out that there is duplication in the system, which leads to at least two unfortunate consequences. First, when multiple organizations are responsible for regulating the same entity, consumers do not know who to call and who makes decisions. Second, the duplication either (depending on one's point of view) places a burden on regulatees by creating an uneven playing field and duplicative rules or allows regulatees to choose their regulator (presumably a less stringent one) based on a business strategy.

Executive Director Romero then offered several goals to consider when designing a consolidated regulatory system. First, like substitutes should be regulated by the same entity. Executive Director Romero suggested starting with single oversight authority over prepaid health plans and then consider adding in, in priority order, authority over indemnity insurance, medical groups, individual clinicians, and facilities. Second, in terms of efficiency, the regulator should foster market evolution wherever possible, as long as that evolution is consistent with public policy goals. Third, in terms of fairness and rigor, similar organizations should be subject to similar rules and measured against similar yardsticks by a single regulator. Fourth, the transition costs of consolidating should be kept fairly low or should be compensated with savings. Executive Director Romero then invited comments from the Task Force.

Dr. Alpert suggested separating the regulation of managed care, allowing the Department of Corporations (DOC) to continue to regulate the corporate aspects and moving the regulation of quality to a consumer-centered entity.

Ms. Decker questioned whether a consolidated regulatory structure might have undue influence over regulatees. She was concerned that the regulator have clear lines of authority with appropriate expertise to address the different areas of regulation.

Executive Director Romero raised the question of how the regulator should be organized (e.g., should it have a single, appointed head or should it be a board structure).

Mr. Zatkin brought up three points. First, he stated that while there may be overlapping regulation in terms of quality, the individual functions (e.g., licensure of individuals versus facilities versus plans) are very different and would still need to be maintained even if they were located in the same agency. Second, he stated that Medi-Cal has a fiduciary obligation as purchaser that is different from the Department of Corporations. Executive Director Romero clarified that he would separate purchasing organizations from regulatory organizations. Third, Mr. Zatkin stated that indemnity insurance is fundamentally different from HMOs and advocated that the Task Force focus on managed care.

Mr. Williams stated that before streamlining, each regulatory entity's mission and focus should be examined. That exercise would suggest areas for process improvements without losing the original mission.

Dr. Karpf suggested that the Task Force first identify the important problems that exist, examine how those problems are or are not being addressed, and then consider recommendations about the regulatory structure.
Ms. Severoni noted that accountability to consumers and to providers should be among the core principles for the regulatory system. She also suggested the Task Force that encourages consumer-driven innovation.

Dr. Spurlock asserted that changing the regulatory structure will not restore the public's trust. Dr. Alpert stated that if the regulatory structure were consumer-centered and focused on quality of health care delivery, it might restore public trust.

Mr. Zaremberg questioned why people want to change the regulatory structure. Is it to change the regulatory structure? Is it to restore public trust? Is it because the current regulators have inadequate resources or are not following the law?

Chairman Enthoven asked if a person with an extensive background in health care should head the regulatory agency. He also suggested that the Task Force have a sense of which laws should be enforced with higher priority. Finally, he discussed the need for better coordination among regulators of the various health care system components.

Mr. Hiepler stated that the focus of the Task Force starts with consumer complaints and regulation surrounding the complaint process. He stated that from the consumer perspective, calling a regulatory “1-800” number should be the last resort because it is the least efficient way to solve problems. He suggested that the Task Force find incentives to get the consumer involved in resolving their own disputes.

Mr. Kerr agreed with Dr. Alpert’s distinction between the business side and the quality side of managed care, but he thought there should be one organization dealing with quality of care. Because quality is so important to the public, one organization should oversee “everything that the patient sees.” He also raised the issue of establishing minimum standards of performance, in terms of outcomes, to offer health care in the state of California.

**Break**

**B. Status Report on the Task Force Public Survey - 12:00 P.M.**

Ms. Helen Schaufller, Ph.D., principal investigator for the Task Force public survey, stated that the goal of the survey was to conduct a scientifically valid survey of insured Californians to document the prevalence of problems consumers are experiencing with their health insurance plans and to gain a better understanding of the types of problems, their severity, and the ability of consumers to resolve them successfully.

The survey was composed of three randomly drawn samples. The first sample contained 1200 insured Californians over 18 years of age who had lived in California for at least one year. The second was a specific sample of people who indicated they are either dissatisfied or very dissatisfied with their current health insurance plan and/or people who indicated that they have had a specific problem with their health plan or health insurance in the past 12 months. The third sample was composed of approximately 500 insured Californians who are frequent users of the health care system and have a high level of contact with the health care system in the last year.

Dr. Schaufller described the survey instrument development process. Eleven members of the Task Force and thirteen national experts participated. The final survey was 25 minutes in length and was sent to the Field Research Corporation for pre-testing.

The purpose was to compare consumers’ experiences across health insurance plan types, gathering information about plan characteristics, choices of health plan physicians, specialist care, hospital care, specific problems consumers have had with the health insurance [type and severity], grievance process, extent to which the problem was resolved, satisfaction with their plan, opinions on policy issues, health status, demographics, etc.
V. Public Comment - 12:20 P.M.
Chairman Enthoven then proceeded to public comment. Two persons indicated their wish to speak.

1) Ms. Lynnie Morgan described her experiences related to her daughter’s health care. She suggested that Task Force members reinstate the integrity of the doctor-patient relationship by encouraging stronger regulations from the Department of Corporations. She expressed regret that there were no “pure consumers” on the Task Force. She asked that the Task Force vote in favor of policies that are in the best interest of the consumer/patient.

2) Ms. Gerda Miller thanked the Task Force members for standing up to the Governor and telling him that he should not use the Task Force as a reason to veto enrolled managed health care legislation. She also voiced her wish that the Task Force conduct additional public hearings and publicize them better, so as to encourage ordinary people to participate in the decision making process.

Lunch Break

VI. Expert Resource Group Reports and Discussion - 12:45 P.M.
A. Expanding Consumer Choice [Task Force members: John Ramey and Allan Zaremberg]
In his introduction, Chairman Enthoven said that in the early days in the HMO movement, one of the cardinal principles was individual choice. Doctors did not want to be required to take care of patients who really did not want to be there, because that would undermine the doctor-patient relationship. He discussed the importance of the HMO Act of 1973 in opening up the market to competition among health plans. He said that the state is highly constrained from regulating in this area due to the Employee Retirement and Income Security Act [ERISA].

Mr. Zaremberg started his presentation by saying that the economics of choice are different in the health care arena because one entity pays and another consumes.

Mr. Zaremberg stated that one way to increase choice would be to increase the number of people in purchasing pools and for each purchasing pool to have a superdirectory of physicians. He said that small, medium, and large size employers should be able to offer their employees a menu of health plans. Consumers should be able to look at the directory and decide which physician they want for their primary care provider. Mr. Zaremberg felt that employers who offer employee benefits might pay for one hundred percent of an HMO plan and then have employees decide if they want to pay for the additional cost of a plan that allows access to physicians outside the network. This scenario would bring into play the traditional economics of elasticity for the consumer.

Mr. Zaremberg questioned how to go about increasing the number of people in purchasing pools. He stated that nobody had applied to create their own purchasing pool under recent legislation, SB 1559. He felt this might be related to the legislation’s restrictions on the role of agents and brokers. He suggested finding a way to bring the agents’ and brokers’ incentives in the development of more purchasing pools without compromising the pools’ integrity. He also stated that a recommendation regarding streamlining the purchasing pool process would be forthcoming.

Mr. Ramey stated that one of the reasons the Task Force is able to discuss choice is that there have been relatively stable premiums in California lately. He cautioned against making recommendations that would undermine that stability and cause a focus on price rather than quality.

Mr. Ramey pointed out that risk selection is a primary factor when thinking about creating more choice in the marketplace. He questioned whether, as more purchasing pools entered the market, they might begin to distinguish themselves by their ability to attract the best risks.
Mr. Zaremberg mentioned the possibility of subsidies for the creation of purchasing pools or for employers who use purchasing pools. He cautioned all Task Force members to ask themselves, when considering subsidies, where the taxpayer’s money would be best spent in health care.

In response to a question from Executive Director Romero, Mr. Ramey stated that he would not be comfortable with any recommendation that added cost to the system because many people are not able to afford health coverage now.

Mr. Zatkin asked for Mr. Ramey’s opinion as to why the Health Insurance Plan of California [HIPC, a purchasing pool for employers with 2 to 50 employees] hadn’t attracted more employers and what he thought of proposals to expand its eligibility. Mr. Ramey responded that the growth of the HIPC has been phenomenal given that it is a new product in a completely voluntary system and that it has no marketing funds. He also felt that the HIPC’s eligibility could not be expanded without also creating underwriting reforms, guaranteed issue, rate bands, etc. Mr. Zaremberg questioned whether such reforms might leave employers with fewer choices, especially in terms of the availability of PPO products.

Mr. Zaremberg noted that with increased choice and competition, health plans have to divert more money from treatment to marketing. Mr. Kerr commented that there is a difference between information and marketing. Ms. Severoni stated that in one Medi-Cal program plans were not allowed to advertise— all information had to come through the program. Dr. Conom noted that Knox-Keene has very specific disclosure laws and that those laws are essentially not being enforced. She suggested the Task Force recommend enforcement of those laws.

Chairman Enthoven mentioned that ERISA [Employee Retirement Income Security Act] preempts state regulation of employee benefits, meaning states may not mandate benefit choices on employers.

Dr. Karpf stated that discussion of informed choice leads to the issue of standardized coverage. Chairman Enthoven agreed, stating that when the University of California adopted a standardized coverage contract people were more willing to switch plans and shop for price. Ms. Bowne cautioned against expanding choice solely through purchasing pools and against having only one plan design. She stated that such an approach leads to homogenized commodities and suggested creating a structure that leaves room for indemnity plans for those people who want to choose and pay for them. Dr. Karpf clarified that he was advocating a basic plan with opportunities to buy upgrades. Mr. Ramey stated that it is impossible to have informed choice of plan without some standard for comparison.

Mr. Bishop stated that the Knox-Keene Act imposes both disclosure and marketing requirements and that those laws are being enforced.

B. Provider Incentives [Task Force members: Dr. Donna Conom and Steve Zatkin] - 2:30 P.M.

Dr. Conom commented that there has been a pendulum-type swing from fee-for-service indemnity insurance to capitation via managed care. The pendulum needs to swing back somewhere in between since both extremes have drawbacks.

Dr. Conom then described the basic types of physician compensation, including fee-for-service, salary, and capitation. She also described some incentive methods, including withholds and bonuses. She listed reasons that physicians complain about capitation, including reasons such as it creates financial conflict of interest, encourages cherry picking, and discourages improved care of chronic and serious diseases.

Dr. Conom described how the intensity of incentives varies, stating that if incentives are too intense they result in inferior care even if it is assumed that physicians desire to give good care. She said that the intensity decreases as the incentive is spread over more procedures, physicians and patients; involves a smaller percentage of the individual physician’s practice; or is calculated over a longer period of time. She noted that physicians are also motivated by non-financial incentives.
Dr. Conom stated that the ideal patient-physician relationship includes choice, competence, communication, compassion, continuity, no conflict of interest, and confidentiality. She described a successful incentive strategy as one that is perceived as fair by individual physicians, is easy to understand, has a quick impact, and has a positive structure focusing on carrots rather than sticks.

Mr. Zatkin described how physician incentives are currently addressed in law, both at the federal and state levels. At the federal level, health plans that participate in Medicare or Medicaid on a prepaid basis are prohibited from using incentives to limit services to an individual enrollee. In addition, plans must meet certain requirements if they place physicians at "substantial financial risk", meaning more than 25% of the potential payment is at risk. In that case, the plan must provide stop-loss protection and survey its members for satisfaction. At the state level, the Department of Corporations requires medical decisions to be free of administrative and financial involvement. AB 2649, enacted in 1996, prohibits incentives to reduce services to individuals or groups of enrollees. It also requires health plans to disclose their basic method of reimbursement and whether financial incentives are used.

Mr. Zatkin identified three issues for the Task Force to address: are there additional incentive arrangements that should be prohibited; should there be additional disclosure; and are there incentive arrangements that encourage best practices that the Task Force might recommend.

Dr. Karpf noted that fee-for-service might encourage physicians to provide more care than is appropriate and capitation might encourage physicians to provide less care than is appropriate, but the concern is that no one knows what the appropriate level really is. He suggested developing a body that can define what is "appropriate".

Mr. Hiepler argued for more explicit disclosure of how physicians are paid because "an informed patient is going to be the best served patient." He stated that disputes are best handled at the doctor-patient level, but if a patient doesn't know or understand the physician's incentives, resolution is harder. Task Force members discussed the details of how such disclosure might be made. Dr. Spurlock argued that disclosure of the specific dollar amounts would be an infringement on the physician's or medical group's ability to negotiate rates. Mr. Shapiro suggested that rather than relying too heavily on disclosure the Task Force should examine systemic approaches to removing incentives that are too intense. Mr. Bishop questioned how empowering or meaningful such disclosure would really be to consumers and whether incentives other than capitation should be disclosed. He felt that quality of care should be the focus.

C. Dispute Resolution Process [Task Force members Ms. Barbara Decker and Mr. Peter Lee] - 4:15 P.M.

Ms. Barbara Decker suggested maintaining some level of consistency in the dispute resolution process, because consumers do not know how to navigate the system when there is so much variation between plans and plan types. She stated that her staff spend a lot of time helping employees deal with their healthcare problems because they can't figure out how to resolve their complaints. She described differences in terminology and timing that lead to confusion. She also discussed differences in the ultimate recourse available to consumers in different types of plans, including binding arbitration, external review, administrative law judge hearings, federal courts, etc.

Several Task Force members expressed support for consistent standards. Mr. Kerr stated that there must also be penalties for those who fail to meet the standards. Regarding the issue of whether DOI-regulated plans should be subject to those same standards, Mr. Zatkin stated that if there is no discernible rationale that relates to the nature of the organization, consistency should be the goal. Mr. Lee pointed out that ERISA plans are subject to very different standards. Chairman Enthoven suggested the Task Force could recommend that the legislature petition the US Congress to change ERISA. Mr. Kerr further suggested making the recommendation to the Presidential Commission. Ms. Bowne cautioned that if there are too many changes to ERISA employers may decide not to offer coverage.
Mr. Lee mentioned that in future meetings, he would like to discuss external sources of assistance for patients who are having problems with their health plan and the possibility of third party review of medical assessment issues.

PUBLIC COMMENT - 4:45 P.M.
1) Mr. Warren Leach commented on the Diabetic Supply Bill [SB 1220 introduced in 1997]. He said that the cost of diabetic testing strips continues to rise. Mr. Warren also added that an ounce of prevention is worth a pound of cure so he suggested that provision of these devices should be mandated by law.

V. Adjournment - 5:00 P.M.
Chairman Enthoven said that without objection, the study session would be adjourned. Hearing and seeing no objection, Chairman Enthoven declared that the August 28th Study Session was adjourned.

Prepared by: Enrique J. Ramirez, Ph.D.
I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 9:00 A.M.

The sixth study session meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. Roll Call

The following Task Force members were present: Dr. Bernard Alpert; Dr. Rodney Armstead; Ms. Rebecca Bowne; Dr. Donna Conom; Dr. Alain Enthoven; Ms. Nancy Farber; Ms. Jeanne Finberg; Hn. Martin Gallegos; Dr. Bradley Gilbert; Ms. Diane Griffiths; Mr. William Hauck; Mr. Mark Hiepler; Dr. Michael Karpf; Mr. Peter Lee; Dr. J.D. Northway; Ms. Maryann O’Sullivan; Mr. John Perez; Mr. John Ramey; Mr. Anthony Rodgers; Dr. Helen Rodriguez-Trias; Ms. Ellen Severon; Dr. Bruce Spurlock; Mr. Ronald Williams; Mr. Allan Zaremberg; and Mr. Steve Zatkin.

The following ex-officio members were also present: Ms. Kim Belshe; Ms. Marjorie Berte; Mr. Keith Bishop; and Mr. David Werdegar.

III. Opening Remarks - 9:20 A.M.

Chairman Enthoven stated that the following are potential areas of Task Force recommendations:

- restructuring the dispute resolution process
- streamlining the regulatory process (public and private sectors)
- establishing new limits on provider incentives and how doctors are paid
- expanding consumer choice and information disclosure accessibility
- improving avenues for consumer involvement
- establishing risk adjustment procedures
- applying new quality information practices to allow OSHPD to publish better risk adjustment data
- the reconfiguration of the state government regulatory structure
- allowing innovative information dissemination
- moving towards managed care improvement
- encouraging multiple choice of plans (may need ERISA reform).

Chairman Enthoven also provided members with the day’s tentative schedule and asked Ms. Alice Singh, Deputy Director for Legislation and Operations, to address the Task Force on a few administrative details. Deputy Director Singh said that a letter signed by Executive Director Phil Romero faxed to members earlier in the week provided members with a proposed development schedule for the Task Force’s final report. The letter further confirmed the due dates of each Expert Resource Group paper.

Deputy Director Singh then reported that staff are awaiting information pertaining to the status of the budget trailer bill containing language which would allow Task Force members to be reimbursed for travel costs associated with attending Task Force meetings and hearings.
Deputy Director Singh also said that given that Task Force members have recently received numerous correspondence and reports from interested parties at the Sacramento office, instead of mailing these documents, staff compiled them and placed them in manila folders in each member's desk area. Included in these folders was a memo written by Dr. Northway entitled, “Children: a vulnerable population”.

IV. Reports and Presentations

A. Expert Resource Group Report and Discussion [1 hour] - 10:00 A.M.

1. Consumer Involvement, Communication and Information [Task Force members Jeanne Finberg and Ellen Severoni]

Ms. Finberg stated that the way consumers receive their health care has changed dramatically with the shift from fee for service to managed care. She felt that many consumers do not understand or have not been able to adapt positively to these changes. She stated that consumers have scanty information to help them choose their health plan medical group or primary care physician. Information that is available to them is often incomplete, biased, unintelligible, or not helpful. Moreover, Ms. Finberg stated that consumers often are not confident they are getting the necessary information to make important decisions and they are unsure how to get help when they have problems with their health care.

Ms. Finberg outlined principles for consumer information. She stated that consumers should have useful, unbiased, standardized information that would assist in decision-making. In addition, consumers should have information about the managed care system, how it might affect their health care, how to navigate their health plan, and how to access their plan's internal grievance process, and external resources, and the relevant regulatory authorities. She noted that there may need to be information specifically designed to meet the needs of certain populations, such as patients with chronic conditions. She also stated that full and accurate disclosure fosters competition and best practices. Mr. Williams added that information should be available in different forms and languages to meet consumers' needs.

Dr. Karpf then discussed standardization. He said that standardization would allow consumers to make appropriate comparisons and would make information dissemination more efficient for providers. Responding to a question from Dr. Gilbert, Dr. Karpf clarified that the data elements have to be standardized, but not necessarily the language.

Ms. Finberg mentioned some options to improve consumer information, including developing basic information about how the managed care system works and how to pursue a grievance, developing incentives for plans to provide standardized information on quality of care, rules, restrictions, and options for their members, mandating reports of standardized information to an independent party; requiring health plans and medical groups to disclose information on treatment guidelines and/or financial incentives; developing incentives or mandates to improve quality measures; and requiring governmental agencies to work cooperatively in producing consumer information and responding to consumer complaints. Ms. Finberg stated that consumer information could be provided by plans, groups and providers working cooperatively, by an independent entity, or by a government agency.

Mr. Williams and Mr. Zaremberg questioned whether these issues were unique to managed care or endemic throughout health care. Mr. Zaremberg further questioned whether this information should be provided to consumers in advance, given that most people do not look at this type of information until they are having a problem.

On the topic of who should provide the information, Mr. Zaremberg cautioned against creating a new government agency without knowing whether the public would find this information useful. Chairman Enthoven noted that due to Fifth Amendment rights and other issues regulated entities sometimes fail to disclose information to government agencies. He favored indirect regulation through the buyer-seller relationship.
Task Force members discussed the information provided by one purchasing group, the Pacific Business Group on Health (PBGH). Mr. Zaremberg asked if PBGH’s information had been tested to see how well it satisfied consumers’ needs and whether it should be a model. Dr. Spurlock stated that PBGH had done some focus group tests about how to present the information but did research how useful the information actually is to consumers.

Regarding the range of options Ms. Finberg presented, Mr. Lee suggested the Task Force focus on providing information on how to use the managed care system. Regarding disclosure, Mr. Lee felt this information should not be contained in the evidence of coverage (EOC) documents. Regarding standardization, Mr. Lee felt there were two issues to be addressed: standardization of data collection and standardization of the dispute resolution process.

Mr. Williams argued for standards (assurances that products meet established guidelines) rather than standardization. He also advocated developing methods to get consumers more involved in the decision-making process and understanding their choices. Mr. Zaremberg noted that, particularly for small and medium size businesses, employers often make decisions for consumers. He suggested developing information that would be helpful to agents, brokers, and businesses.

Next, Ms. Severoni discussed consumer involvement. She suggested that public values should be incorporated into health plans’ policies and practices, but that there is a dearth of consumer involvement in health care decision making. She felt the industry needs strong incentives to promote consumer involvement. She outlined two consumer involvement mechanisms: member advisory committees and feedback models.

Task Force members discussed the paper’s “guiding principles” for consumer involvement. Mr. Williams felt that plans were already attempting to involve their consumers through focus groups, member advisory committees on product designs, etc. Both he and Mr. Zatkin stated that there was room for improvement.

Dr. Alpert stated that the ultimate time for consumer involvement is at the time the patient is contemplating care. He felt the patient is most vulnerable at that point, most in need of information, and least satisfied with the information available. Dr. Spurlock agreed that this kind of individual involvement is as important as group involvement through advisory panels and such activities.

Hn. Mr. Gallegos clarified the distinction between advertising (and the focus groups often used to develop advertising) and the kind of information and consumer involvement this paper discussed.

On the issue of incentives to foster consumer involvement, Mr. Williams felt that if consumer involvement would increase plan enrollment, that would be a strong incentive.

Ms. Finberg commented that plans are very concerned with consumers while the consumer is deciding which plan to choose, but once the consumers pick a plan they really do not have the mechanisms to be able to improve their relationship with their providers.

Ms. Severoni suggested that purchasers might create incentives by requiring consumer feedback mechanisms in their plan contracts.

Mr. Zatkin described consumer involvement in the development of Kaiser’s breast cancer testing guidelines. Dr. Karpf questioned the validity and legitimacy of public involvement in treatment guidelines because he felt they should not be developed through public consensus but through careful investigation and evaluation by physicians. Mr. Zatkin stated that plans ought to be able to explain the basis for their guidelines and listen to consumer input. Dr. Spurlock stated that in medicine there is a lot of uncertainty. Whenever there is uncertainty, the values of the patient become much more important on how providers proceed.

Ms. Severoni discussed the paper’s first recommendation, that government purchasers and plans should develop and implement formal consumer feedback mechanisms that result in useful measures of the

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extent to which the plan and their provider group is successful in involving consumers in organizational design and decision making. Ms. Bowne disagreed with this recommendation, stating that while consumer involvement is important, “you could have very happy but very sick consumers.” Ms. Bowne also felt that plans are involving consumers and criticized Ms. Severoni for over-generalizing about the lack of consumer involvement. Ms. Bowne did suggest, however, that there could be more consumer testing of the information plans provide. Mr. Williams felt that the cost of providing all of this information and involvement would need to be considered.

B. Presentation and Discussion - 11:30 A.M.
1. Risk Adjustment [Harold S. Luft, Ph.D., Director, Institute for Health Policy Studies and Professor of Health Policy and Health Economics at the University of California, San Francisco; and Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board]

Dr. Luft started the discussion by raising the issue of how to get plans to want to take care of sick people. He described risk adjustment - adjusting for differences in enrollee risks that might account for higher or lower expenditure in a health plan - as a way to address the issue.

Risk adjustment, Dr. Luft said, can take many types of risks into account. First, there is the risk of an event's occurrence. The probability may vary and is often unknown. He gave the example of birth. We know genetically that women are much more likely than men to bear children. It is known that there are other probabilities that will increase or decrease the likelihood that a woman might have a child in the next year. Second, there is the risk of the need for medical care. That is, the amount of medical care needed given that an event happens. All of these risks affect the amount of money that will be spent on the person's care.

Dr. Luft stated that plans should be held accountable for those things they can control but not for things they can't control. If, for example, a provider happens to attract more women who are going to give birth, the plan should pay that provider more. What is needed, he said, is a method to adjust the payment to the plan to reflect the differences in risk that the plan cannot control. Such predictions cannot be made at the individual level, but can be made for large groups. He estimated that roughly twenty percent of the variation in health care expenditures can be explained by non-random events and that current statistical models can account for roughly forty percent of those non-random events, which he and other experts felt was adequate to begin using the models to risk adjust payments to health plans.

In summary, Dr. Luft stated that risk adjustment is not only about paying plans fairly but also establishes a mechanism by which plans can focus on improved outcomes, improved consumer involvement, and move the health care system towards having physicians and other health care professionals take care of their patients who really need help.

Ms. Shewry described how the Health Insurance Plan of California (HIPC), the state's small employer purchasing pool, uses risk adjustment. She said the HIPC was motivated by a desire to stop plans from seeking healthier enrollees, to protect plans that attract costlier patients, and to provide an incentive for health plans to specialize in treating patients who are sick.

Ms. Shewry stated that the HIPC enjoys some protections against risk segmentation (the ability for plans to selectively enroll healthier patients), such as guaranteed issuance and renewal, annual open enrollment,
and fair marketing laws. She noted, however, that plans still have ways to segment risk. She also added that there are certain aspects of purchasing groups that make risk segmentation worse. First, the employee's ability to choose among plans means that certain types of patients may gravitate towards certain plans or certain types of plans. Second, as purchasers aggressively negotiate price, plans have an incentive to “scrimp” on quality to lower price. Therefore, the HIPC felt risk adjustment was necessary.

Ms. Shewry stated that the HIPC risk adjusts premiums based on age-stratified gender, 200 marker diagnoses, and the number of children per contract compared to the norm within the HIPC population. Under the HIPC’s risk adjustment program, premium dollars are taken away from plans that have very favorable risk selection and given to plans that have unfavorable risk selection. Ms. Shewry stated that this information is not disclosed to consumers.

Chairman Enthoven asked Dr. Luft and Ms. Shewry for any suggestions they thought the Task Force should make regarding risk adjustment. Ms. Shewry felt that larger purchasers, such as CalPERS or PBGH, should institute risk adjustment. Dr. Luft stated that there are risk adjustment experiments happening in Medicaid and Medicare. Dr. Luft suggested that if health plans would pass some of the additional money they receive from risk adjustment on to their medical groups, the medical groups would have an incentive to report more data to the plans. However, he felt that the HIPC was not large enough to provide that kind of incentive to plans.

Based on these remarks, Chairman Enthoven suggested that the Task Force might recommend that CalPERS implement risk adjustment. A representative from the Department of Personnel Administration stated that CalPERS just released a request for proposals on this issue, but only with the intent of adjustments based on age. Chairman Enthoven explained that because of the state’s current contribution structure, risk adjustment would probably actually cost the state money. For this reason, Dr. Luft assessed risk adjustment as more of a political issue than a technical issue.

Mr. Lee asked whether medical groups are risk adjusted and what administrative costs risk adjustment entails. Dr. Luft responded that medical groups are not receiving risk-adjusted payments because plans are not generally receiving risk-adjusted payments. Ms. Shewry stated that administrative costs are not overwhelming because the audits are done on an annual basis and the advisory group is made up of volunteers. She stated that the high costs result from the necessary data infrastructure.

2. The Standardization of Health Benefits Packages [Linda Bergthold, Ph.D., Health Care Consultant; Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board] - 12:30 P.M.

Ms. Bergthold stated that sponsored groups (e.g., Medicare, HIPC, PBGH, CalPERS) are doing a lot of standardization. She presented a chart showing that approximately 95% of large employers in the US cover about the same services and that the variation in benefits is small but significant.

Ms. Bergthold felt that standardization is done for purposes of equity and simplicity. She stated that to help consumers choose among plans, the consumers ought to have the same financial protections no matter what plan they choose.

Ms. Bergthold discussed the disadvantages of standardization, including delaying the introduction of life saving technologies, raising costs for smaller self-insured firms, and discouraging innovations in benefit design – though she felt this last point was more rhetoric than reality.

Ms. Bergthold described categories of services that have the least standardized coverage, including mental health, substance abuse, prescription drugs, dental care, infertility services, abortion, and investigational/experimental treatments. She felt such services could be categorized as 1) services for which there is not good clinical consensus on standard treatment, 2) services which plans have good reason to want to avoid covering, or 3) services for which there are genuine value differences in society (e.g., abortion and infertility).
Ms. Bergthold stated that the degree of variability in coverage in California is driven mainly by mandates; she stated that California has relatively few mandates compared to other states. She suggested that the Task Force consider the issue of creating a core benefit as the basis for plan competition. She cautioned, however, that there would and should always be some variability until there is clinical agreement about what is safe and effective treatment for specific conditions. She felt that the standardized benefit package should be developed with consumer input.

Ms. Bergthold stated that benefit design “tinkering” has not been proven effective in lowering premiums. She urged the Task Force at the very least to make a statement about the need for benefit booklets to be understandable, including clarification of the term “medically necessary.”

Lunch Break

PUBLIC COMMENT - 2:15 P.M.

1) Mr. Thomas Swan - an AIDS activist. Mr. Swan described his own experience trying to access services related to the onset of blindness and commented on how some HMOs discriminate against AIDS patients. He called on the Task Force to recommend that HMOs not tolerate such discrimination, that HMOs institute training and advisory panels with AIDS patients, and that HMOs refer AIDS patients to specialists. He added that if he had been referred to an AIDS specialist sooner, his health plan would have saved money in the long run and he would be healthier and able to work.

Mr. Lee commented to the other Task Force members that one of the real challenges for managed care is caring for people who are “expensive” and that the responsibility of the health care system is to provide care for those who need it most.

2) Mr. Keith Bishop - Commissioner of the Department of Corporations. Mr. Bishop announced to the Task Force that he would be resigning from the DOC, effective September 30th. He offered some final advice to the Task Force.

Mr. Bishop advised the Task Force to act on the basis of facts and to remember that “we are a country of laws.” He also urged members to treat consumers with dignity and respect and to give consumers the authority to make autonomous decisions by leveling the playing field between group-purchased and individual-purchased health coverage.

Mr. Bishop thanked everyone for their work.

C. Expert Resource Group Report and Discussion

1. Doctor-Patient Relationship - (Members: Brad Gilbert, MD, Mark Hiepler, and John Perez).

This topic was moved for discussion at future Task Force meetings.

D. Perspectives on Managed Care - Presentations - 2:35 P.M.

1. California Academic Medicine [William H. Gurtner, Vice President, Clinical Services Development, University of California, Office of the President; Brian S. Bull, MD, Vice President of Clinical Faculty and Dean of Loma Linda University's School of Medicine; Jeffrey Huffman, President and CEO of USC's Care Medical Group; Kenneth Wolfe, Ph.D., Assistant Dean for Educational Affairs, Edgar University School of Medicine; and Joseph Hopkins, Stanford Health Services and Medical Director for Health Plans].

Mr. Gurtner felt that the early debates about managed care failed to take into account the domino effect managed care has on a broader set of assets owned and operated by the state of California. He stated that managed care has had a dramatic effect on the University of California and questioned whether Californians would be pleased with the end result. Mr. Gurtner stated that one of the products of the University of California is research, which is being impacted by managed care. He felt it would be a mistake for the Task Force to simply address these issues through a market approach. He advocated using a public policy approach that considers the implications for state resources.
Dr. Bull then addressed the issue of adverse selection. He said that adverse selection affects not only academic medical centers but all providers who are perceived to be of higher quality in the health care market. Dr. Bull also pointed out that non-white physicians are more likely to care for minority, medically indigent, and sicker patients. However, caring for less affluent and sicker patients may financially penalize non-white physicians and make them particularly vulnerable to capitation arrangements. He also stated that sick patients tend to seek out what they perceive as higher quality care, while healthy patients choose among HMOs more or less randomly. Therefore, in his opinion, higher quality providers are penalized for their higher quality reputation because under managed care payment no longer travels with the individual patient. He felt that the system will, in time, self-destruct and presented an analysis of the financial changes that would be needed to address the issue.

Dr. Huffman identified several stresses resulting from managed care, including Medi-Cal managed care, patients being recruited out of the traditional academic medical center system, reimbursements well below costs, and Medicare managed care. He stated that his AMC has relatively recently developed a private medical group practice. He said that his organization (USC’s Care) has succeeded in getting its practice and costs down which has allowed them to compete favorably in the market. He also said that it is mostly faculty members delivering medical services. However, these medical doctors are also the ones who teach undergraduate students. So as physicians compete more in the private sector, less time is devoted to the educational side. Dr. Huffman emphasized the societal benefits from quality education and medical research.

Dr. Wolfe said that faculty needs to understand the new health care system in order to be effective teachers as well as effective deliverers of health care education. Dr. Wolfe also stated that the method of reimbursement impacts the way individual providers practice. Under the traditional fee-for-service system, consumers wanted providers to do as little as possible to keep consumers’ costs under control. Medical providers, on the other hand, wanted to do as much as medically justifiable to maximize the revenues. By contrast, Dr. Wolfe continued, under capitation consumers want providers to do as much as possible because their payments for the individual provider are fixed. Providers, on the other hand, want to provide only the minimum amount of service required to meet their medical responsibilities. Consumers have also started to demand accountability of outcomes for expenditures, creating economic disincentives for the use of academic medicine. He stated the impact that increased mergers between academic medical centers and managed care organizations will have on faculty structure, productivity, education, and research. He stated that his institution’s philosophy is that preparations for the managed care environment has to occur throughout medical education, including undergraduate education, graduate education, residency training, and faculty development.

Dr. Hopkins stated that his AMC treats sicker, costlier patients, compared to the general population, but does not receive higher payments. He stated that patients who have the ability to switch plans every 30 days frequently transfer into his organization’s care for the short time they need major procedures and then return to their previous provider when they are healthy. Under these circumstances, his organization receives just one or two months of capitation to cover the patients’ major care. He added that physicians are being asked to see more patients and have less time for academic pursuits. Dr. Hopkins also discussed a published study that looked at the rate of National Institute of Health (NIH) grants for clinical research. He said the study found that in areas where managed care has a large penetration, NIH grants are decreasing. He recommended preserving access to AMCs by expanding the centers of excellence concept, improving guidelines for referrals to AMCs, improving cooperation between community medical groups and AMCs, strengthening appeals processes, paying AMCs for the level of complexity of care they provide, and addressing the issue of frequent movement of patients between plans and groups.

V. Discussion - 4:30 P.M.

A. Formulation of Policy Options Work Groups

Ms. Hattie Skubik, Deputy Director of Policy and Research at the Task Force, summarized the process outlined in Executive Director Romero’s letter.
Dr. Rodriguez-Trias requested that the Task Force discontinue informational presentations. She suggested discussing key points either through the ERG or through working groups.

Mr. Lee supported Dr. Rodriguez-Trias' suggestion. He said that the Task Force needs time to talk about the proposals made by the working groups so the Task Force could reach a consensus on substantive issues. Mr. Lee said that the whole purpose of the Delphi process is to be able to discuss the results publicly. Dr. Gilbert, Mr. Werdegar, and Ms. Finberg supported these positions.

On the topic of broad policy statements versus specific recommendations, Ms. Griffiths noted that the more specific the recommendations are, the more likely the resulting legislation will carry the same intent. However, she acknowledged that consensus on very specific recommendations is harder to achieve. Deputy Director Skubik advocated creating a range of possible recommendations, varying in their specificity and intensity.

VI. Public Comment - 4:55 P.M.

1) Ms. Arlis Anderson Rothma - the University of California Commission of the Future of Medical Education and the California Coalition of Nurse Practitioners. Ms. Rothma commented on the need for managed care organizations to support academic medicine. She also stated that many nurse practitioners and nurse midwives are having difficulties getting reimbursement through managed care.

2) Ms. Lynnie Morgan. Ms. Morgan felt that Dr. Luft's comments on risk adjustment were extremely encouraging from a consumer standpoint. She was concerned, however, that risk adjustment would focus on "politically correct" diseases such as AIDS and diabetes and would not address the needs of people who have difficulties obtaining a diagnosis or who have rare diseases. Dr. Spurlock and Chairman Enthoven discussed the possibility of carving out funds for rare diseases.

3) Mr. Butley - California Association of Catholic Hospitals. Mr. Butley discussed a policy paper related to universal health care coverage that he would submit to the Task Force in time for the November meeting.

VII. Adjournment [Chairman Enthoven] - 5:05 P.M.

Hearing and seeing no objection, Chairman Enthoven declared the Study Session adjourned at 5:05 P.M.

Prepared by: Enrique J. Ramirez, Ph.D.
I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 8:45 A.M.
The fifth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Imagine That! Conference Facility in Upland, California.

II. Opening Remarks [Chairman Enthoven] - 8:46 A.M.
Chairman Enthoven began the meeting by summarizing the day's agenda. Specifically, he stated that the five papers listed on the agenda were scheduled for discussion only, and he reiterated that these papers would be scheduled for a vote at a subsequent meeting. The only vote that would be taken at this meeting would be a vote to adopt the amended meeting schedule to include additional meeting dates. Chairman Enthoven asked that, in keeping with the tight agenda for the day, all comments on the five papers be as concise as possible, including comments that the public might wish to make. Chairman Enthoven also encouraged members to submit any comments on the papers to him in writing.

He also briefly addressed a question that had been raised by several Task Force members regarding the ownership of the ERG [expert resource group] papers. He stated that ultimately the documents will be Task Force papers and not the papers of any individual authors. He also said that at this point, the papers have had the "ambiguous status" of being joint products of the ERG members and the Chairman and his staff. He clarified that the Executive Director’s role in the papers would now increase substantially.

III. Roll Call and Declaration of a Quorum - 8:59 A.M.
Chairman Enthoven asked Ms. Stephanie Kauss to take roll, and she compiled. The following Task Force members indicated they were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Ms. Diane Griffiths, Dr. Michael Karpf, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Steve Zatkin, Hn. Martin Gallegos, Mr. Mark Hiepler, Mr. Anthony Rodgers, and Mr. Terry Hartshorn arrived after roll call.

The following Ex-Officio members were also present: Ms. Kim Belshe, Mr. Michael Shapiro, and Ms. Marjorie Berte.

A. Executive Director’s Report [Dr. Phil Romero] - 9:00 A.M.
Executive Director Romero strongly endorsed the comments made by Chairman Enthoven. He also stressed that all papers, the five being discussed on today and all future papers, would be available on the Task Force’s Internet Web page [www.chipp.cahwnet.gov/mctf/front.htm].

IV. New Business - 9:05 A.M.
A. Amendments to Task Force Meeting Schedule - 9:05 A.M.
Chairman Enthoven introduced the first order of business as the discussion and adoption of amendments
to the Task Force meeting schedule. Chairman Enthoven asked Deputy Director Alice Singh to summarize the amendments. Ms. Singh indicated that the proposed amendments would allow the Chair to call up to three additional meetings on a “as needed” basis. After some discussion, Mr. Lee moved to adopt the amended meeting schedule with the following additional amendment: that the October 29 meeting date be eliminated. Ms. Severoni seconded the motion and it was adopted unanimously. After Mr. Zatkin indicated that December 15th would not be an acceptable meeting date for him, Chairman Enthoven took an informal poll on this issue. Seeing that a December 13th meeting date was more conducive, Mr. Lee moved that the meeting schedule be amended to change the December 13th meeting to December 15th. Ms. Bowne seconded the motion, and it was unanimously adopted.

Ms. O’Sullivan wanted to confirm that time would be set aside for public comment after Task Force discussion on each paper. Chairman Enthoven confirmed that time would be made available and encouraged members of the public to keep their comments concise.

Ms. Finberg asked about the public availability of the EGR papers. Ms. Singh reiterated that all papers are made available to the public once they have been mailed out to the Task Force members. To increase accessibility, the papers will and are made available on the Task Force Internet Web page.

Mr. Lee commented briefly on the outline of the January 1 report, which he wanted to confirm was a working draft only. He also suggested that the report contain a section dedicated to both the public testimony obtained during Task Force public hearings and the results of the public survey. He also stressed the importance of cataloging public testimony and information as received by the Task Force and including this information in the report as an appendix.

B. Discussion of the Health Industry Profile ERG Paper - 9:20 A.M.
Margaret Laws, a member of the Stanford staff, presented the Health Industry Profile paper. She gave a brief overview, quickly running through the sections of the document, and then asked for comments and changes from the members.

The Health Industry Profile paper provides background (as required in the Task Force authorizing legislation) on the history of managed care. It includes a brief look at the fee-for-service system that preceded it, the passage of the HMO Act in 1973, the cost pressures that forced the spread of managed care in the 80’s, and the current regulatory environment. The paper also contains a description of major industry terms, trends and structures. Finally, the paper discusses the area of tax status and the shift from not-for-profit to for-profit status.

After Ms. Laws’ overview, members had an opportunity to discuss and suggest changes to the paper. Dr. Northway began the discussion by suggesting that the paper be revised to include a discussion of trends in the number of uninsured persons and any relationship between that trend and the rise in managed care. He was particularly concerned with the increased number of uninsured persons despite the current low unemployment rate. Dr. Alpert pointed out that one of the hopes of managed care was that it would provide a “dividend” that might ameliorate the problem of the uninsured. Mr. Williams suggested that the Task Force be mindful of the degree to which its actions either increase or decrease the severity of the problem. Ms. O’Sullivan requested that the paper discuss the impact of managed care on providers’ willingness to provide charity care.

Mr. Lee made two suggestions: the paper should include 1) more information about the growing importance of medical groups and 2) a more complete description of the fee-for-service system, particularly regarding quality assurance mechanisms, so as not to create a “straw man”.

Regarding Mr. Lee’s first point, Dr. Gilbert suggested that the paper include a discussion of the changing physician practice and the growth of integrated medical groups and IPAs. Ms. Decker asked that the paper describe the growing trend of health plans delegating authority to medical groups. Dr. Spurlock requested
that the paper include a substantive discussion about the different ways medical groups are managed. Mr. Williams suggested the paper comment on the role of medical groups in clinical quality management processes and customer service.

Regarding Mr. Lee's second point, other members thought that the papers should focus on presenting an accurate description of and suggesting improvements to managed care, rather than comparing managed care to fee-for-service. Ms. Severoni suggested that the principles and values that guide both managed care and fee-for-service be included as a starting point in the discussion. For example, there has been a shift from focusing on the care of individuals to the care of populations. Ms. Griffiths suggested that the paper should provide more evidence to support its arguments, particularly regarding criticisms of fee-for-service. Mr. Lee suggested that the paper should make more comparisons among types of managed care organizations. Dr. Rodriguez-Trias suggested that managed care be evaluated in terms of how well it meets the health care needs of the population, rather than comparing it to the fee-for-service system.

Ms. Finberg suggested that the paper should describe the industry from the consumer point of view, especially in terms of system navigation, access, and accountability. Mr. Williams further commented that the paper should discuss the tradeoffs to consumers when they move from one type of health plan to another. He also requested more data on trends in the percentage of medical expenditures paid by consumers, including a discussion of the difference between deductibles and co-payments.

Mr. Gallegos commented on a section of the paper that he felt had a strong negative slant regarding the physician in the fee-for-service system. He felt that some of the statements in the paper imply that the doctors working in the fee-for-service system were motivated by economics and not by the practice of good quality medicine. He asked that this particular section be omitted or at least made more balanced. Ms. O'Sullivan also asked for some added clarification or balance to the discussion of mental health benefits. Dr. Alpert discussed "spin" and the need to portray both sides of the issues. Ms. Griffiths suggested that where statements are controversial, they be identified as beliefs of a particular group rather than portrayed as a matter of fact.

Other suggestions included:

- Add a discussion of national trends that influence managed care structures in California. For example, discuss the move towards standardization of benefit packages, changes in HCFA regulation and financing, etc. (Dr. Rodriguez-Trias)
- Expand and balance the discussion of excess capacity in physician and hospital bed supply. (Dr. Spurlock)
- Add a discussion of Medi-Cal managed care. (Ms. O'Sullivan)
- Clarify and strengthen the discussion of ERISA. (Mr. Hiepler)
- Broaden and balance the discussion of tax status, particularly the consequences of the movement towards for-profit medicine. (Mr. Shapiro)

PUBLIC COMMENT - 10:20 A.M.

1) Richard Van Horn - President, California Coalition for Mental Health. He asked that the Health Industry Profile paper be amended to indicate that there are some very different views on just how available the care for the mentally ill really is. He asserted that private mental health programs are less accessible than the public system and that the private system is cost shifting onto the public sector. He offered to produce documentation regarding this issue, which Chairman Enthoven asked him to forward to the Task Force.

2) Verah Mthombeni - Loma Linda Child Adolescent Medical Clinic. Ms. Mthombeni requested that HMOs have qualified personal in related fields making the decisions needed for the patients. She asserted that IPAs have the power to manipulate their physicians' patient lists without the physicians' knowledge. She pointed out that IPAs do not have appropriate specialists in all fields.
Break - 10:40 A.M.

C. Discussion of the Impact of Managed Care on Quality, Access and Cost ERG Paper - 11:00 A.M.
Chairman Enthoven introduced Sara Singer, a member of the Stanford staff, who presented the second ERG paper, The Impact of Managed Care on Quality, Access and Cost.

Executive Director Romero had a few comments to make before the discussion of the second ERG paper began. He wanted to comment on the issues of spin or comparison that were discussed regarding the first paper. He put a question to the Task Force members: “If we don’t compare managed care to fee-for-service, what do we compare it to?” The members responded that the comparison between these two systems was unavoidable, but it had to be written and presented in an unbiased way to the greatest extent possible. Also, several members stressed that there are systems, standards and measurements that can be used as additional comparison tools between managed care and fee-for-service (e.g., Healthy People 2000, HEDIS).

Ms. Singer summarized the second ERG paper. With regard to quality, she summarized that outcomes are highly dependent on the organization and the disease. She highlighted positive and negative findings about managed care quality. With regard to cost, the paper concluded that California generally has a lower cost structure than the nation as a whole. With regard to access, the paper discussed tradeoffs. For example, managed care entails better access in terms of cost and some services, but worse access in terms of doctor and referral restrictions. She pointed out that there are some concerns that cost containment is leading to problems in quality.

Dr. Alpert began the discussion by questioning a statement in the paper’s Executive Summary that asserted that managed care has likely improved access by preventing more people from becoming uninsured. He felt that it was a speculative sentence that was not backed up with evidence. Ms. O’Sullivan stated her concern that people actually have poorer access under managed care. Mr. Zatkin described a Congressional Budget Office study that looked at this issue, which Chairman Enthoven said he would get.

Mr. Lee asked that section G of the paper be deleted because it recommendations. He felt that potential solutions should arise from the discussion between the members and should not be listed in the papers. The members agreed to omit section G. Mr. Zatkin agreed with Mr. Lee’s recommendation and stated that all the ERG papers should remain background papers only.

Dr. Spurlock stated his belief that a lot of the concerns related to managed care quality are based on perception rather than reality. He requested that the paper discuss and highlight the tension of trying to look at population health measures from an individual perspective.

Dr. Rodriguez-Trias wanted to add to the paper a discussion of the cost to the consumer, as opposed to system costs. She also wanted to make sure that a discussion of this issue would not make HMOs synonymous with managed care.

Ms. O’Sullivan had some major concerns about this paper. She felt the paper was written to make managed care look great. She wanted the paper to be completely rewritten in a more concise, factual, objective way. Ms. Bowne felt the paper was well written with very valuable information. She stated that there were certain sections that could be more balanced, but as a whole it was a very good background paper. Mr. Lee thought that the paper should be more balanced rather than shorter and he also felt that the paper needed to discuss a broader range of public perception.

A discussion ensued by several members as to whether the papers should be more concise, which could help cut down on the balance and controversy issues, or whether they should remain as they are. Mr. Gallegos suggested that the Task Force consult with the author of the legislation (Assembly Member Richter) to determine what the intent of the legislation really is regarding the reports.
Many of the members felt that the executive summaries of the papers would be, realistically, what people would read of the papers. They wanted to make sure that all the data in the papers was included in some way in the summaries, so that people can make the same conclusions even if they didn’t read the complete paper.

Both Dr. Gilbert and Mr. Zatkin asked that specific references to HMOs be omitted from the papers. All plans should be referred to in generic terms.

Ms. Severoni thought the paper should recommend that information about quality be presented in a way that is meaningful to consumers. She further stated that while costs may have decreased, the public very strongly believes that they are paying more. She recommended that employers periodically include in their employees’ pay stub what their health care contribution is. Ms. Finberg further requested that the quality and access sections, in addition to the cost section, be expanded from the consumer perspective.

PUBLIC COMMENT - 11:53 A.M.
1) Richard Van Horn, President, California Coalition for Mental Health. Mr. Van Horn asked the Task Force to recommend passage of AB 1100, a mental health parity bill.
2) Mariana Lamb, Director, Medical Oncology Association of Southern California. Ms. Lamb cautioned the Task Force against shortening the papers, especially when discussing quality, access, and cost. She felt the members would lose the focus and the intent of the papers by shortening them.

Lunch Break - 12:05 P.M.

Upon reconvening after lunch, Chairman Enthoven said that without objection, he would move to the discussion of the Risk Adjustment paper instead of the Balancing Public and Private Sector Roles paper. Seeing no objection, Chairman Enthoven moved to the Risk Adjustment Paper.

E. Discussion of the Risk Adjustment Paper - 12:20 P.M.
Chairman Enthoven began the discussion by commenting that there are many reasons for risk adjustment. One is to give consumers a level playing field and give them a fair economic choice of a wide access product. Another is concerns over fairness and leaving out large portions of the population (“skimming”).

Mr. Zatkin responded that he is in favor of risk adjustment and its ability to help create a better system. He also wanted to know if the risk adjustment technology was available and accepted for hospitals as opposed to medical groups. Dr. Spurlock added that he felt a recommendation by the members was needed to encourage further research regarding the technology of risk adjustment.

A discussion was held regarding the difference is this paper compared to the previous two that were discussed. Mr. Lee felt this paper was more of a recommendation paper rather than a background paper and it needed to be stated as such.

Ms. Griffiths raised the issue of patients’ right to privacy around the information sharing that would be required with risk adjusting. Chairman Enthoven thought that the technology was in place so that when a patient transfers their information it is re-coded in such a way so that it is not possible to identify the individual. Mr. Williams expanded on this issue, asking the members to really understand the data limitations in terms of coding and methodology. He also felt it is important to grasp the difference between Medicare populations and the commercial populations. He suggested that the Task Force explore other options such as stop-loss insurance and enrollment protection.

Ms. Bowne expressed some major concerns with the paper and some of its recommendations. She felt that risk adjustment is a good idea but she strongly cautioned members to get the facts straight before plunging in and possibly mandating everyone to do it. Dr. Karpf agreed, but he added that a consensus needs to be reached as to what system is going to be used and to see that it is used in a uniform way.
Mr. Hartshorn wanted assurances that the risk adjustment process would be cost neutral to individual consumers, as much as possible.

The members discussed the recommendations that were expressed in the executive summary of the papers. They discussed, revised and changed several of the recommendations. In general, they wanted an approach of first recommending a certain course of action and then requiring it after a certain time period. They recommended that major purchasers and foundations should support the development of appropriate research and development in risk adjustment. They also recommended that CalPERS report back to the legislature in a certain period of time on what they have done to implement risk adjustment. The third recommendation called for the Department of Health Services to join with HCFA in a project exploring risk adjustment in plans serving Medi-Cal beneficiaries. Several of the changes that the members suggested included revision of some of the words and expressions used in the recommendations. They also revised several of the timelines set forth in the recommendations.

Break - 1:5 P.M.

Upon reconvening from the break, Chairman Enthoven stated that without objection, he would move to the Expert Resource Group oral reports as opposed to finishing the remaining two ERG papers. Seeing no objection, Chairman Enthoven moved to the ERG Reports.

V. Expert Resource Group Reports and Discussions - 2:15 P.M.

A. Doctor-Patient Relationship [Members Gilbert, Hiepler, Perez]

Dr. Gilbert began the discussion with an overview of what his ERG did in preparation of this presentation. First, they incorporated as much information as possible about physician-patient relationships. They tried to add all the information that was presented by the public at all the public hearings. Second, they did a semi-intensive review of the literature regarding this issue. Third, they conducted a hearing with all three ERG members. Members of the public testified at that hearing. Lastly, they spent a lot of time with primary care doctors, talking to them and gathering information. Using all this gathered data, they have identified areas of concern in the physician-patient relationship relating to managed care. They presented their initial recommendations to the other members.

In the area of continuity of care, they first recommended that health plans and medical groups be required make contractual arrangements that allow patients, or a subset of patients, to continue seeing their doctors until the end of the contract year. They next recommended that plans be required to disclose the PCP’s, medical groups, IPAs, and specialists available and their access limitations. Third, they recommended that plans be required to give reasons when they terminate providers.

Under quality improvement, they recommended streamlining physician audits and making a standard audit to be used throughout the industry. They also recommended improvements in consumer information.

Mr. Hiepler continued with the overview. He suggested eliminating prior authorization requirements for specialty visits. He felt this would force HMOs to do a better job of selecting their primary care physicians, cut down on malpractice claims, allow doctors to practice their specialty, and reduce the frustration level of both doctor and patients. The ERG recommended a more modest approach of setting a time limit by which a primary care physician can earn a “gold card” exempting them from prior authorization requirements. They also recommended requiring explanations for referral denials, disclosure of the basis for medical necessity decisions, disclosure of who made the denial decision, and disclosure of financial incentives.

Dr. Gilbert also touched upon several other areas that their group had studied, including physician and appointment availability, physician standards, and supervision and oversight of physician extenders.

After their presentation members had an opportunity to comment and discuss their recommendations and suggestions. Both Ms. Bowne and Mr. Gallegos asked about the process that doctors could use once
they had been terminated from a plan, including notifying the enrollees of the pending termination. Mr. Hiepler stated that although logistically difficult, they recommend that a letter go out to all patients letting them know that their physician is being terminated and they have a certain amount of time to secure a new physician.

Mr. Shapiro commented on the idea of plans giving a “gold card” to physicians in their groups. He wanted to make sure that the physicians getting these cards were not referring patients to specialists because of the high cost to the HMO, or being pressed into denying care.

Chairman Enthoven spoke on the issue of financial incentives. He recommended that a pilot project be done in which randomly selected medical groups come up with a model statement regarding financial incentives and then present it to their members, asking for some feedback on the model and ultimately sharing the information with the legislature. Dr. Karpf mentioned that he would like this information regarding disclosures to be made available to the physicians as well.

Break - 3:55 P.M.

B. Academic Medical Centers and Health Care Workforce [Task Force Members Bowne, Karpf]

Dr. Karpf began the discussion with a description of a health center. He described a health center as an entity that consists of a school of medicine, a hospital and a variety of other services that provide health care to a number of patients. There are about 125 to 140 health centers and they have essentially three missions: education, research, and service. There are two types of service: high-end tertiary care and the safety net of health care. Health centers flourished in the 50’s and 60’s and then in the mid 80’s the money for research and education dried up and the centers had to become much more accountable for health care costs. In order to resolve these cost issues and to help these centers survive, he felt the Task Force needed to take a look at what they provide for us and what is appropriate to support.

Because of the nature of the health center, they tend to draw the sickest, most critical patients. He stated that this issue needs to be recognized in the form of risk adjustment. He felt the surplus and maldistribution of physicians will need to be addressed. He stated that the cost of medical education is a growing problem. Dr. Karpf stated that it will become incumbent upon the state of California to study and analyze and understand what its medical educational needs are and if it is going to support the needs for the future. The last issue he discussed was the issue of how to ensure that society will allow and encourage academic health centers to continue to push the envelope of care and continue on with the evolution of medical knowledge.

Ms. Bowne spoke about the oversupply of physicians. She suggested that the State provide incentives for training of residents in managed care and ambulatory settings, particularly in under-served areas. Regarding research, she felt that the costs need to be shared by society as a whole because society does benefit from the results of the research.

The members now had a chance to ask questions and give comments on the presentation. Dr. Rodriguez-Trias asked about the incentivising and distribution of physicians on California. Dr. Karpf stated that there are benchmarks in California that continue to be met and reengineered to become better. Ms. Bowne remarked that the progress on this issue needs to be better documented and more available for study.

Mr. Rodgers asked about the mechanisms that could be used to better understand what is best for different regions of the state and how to make the medical centers successful and possibly integrated. He also suggested that the group draft some sort of a suggestion about how to proportion the work force in an appropriate way. Dr. Karpf stated that medical centers are working hard to create relationships with other centers and merging with other hospitals in order to survive. He also suggested that in regards to paying for the education of medical research, he felt that an all payer system is appropriate.
PUBLIC COMMENT - 4:50 P.M.

1) Teresa Bush-Zurn, California Dietetic Association. Ms. Bush-Zurn asked the members to recommend that HMOs encourage the maintenance and expansion of the dietetic internship and educational process.

2) Nell Woodward, California Dietetic Association. Ms. Woodward asked the members to recommend that HMOs maintain and expand supervised practice studies of dietitians and technicians.

3) Mary Ann Schultz, American Nurses Association. Ms. Schultz asked the Task Force to consider working with the Nurses Association on specific issues. She volunteered her time to work on the Task Force on behalf of her organization.

Before the last two speakers were asked to comment, Chairman Enthoven wanted to make some brief remarks about the remainder of the meeting and the agendas for future meetings. He proposed to postpone until the next meeting the two ERG papers that were not discussed at this meeting, Standardization of Benefits and Balancing of Private and Public Sector Roles. He felt that the Balancing of Roles paper would need some additional work and would be re-sent to the members in a revised form. Because of the length of discussion of the papers and the amount of papers to be reviewed, he asked that members be aware of their demands for rewrites and revisions.

4) Barbara Smith, Orange County Managed Care Task Force. Ms. Smith described the organization and their mission, which arose from a Washington, D.C report on the vulnerable elderly. They recommend improved case management in the vulnerable elderly population and would like to consider risk adjustment for this group.

5) Patti Strong, Service Center for Independent Living. Ms. Strong encouraged the Task Force to take a long-term view of its issues. She argued for good case management and the right to have good, quality care in the short run as well as in the long run.

VII. Adjournment - 5:35 P.M.

Chairman Enthoven declared that without objection, the business meeting would be adjourned. Seeing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Stepanie Kauss
Improving Managed Health Care in California Volume Three

Managed Health Care Improvement Task Force
October 28, 1997 Regular Business Meeting Minutes

Adopted by the Task Force on December 12, 1997

Tuesday, October 28, 1997 — 9:00 A.M.
1201 K Street, California Room
California Chamber of Commerce
Sacramento, California

I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 9:15 A.M.
The sixth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by the Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. Roll Call and Declaration of a Quorum - [9:15 A.M.]
The following Task Force members were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Dr. Donna Comor, Dr. Alain Enthoven, Ms. Nancy Farber, Ms. Jeanne Finberg, Hon. Martin Gallegos, Ms. Diane Griffiths, Mr. Bill Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Ronald Williams, Mr. Allan Zaremberg, and Mr. Steve Zatkin.

The following Ex-Officio Members were also present: Ms. Kim Belshé, Ms. Marjorie Berte, Mr. Michael Shapiro, and Dr. David Wedegar.

III. Opening Remarks [Chairman Enthoven] - 9:19 A.M.
Chairman Enthoven began the meeting by stating that the procedures by which members will vote to adopt various components of the final report would be included on the November 21 meeting agenda for discussion. He also told members that the President’s Commission on managed care has released its preliminary recommendations and that they are available on the Commission’s web page.

He next introduced Assemblywoman Helen Thomson who requested an opportunity to address the Task Force on mental health issues as they relate to managed care. She discussed the issue of the State taking the necessary steps to correct discrimination against mental health patients and the enormous cost of mental health care. [The Assemblywoman introduced AB 1100 last session addressing this issue]. The Assemblywoman noted that there is a $28.8 billion cost to United States employers due to mental illness of some employees. She suggested that the movement be to eliminate the capitation of dollars spent on visits and treatment. Assemblywoman Thomson next introduced Dr. Goldman.

Dr. Goldman said that he hoped the Task Force would address the fact that many Californians are suffering from some form of mental illness and propose recommendations on the treatment of mental health and the cost thereof. He indicated that pursuant to a study he conducted, if employers paid an additional $1 in managed care benefits to cover mental health services, employees could have managed mental health care with unlimited access.

A. Executive Director’s Report [Phil Romero, Ph.D.] - 9:34 A.M.
Executive Director Phil Romero said that he planned to discuss the Expert Resource Group papers and the report completion process, but felt that due to the complexity and time constraints of today’s agenda, he would defer this discussion.
IV. Consent Calendar - 9:36 A.M.
Chairman Enthoven introduced the consent calendar, which was composed of one item - the proposed October 10, 1997 Business Meeting minutes. Dr. Spurlock moved to adopt the Consent Calendar and Ms. Severoni seconded the motion. The motion was unanimously adopted.

V. Old Business - 9:37 A.M.
Before moving to old business, Chairman Enthoven clarified that members would be asked to vote on AB 2343 [Chapter 815, Statutes of 1996] mandated papers in their entirety while members would be asked to vote only on the Executive Summaries of non-mandated papers. Several members asked questions of the Chairman regarding which documents would be included in the final report. The Chairman indicated that the main portion of the report would contain all adopted papers/executive summaries and that all non-adopted background papers would be included as part of the report appendices.

In response to a question posed by Ms. Farber, Chairman Enthoven stated that there is not sufficient staff or staff time to devote to the production of minority reports.

Recognizing that papers undergo several versions before they are scheduled for Task Force adoption, Dr. Karpf requested that all subsequent changes to papers be indicated in “redline” text to ease their identification. Chairman Enthoven agreed and stated that this would be the method used from this point forward.

Ms. Farber requested that a roll call vote be taken on each paper/executive summary. After some discussion, Ms. Alice Singh, Deputy Director for Legislation and Operations, indicated that pursuant to the Task Force Bylaws and Rules, and Robert's Rules of Order, roll call votes would be allowed when requested, and must be requested after votes on an individual item have been cast (a.k.a. Division).

A. Discussion/Adoption of the Health Industry Profile ERG paper - 10:12 A.M.
Chairman Enthoven opened the floor for discussion of the Health Industry Profile paper. Dr. Werdegar began the discussion by asking for a full and fair description of the differences between for-profit and not-for-profit organizations. Ms. Griffiths stated that the for-profit/not-for-profit discussion in the paper contained gratuitous criticisms of physicians. She felt the paper should be more balanced, including a discussion of who profits from the current system. Mr. Shapiro was also concerned with the paper’s characterization of research results comparing outcomes in for-profit and not-for-profit settings.

Mr. Lee made the suggestion to shelve voting of this paper given that he had only recently received several suggested changes from the California Medical Association (CMA) and that half of the Health Industry Profile paper had arrived late. Chairman Enthoven agreed. Both the Chairman and the Executive Director urged the members to submit suggested changes in writing to staff.

Mr. Zaremberg raised the point that the Health Industry Profile paper does not cover all of the topics listed in section (3)b(1) of AB 2343. Dr. Romero clarified that the papers under Task Force consideration do not each cover one topic in the legislation, but that collectively all of the topics are covered. Mr. Hauck suggested that the staff identify which papers cover which points of the legislation.

Ms. Severoni felt that consumer concerns, which compelled the Governor and Legislature to create the Task Force, were not adequately addressed. She requested that a discussion of the results from the Task Force's public survey and concerns raised during public testimony be included. Dr. Enthoven suggested that these issues be discussed in the paper about the impact of managed care on access, quality and cost. Dr. Romero suggested that this discussion be reserved for a more important location such as the Executive Summary.

Mr. Lee suggested that the descriptive sections from the Balancing Public and Private Sector Roles paper be moved into the Health Industry Profile paper.
Dr. Spurlock requested that the paper include more discussion of changes in the hospital industry. Ms. Farber had some concerns about using data about licensed beds rather than operational beds. She felt that data about licensed beds does not accurately reflect hospital capacity and suggested that the Department of Health Services determine how many hospital beds are actually operational. She also raised the point that the reduction of bed utilization may be due to the growing number of uninsured rather than the impact of managed care. Ms. O’Sullivan asked for more information about geographic variation in hospital bed supply, including different types of hospital beds.

Dr. Karpf requested that a discussion of the medical loss ratio be included in the paper. Chairman Enthoven stated that those figures are very hard to interpret. Dr. Romero suggested that the Task Force make a recommendation to standardize the accounting framework used to calculate the medical loss ratio.

Ms. O’Sullivan suggested that language be included stating that the consumers have no formal voice in plan decision making. She also suggested that the section regarding health industry integration be more balanced. She questioned whether the primary problems facing the health system could actually be met through integration and whether the industry was actually doing all of the things listed. She requested that there be qualifying language to the effect that the descriptions apply to the health care delivery system operating at its best.

Ms. Farber asked that the members recommend standardizing accounting with respect to the medical loss ratio, as the government did for the hospital industry. Dr. Karpf concurred with this suggestion.

Dr. Alpert moved that voting on the Health Industry Profile paper be deferred until the November 21 meeting. Mr. Kerr seconded the motion and it was unanimously adopted. The Chairman then encouraged members to forward any additional comments on the paper ASAP so that they could be included before the paper would be adopted.

PUBLIC COMMENT: - 11:00 A.M.

1. Carol Lee - California Medical Association. Ms. Lee expressed concern about a market bias in the paper. She suggested that there be a discussion in the paper of the problems with managed care just as was done with the fee-for-service system. She also pointed out that AB 2343 does not call for a historical analysis of the industry, so perhaps that analysis should be left out of the paper.

2. Beth Capell - California Physicians Alliance. Ms. Capell asked that the members be aware of the important role medical groups have assumed in terms of managing risk.

3. Catherine Dodd - American Nurses Association of California. Ms. Dodd asked that the term “doctor” be replaced with the term “provider”, which includes clinics, physicians, nurse practitioners, etc.

B. Discussion/Adoption of the Risk Adjustment Executive Summary - 11:16 A.M.

Chairman Enthoven began the discussion of this paper with an explanation about why he had chosen to make a change in the first recommendation before it was discussed by the Task Force. Dr. Enthoven stated that he altered the language after talking to members of the CalPERS board and getting their input. He felt the Task Force had a better chance of getting positive results from CalPERS with the new wording. He also explained that the recommended $500,000 was based on the amount of a Robert Wood Johnson Foundation grant.

Prior to discussion of the paper, Dr. Spurlock suggested the Task Force develop a mechanism to prioritize the recommendations once they are all passed. Mr. Zaremberg agreed and further suggested that staff create for the next meeting a matrix of each new government program or mandate under Task Force consideration.

Following there ensued a general discussion regarding risk adjustment. Comments from the members included:
• Mr. Zaremberg asked why CalPERS hadn’t already adopted risk adjustment. Chairman Enthoven responded that the experts have only recently said that the methodology is good enough. He added that under the state’s current health premium contribution method, risk adjusting premiums would lead to increased state costs. However, he stated that the state is currently considering adoption of a new contribution system that would make risk adjustment cost neutral.

• Mr. Williams stated that risk adjustment was a good objective, but he was concerned that it has been tested mostly on the Medicare population as opposed to the young population. He referred to an actuary report’s conclusion that risk adjustment is untested and that any proposal should consider a modeling period.

• Mr. Kerr felt that risk adjustment was crucial to addressing incentives under capitation and that the system was sufficiently advanced to merit adoption now.

• Ms. Farber asked for a mechanism to assure that the larger risk adjusted premiums would actually go to providers and not be diverted to corporate profits.

• Ms. Finberg asked for more information about what is happening with risk adjustment in Medi-Cal and for descriptions of other risk adjustment models.

• Mr. Tirapelle stated that CalPERS is exploring risk adjustment based on age and gender rather than diagnoses. He also mentioned, and Chairman Enthoven confirmed, that risk adjustment would have the effect of transferring some money from lower to higher income employees. Mr. Ramey disagreed with this statement.

• Mr. Ramey asked that the wording in the paper specify that risk adjustment be based on diagnosis or medical condition in addition to demographics.

Lunch Break - 12:10 P.M.-12:45 P.M.

Chairman Enthoven resumed the meeting by asking the members if there was enough interest in moving forward with the concept of recommending risk adjustment. Several members were concerned with the specific details and instead recommended creating a formal body or commission to devise a specific model for the state. Chairman Enthoven asked for public comment before a vote was taken.

PUBLIC COMMENT - 1:05 P.M.

1. Judith Regeal - California Medical Association. Ms. Regeal stressed the importance of risk adjusting payments to providers, not just plans.

2. Nancy Welsh - CalPERS. Ms. Welsh stated that CalPERS is very interested in risk adjustment but that their current plan does not include health status as a risk adjuster, largely due to confidentiality issues. Mr. Tirapelle asked why CalPERS was chosen to implement risk adjustment. Dr. Enthoven responded that they have the centralized capability to handle implementation and also they are the largest cohesive purchasing entity. He pointed out that the recommendations request that CalPERS work with the University of California and the Pacific Business Group on Health to implement risk adjustment.

Proposed Recommendation No. 1

The Task Force strongly recommends to the CalPERS Board of Administration 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 risk adjustment system within three years. The legislature should provide $500,000 for a study of how best to implement risk adjustment and ask CalPERS 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. 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.

Mr. Perez suggested that Recommendation No. 1 be amended so that it accurately reflected the discussion/agreement made by members at the October 10 meeting. Chairman Enthoven said that without objection, he would ensure such changes were made.
Ms. Farber moved to adopt Recommendation No. 1, as it is amended to reflect Mr. Perez's previous comment. Mr. Perez seconded the motion.

Mr. Kerr then moved to amend the recommendation to add “diagnosis based” language to it. Mr. Lee seconded this motion. The motion to amend Recommendation No. 1 was unanimously adopted, however, a vote on the main motion, as amended, failed with only 12 affirmative votes.

Mr. Perez then moved to adopt the Recommendation No. 1 [with the October 10 language] with one substitution: to change the word “direct” to “urge” so that the recommendation states “…that the Legislature urges CalPERS to…” Mr. Tirapelle seconded the motion. The Chairman then read the recommendation for the record1. The motion was adopted 17 to 0 in favor.

Proposed Recommendation No. 2

The legislature or Governor should instruct the California Department of Health Services (DHS) 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 payments to managed care plans serving Medi-Cal beneficiaries. The legislature or Governor should require DHS 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.

Mr. Lee moved to adopt Recommendation No. 2 as proposed and Dr. Karpf seconded it. Mr. Zaremberg asked Ms. Belshe, as Director of the Department of Health Services, to comment on this recommendation before a vote is taken. Ms. Belshe indicated that from her perspective, the concept of Recommendation No. 2 merits further discussion, consideration and direction to the Department to engage in “that type of dialogue”. She further indicated that as to the predictability of risk assessment to the medical population, the department is doing some adjusting. Those risk adjustments, according to Ms. Belshe, are based upon demographic characteristics.

After discussion by Task Force members on the issue of risk adjustment as it pertained to Recommendation No. 2, Mr. Lee moved to amendment the recommendation to add in the fourth line where it ends “…to do risk adjustments for services to medical beneficiaries…”, to then strike “…payment to managed care plans serving…” Dr. Northway seconded the motion. The motion was adopted with 20 affirmative votes.

Proposed Recommendation No. 3

Similarly, the legislature or Governor should instruct DHS to participate in HCFA-sponsored risk adjustment demonstration projects for managed care plans serving Medicare beneficiaries as and when such demonstration projects are proposed.

Mr. Perez moved that Recommendation No. 3 be adopted as proposed and Ms. Farber seconded it. Without discussion, the motion was adopted 19 to 0.

Proposed Recommendation No. 4

The legislature or Governor should direct DHS to 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).

Ms. Severoni moved that Recommendation No. 4 be adopted as proposed, and Mr. Kerr seconded it. Ms. Belshe questioned whether it is an appropriate means for the Department of Health Services to work in the direction given in Recommendation No. 4. Given that this would be a clarifying amendment, the Chairman ruled that without objection, an amendment would be made to the recommendation to read “…recommends the state explore with the Federal Office of Personnel Management the California pilot

1 Please see page 111 of the October 28, 1997 Task Force Meeting Transcript for exact language.
project for risk adjustment of premiums for health plans serving federal employees in California...”. The motion to adopt the recommendation, as amended, was adopted with 20 affirmative votes.

Proposed Recommendation No. 5

Upon implementation by CalPERS of a risk adjustment mechanism, the legislature or Governor should consider requiring other new purchasing groups to risk adjust payments to participating plans within a reasonable timeframe after formation.

Mr. Perez moved to adopt recommendation No. 5 as proposed, and Dr. Spurlock seconded it. Mr. Zaremberg stated that he felt the Recommendation was premature. Although the Task Force will not be in existence when CalPERS completes the study urged in the Recommendation No. 1, he said that this recommendation should not be made until such a study is completed.

In response to Mr. Zaremberg’s comments, Mr. Kerr suggested an amendment to read “…upon successful implementation by CalPERS in the risk adjustment system…” . Mr. Perez said that he felt the existing language added more flexibility. Mr. Kerr’s suggestion was not placed in the form of a motion.

Mr. Williams moved to replace “direct” with “urge” where stated in Recommendation No. 4. Mr. Hauck seconded the motion. The motion failed with 3 affirmative votes.

Mr. Kerr then moved to amend the recommendation to replace “…other new…” with “all.” Mr. Lee seconded the motion which was adopted with 17 affirmative votes.

Mr. Lee then moved to amend the recommendation to add “…upon receipt of reports recommended from CalPERS and DHS”. Mr. Lee’s motion was not seconded.

Chairman Enthoven then called to question on the main motion as amended. The motion was adopted with 17 affirmative votes.

Break - 3:30 P.M.

Proposed Recommendation No. 6

Major purchasers doing risk adjustment should require as a matter of contract, and as soon as technically feasible but no later than the year 2000, the state should require as a matter of licensure, that health plans pass through risk adjustment to their contracting providers or use some other mechanism that appropriately compensates for risk (e.g., stop loss coverage, carve outs, global case rates.

Dr. Karpf suggested that “or” be replaced with “and” or to stop the sentence after “…providers....”. Chairman Enthoven suggested that in place of Dr. Karpf suggestion, the sentence “In addition to other mechanisms that appropriately compensate for risk” be added to the recommendation. Dr. Karpf indicated this addressed his concerns.

Ms. Farber then moved to adopt Recommendation No. 6 as revised, and Mr. Perez seconded it. Chairman Enthoven stated that without objection, he would delete “…no later than the year 2000…” from the recommendation. No objection was raised.

After much discussion, Mr. Kerr moved to amend the recommendation to make it applicable to “treating providers”. Ms. Farber seconded the motion. The amendment was adopted with 19 affirmative votes.

Dr. Conom then moved to delete the words “…pass through” and just say “risk adjusted payments to treating providers”. Dr. Karpf seconded the motion to amend. The motion to amend failed with 8 affirmative votes.
Chairman Enthoven moved to replace Recommendation No. 6 with the following language:

As soon as technically feasible, the state should require as a matter of licensure, that health plans risk adjust payments to their contracting treating providers in addition to using other mechanisms that appropriately compensate for risk, [e.g., stop/loss coverage, carve outs, global base rates]. When premiums are risk adjusted so that those risk adjustments flow through to treating providers as well.

Mr. Kerr seconded the motion was adopted with 18 affirmative votes.

Proposed Recommendation No. 7

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

Mr. Lee suggested that the word “should” be replaced with “are strongly encouraged to” as indicated in Recommendation No. 7. Dr. Spurlock also suggested replacing “vulnerable populations” to “different populations”. Chairman Enthoven asked if there was objection to these replacements. Seeing and hearing none, he declared the Recommendation revised to incorporate Mr. Lee and Dr. Spurlock’s suggestions.

Mr. Lee then moved to adopt Recommendation No. 7 as amended. Mr. Kerr seconded it and the motion was adopted with 20 affirmative votes.

New Recommendation No. 8

Dr. Romero read into the record the following newly proposed recommendation:

A state regulatory organization such as the Department of Corporations or a new office of State Health System Oversight if created, should be charged with facilitating these [recommendations 1 through 7] efforts and reporting the progress annually to the Governor and the Legislature.

Mr. Rodgers moved to adopt Dr. Romero’s language and Ms. Farber seconded it. Chairman Enthoven then moved to replace “…a state regulatory organization such as the Department of Corporations or a new office of State Health System Oversight if created should be charged with facilitating…” with “the lead state agency responsible for managed care oversight should be charged for overseeing…” Mr. Perez seconded the motion and it was adopted with 19 affirmative votes.

Executive Summary

Mr. Perez moved to adopt the Executive Summary, as amended to reflect the newly adopted recommendations. Ms. Severoni seconded the motion.

Ms. Belshe, Mr. Zatkin and Mr. Zaremberg all expressed concerns about voting to give responsibility to an agency or new office without first identifying all the problems. Mr. Zaremberg also wanted some clarification about the term “skimming”. He and Mr. Williams both felt that the paper focuses largely on adverse selection as a problem in the marketplace. They were trying to understand what the true intent of the paper really is. Whether it is appropriate to avoid and accept risk and to market to the healthy populations. Chairman Enthoven stated that the intent of the paper is not to stigmatize people but to develop a system that requires or causes people to pool risk broadly. He thinks that the system that allows people who are healthy to escape contributing to the cost of the sick is a defective system.

Mr. Williams then moved to amend the Executive Summary to read “some leading experts believe that good enough methods are now available and already put into practice.” Mr. Hauck seconded the motion and it failed with 14 affirmative votes.

The Executive Summary was adopted with 17 affirmative votes.
PUBLIC COMMENT:

Steve Thomson - California Medical Association. Mr. Thomson felt it was entirely appropriate to use the word “skimming” in the report.

Break

C. Discussion of the Balancing Private and Public Sector Roles Paper - 4:00 P.M.

This paper was for discussion only with no votes taken. Chairman Enthoven briefly summarized the paper’s contents, explaining that it was written as a response to the Governor’s request for the Task Force to advise on the appropriate role of government and how that role should be carried out. He asked the Task Force members for their opinions as to whether this paper was worth pursuing. Many members felt that the paper should be abandoned. Others liked the material and suggested that sections of it be used in other papers. A few members felt the paper was premature and should be tabled until a later date. Chairman Enthoven agreed to abandon the paper and have staff move portions of it to other papers.

D. Discussion of the Standardization of Benefits paper - 4:18 P.M.

Task Force members discussed requiring plans, government or a non-profit group to compare each plan’s benefits to one of several established benchmark benefit packages, rather than mandating that certain standardized packages be used. Ms. Finberg advocated requiring the plans, if they offer any packages at all, to offer one or more of the standardized packages. Mr. Shapiro suggested that an appropriate role for government might include screening the comparisons the health plans make or consolidating the information to produce one comprehensive comparison. Dr. Spurlock made an analogy to the rules government establishes regarding food labels.

PUBLIC COMMENT - 4:40 P.M.

Carol Lee - California Medical Association. Ms. Lee stated that in general the CMA felt that this paper was very positive. She suggested that the paper include a recommendation for stakeholders to devise a comprehensive, standardized Evidence of Coverage disclosure form. She suggested that the disclosure be publicly available so that various groups could have the data to compare plans.

Mr. Shapiro suggested that the Task Force consider standardizing the disclosures. Ms. Belshé stated that Medi-Cal uses standardized disclosure forms to some extent. Mr. Tirapelle stated that CalPERS does also.

Break - 5:00 P.M.

VI. New Business - 5:15 P.M.

A. Discussion of the Expanding Consumer Choice Paper

Chairman Enthoven opened the floor to Mr. Zaremberg for discussion of this paper. Mr. Zaremberg stated that the purpose of the paper is to encourage more utilization of purchasing pools in order to increase consumer choice of plans and physicians. The difficulty is how to go about promoting this concept. Mr. Zaremberg outlined several topics from the paper that he was not certain that he supported, including whether agents should be allowed to be sponsors of purchasing pools; requiring employers to offer choices to their employees; and eliminating plan participation rate requirements. After Mr. Zaremberg’s summary, Chairman Enthoven invited Task Force members to comment on the paper.

Mr. Williams stated that elimination of plan participation requirements would be the death of PPOs due to adverse selection. Chairman Enthoven stated that the rule should be applied only when the employer is trying to offer similar products. Mr. Zatkin suggested that it might be simpler to limit participation requirements to 50%, allowing for dual choice.

Mr. Werdegar asked why so many small employers go through a broker rather than the Health Insurance Plan of California (HIPC). Chairman Enthoven thought the HIPC might not have sufficient marketing
resources. Mr. Zaremberg thought it might be due to the fact that originally the HIPC did not pay a commission to brokers and agents.

Mr. Shapiro stated that he would be developing proposals to expand purchasing pools in the individual and mid-size (51-100 employees) group market, either by expanding the HIPC or creating new purchasing pools. Mr. Zaremberg stated that he did not support expanding the HIPC to the mid-size market because that market does not have the same access problems that the small group market did and the expansion would lead to fewer PPOs.

Dr. Karpf asked if the Task Force was also going to discuss access, in terms of people having an exit strategy when they are uncomfortable with access in their plan. Chairman Enthoven said that the best strategy is to have choice so the plan knows their members can leave. Dr. Alpert stated that maybe the Task Force should consider building in a POS option. Chairman Enthoven said that that strategy had been tried in Maryland but was problematic under the Employee Retirement Income Security Act (ERISA), which prevents the states from mandating any kind of employee benefit. Dr. Northway asked for clarification as to whether the members were suggesting the POS option be available at the annual open enrollment period or at the time that the individual gets sick. Dr. Spurlock stated that POS products tend to rate lowest in terms of patient satisfaction. Ms. O’Sullivan suggested that to avoid ERISA, the Task Force could mandate that all plans have a POS option, similar to state mandates that specific services be covered. Chairman Enthoven believed that would still be a problem under ERISA.

Mr. Lee requested either that this paper be retitled to acknowledge that it does not address individual choice or that it be revised to include options for the individual market. He also felt that the issue of choice of providers was not addressed, only choice of plan.

Returning to the POS topic, Mr. Shapiro stated that the mandate proposed by Ms. O’Sullivan would actually lead to decreased choice. Mr. Romero suggested an alternative that would mandate that if a carrier offers plans, one of those offerings must be a POS plan. Mr. Zatkin responded that not all carriers are in a position to offer POS. Ms. Skubik stated that a POS can be structured in such a way that it is the same price as an HMO. Chairman Enthoven stated that it could even be structured in a way that the plan saves money when the patient goes out of the network.

Mr. Kerr urged Task Force members to think “outside the box.” He suggested a new recommendation that if an employer offers only one choice, the individual should automatically have access to a purchasing pool, regardless of the size of the employer. Mr. Zatkin questioned where the money for this proposal would come from, given that the state can’t force the employer to contribute to the purchasing pool.

PUBLIC COMMENT - 5:55 P.M.

1. **Catherine Dodd** - American Nurses Association of California. Ms. Dodd requested that the Task Force adopt a recommendation stating that provider panels need to reflect all the people who are providing care for the patient, not just physicians. She stated that other states and the President’s Commission have already adopted this proposal. She also asked that regulatory barriers that keep nurse practitioners from providing care within their scope of practice be eliminated.

2. **Judy Gould** - California Dietetic Association. Ms. Gould stated that she agreed with the comments from Ms. Dodd but that she was concerned with the use of the term “licensed”. She suggested using the term “appropriately credentialed” instead because some health professionals, such as registered dieticians and occupational therapists, are not licensed. She also spoke about the issue of consumers being harmed under the managed care system because they cannot get the referrals to dietary programs that they need. She stated that consumers need access to accurate information and scientific, valid nutritional treatments.
3. **Edward Doletsji - California Catholic Coalition.** Mr. Doletsji suggested that the Task Force come to a common understanding about the nature of health care in the state by clarifying whether it is a personal right, a public good, a private commodity, etc.

**VIII. Adjournment - 6:15 P.M.**

Chairman Enthoven declared that without any objection, the business meeting would be adjourned. Seeing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Ms. Stephanie Kauss
I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 8:53 A.M.
The seventh Business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. Roll Call and Declaration of a Quorum - 8:55 A.M.
The following Task Force members were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Barbara Decker, Mr. Alain Enthoven, Ph.D., Ms. Nancy Farber, Ms. Jeanne Finberg, Hon. Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffiths, Mr. Terry Hartshorn, Mr. Bill Hauck, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Mr. Les Schlaegel, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ronald Williams, Mr. Allan Zaremberg, and Mr. Steve Zatkin.

Chairman Enthoven announced that a quorum was present.

The following Ex-Officio Members were also present: Ms. Marjorie Berte, Mr. Michael Shapiro, and Dr. David Werdegar.

III. Opening Remarks [Chairman Alain Enthoven] - 9:00 A.M.
Chairman Enthoven began the meeting with a few housekeeping details. Specifically, he announced that the October 28, 1997 Adopted Risk Adjustment Findings and Recommendations Section was included in members’ manila folders and that copies were also available to the public. He stated that members would be asked to work through the lunch hour in order to complete the business of the day. Pre-ordered lunches would be delivered at approximately 12:30pm. The Chairman also referenced a proposed time scheduled of the business of the November 21, 22 and 25 meetings faxed to members a few days ago.

Chairman Enthoven said that given the amount of work before the Task Force, he would appreciate members complying with the proposed time schedule, and asked members to serve as “time keepers” to ensure discussions on papers do not exceed the time allotted to them.

Understanding that time is constrained given the Task Force’s January deadline to submit its report, Chairman Enthoven requested that members who have additional, written comments on papers discussed November 21 and 22 to submit those comments to his staff by November 25. Members wishing to submit additional, written comments on papers discussed November 25 will be asked to submit their
comments to his staff by November 26. Staff will work through the Thanksgiving holiday to ensure papers are inclusive of comments provided by members and ready for mailing to members on December 2 [for the December 12 and 13 meetings].

Several members indicated their concern that the time frame outlined above was too constraining, however, the Chairman reiterated the Task Force's report deadline and that because of that deadline, members are being asked to comply with the proposed schedule.

Ms. O’Sullivan then questioned whether the Task Force report would continue to sport a prominent statement that several important issues were not considered by the Task Force due to time constraints, but that did not equate that these issues were any “less” important than the issues addressed by the Task Force. Chairman Enthoven assured Ms. O’Sullivan that such a statement would be included in the report and that this issue could be discussed later this morning.

Ms. O’Sullivan also proposed that nothing be included in the Report’s First Volume [Main Report] that was not adopted by Task Force members and that all background papers be included in the Second Volume [Appendices].

After discussion as to whether documents adopted by the Task Force will be included in the report verbatim [without staff alterations], Ms. Alice Singh, Deputy Director for Legislation and Operations indicated that it is the intent of this body and its staff that once a paper [or Findings and Recommendations Section] is adopted by the Task Force, the only changes that can be made to that document by staff are formatting, grammatical and other purely technical changes.

Chairman Enthoven then turned to the subject of the Chairman’s letter saying that if members are too constraining in the development of his letter, he will simply sign a letter that says something like—here is the report. He would then include his own, personal statement in the report just as other members may do. Ms. O’Sullivan suggested the Chairman’s letter be about process and not substance.

Ms. O’Sullivan requested that the Vulnerable Populations paper be discussed today as opposed to tomorrow. Chairman Enthoven responded by stating that the order of business was established pursuant to a Delphi Questionnaire on priorities sent to members about a week ago.

Mr. Williams expressed his concern that members do not have sufficient time to wordsmith each paper and that instead, members should focus their efforts on the recommendations proposed in each paper. Chairman Enthoven agreed.

Mr. Shapiro asked about the economic evaluation of the recommendations to be drafted by Executive Director Romero. Executive Director Romero responded that he would address this issue in his report to the Task Force this morning.

Chairman Enthoven then commented briefly on the revised draft of the Consumer Choice paper that was distributed to the members. Because of the amount of comments that were received regarding this paper, staff felt it was necessary to create a revised version in a line-in/line-out format. He asked members to review the line in/line out version during lunch so that it could be addressed later that afternoon.

He also discouraged members from introducing new topics for inclusion in the Report, due to the fact that staff would not have the time to study and consider them properly. He proposed that a chapter be created in the Report, entitled “Unfinished Business”, for precisely those ideas or comments. He further encouraged members to submit their language for inclusion in this section to his staff by November 25.

A short discussion was held by members regarding some of the members meeting in groups to discuss the finalization of the report and/or minority reports/letter. Pursuant to a request from members, Ms. Singh clarified that the Open Meetings Act allows no more than two members to meet to discuss ideas without such a meeting[s] being publicly noticed.
Chairman Enthoven then turned to the Report transmittal statement stating that he will propose a series of statements to be used to transmit the Report to the Governor and the Legislature, and that members would be asked to adopt the “most positive” statement. The adoption of the Report transmittal statement will be scheduled for the January 5, 1998 meeting.

Lastly, Chairman Enthoven introduced the newest Task Force member, Les Schlaegel. Mr. Schlaegel was appointed by the Governor to replace Katherine Murrell, who had retired a few months ago.

A. Executive Director’s Report [Phil Romero, Ph.D.] - 9:40 A.M.
Executive Director Romero spoke about the economic impact of the Task Force recommendations. He characterized this impact into three categories: spending, trust and the scope of government. He stated that he could have estimates ready for the members review by the December meetings but his recommendation would be to not publish a formal economic impact assessment as a component of the Report. Chairman Enthoven agreed with Executive Director Romero’s recommendation and suggested that an additional “disclosure statement” should be included in the Report stating that the Task Force was not able to cost out each recommendation due to time and staffing constraints.

Mr. Shapiro warned of potential criticism the Task Force may face if a cost analysis is developed too quickly and without members input. Executive Director Romero responded stating that perhaps it would be appropriate to take a straw pole vote on the desirability of effort to establish such a cost analysis before the January 5, 1998 meeting. Ms. Griffiths echoed Mr. Shapiro’s comments.

Dr. Spurlock suggested using the Delphi process to prioritize each adopted Task Force recommendation.

Executive Director Romero concluded his report by stating that without objection, he would think about the cost analysis of each recommendation on “a background basis”, and instead, devote his time to the more qualitative prioritization efforts Dr. Spurlock suggested. He may have more time to prepare a cost analysis of the adopted recommendations after January 5, 1998, but cautioned that such an analysis would not be published under Task Force auspices. No objection was stated.

Chairman Enthoven then moved to the next report.

1. Presentation of the Public Survey Results [Helen Schauffler Ph.D.] - 9:55 A.M.
Executive Director Romero introduced Mr. Mark DiCamillo of Field Research Corporation and Mr. Lee Kemper of the California Center for Health Improvement (CCHI), who both worked on the public survey. Executive Director Romero stated that the survey was still in the field going through the last round of interviews. He also said that two formal products will be produced for the Task Force members, one for inclusion in the final report and one more reader-friendly version produced by CCHI. Most of the survey results had not yet been released in order to curb any bias that might result in the remaining interviews. Also, Executive Director Romero mentioned the California Health Care Foundation, the Robert Wood Johnson Foundation and the Institute for Healthcare Advancement, all of whom contributed financially to the production of the survey.

Dr. Schauffler stated that the objective of the survey was to document the extent to which Californians report having experienced a problem with their health plan in the last year, which problems they were reporting, how severe the problems were and differences in the problems by managed care model type. The survey was conducted in the form of a telephone interview with phone numbers being chosen at random. There were three separate samples done, all of insured, adult Californians. The first dealt with the general insured population; the second dealt with insured, adult Californians who were dissatisfied or very dissatisfied with their health plan; the third sample, which had not yet been completed, included persons who have a serious or chronic illness.
The survey found that 76 percent of the population overall were satisfied or very satisfied with their health plan, with about 10 percent being dissatisfied or very dissatisfied. Satisfaction with the healthcare system as it relates to their families was lower. The percentage who said they were satisfied with the health care system was almost half the rate of those who reported being satisfied with their plan. Similarly, the dissatisfaction rates with the health care system were almost double the health insurance plan dissatisfaction rates.

The survey also tracked the satisfaction rates by type of managed care plan. Three models were looked at: group/staff model HMOs, IPA/network model HMOs and PPOs. Persons in the IPA/network model were less likely to be very satisfied with their plan compared with the group/staff HMO. Similarly, persons in IPA/network plans were significantly more likely to be dissatisfied with their plan compared to both group/ staff HMOs and PPOs.

Californians were also asked whether or not they have had a problem with their health plan in the last year. It was found that 42 percent or 6.7 million people have reported some problem with their plan in the last year. The list of thirteen problems reported were listed in five categories: coverage, claims and payments, care and service, choice, and accessibility. Dr. Schauffler reviewed the prevalence of each of the problems, including: 13% said they had problems with billing or payment of claims or premiums; 11% said that they did not receive the most appropriate medical care or the care they needed; 10% stated that there were delays in getting their medical care; 10% had difficulties getting referrals to specialists; 11% said health care providers were not sensitive to their needs or were not helpful; 8% said they had had difficulty in selecting a doctor; 7% were forced to change their doctor; 4% were forced to change their medications; communications difficulties were reported by 5%; and transportation problems were reported by 4% of the general insured population.

Dr. Schauffler stated that the results show a direct linear relationship between the likelihood of having had a problem with your plan and how satisfied you are with that plan.

Californians were also asked about their overall view of the health care system and the extent to which they feel it needs to be changed. Approximately 84 percent, or 13.4 million people, want some sort of change. This change falls between minor changes to a complete overhaul. Again, a strong linear relationship is found between the desire for change in the health care system and the likelihood of having had a problem with one's plan in the last year.

The survey also looked at the different types of problems reported by people in different types of managed care plan. The survey found that Californians in IPA/network model HMOs were significantly more likely to have difficulty in getting referrals to specialists and selecting a doctor or hospital, compared to those in staff/group model HMOs or PPOs. Californians in IPA/network plans were also more likely to report problems with the plan not covering important benefits, misunderstandings over benefits or coverage, not getting the most appropriate care, and being forced to change doctors. In the group/staff HMO model, transportation problems were significantly more likely. People in PPOs were more likely to have problems with billing and payment of claims or premiums, their plan not covering important benefits, and misunderstandings about benefits or coverage, compared to those in staff/group model HMOs. There were also a number of problems that showed no significant differences between the models which suggests that these problems were really systemic difficulties and not a function of the organization of care.

Californians were also polled about the health impacts of the problems they reported with their plans. 13% of insured, adult Californians said that because of their problem, they experienced pain and suffering longer than they should have. 6% said their problem led to other health conditions that were not previously present. 9% said their problem led to the worsening of their health condition. 2% of insured, adult Californians reported that their problem with their health plan in the last year led to a permanent disability and affected their daily living activities.
Dr. Schauffler wanted to make sure that the Task Force members were presented with information regarding the importance of choice to Californians. 81% of those surveyed stated that having the choice of more than one plan was important or very important. However, 23% were offered only one plan and 41% were offered only one or two plans. This is significant because people who had the choice of only one or two plans were significantly more likely to experience a problem with their plan compared to people who had the choice of three or more plans.

The survey also polled people about whether their problems had ever been resolved. 57% of those who had a problem said that they had tried to resolve their problem, with 4% stating they had contacted a state or local agency for assistance. Over half (52%) said that their problems had been resolved while 42% said that their issues had not yet been resolved.

The survey also asked about satisfaction with the handling and resolution of complaints. Only 11% of those who had a problem were very satisfied with the way their health plan handled their complaint, 28 percent were satisfied, 18 percent were dissatisfied and 11 percent were very dissatisfied. Only 6 percent of those whose problems were resolved said the resolution exceeded their expectations, while 40 percent said their problem was solved satisfactorily. About 32 percent said they were not completely satisfied and 12 percent claimed they were not satisfied at all.

Several members had questions regarding the survey results. Mr. Gallegos asked if problems with the plans were solved through an internal process. Dr. Schauffler indicated that the majority of the issues were solved inside the plan. He also asked if any Medi-Cal or Medicare people were included in the surveys, which Dr. Schauffler said there were. Dr. Werdegar asked wanted to know what language the surveys were done in. They were conducted in both English and Spanish.

IV. Consent Items - 10:36 A.M.
Chairman Enthoven introduced the next order of business, the adoption of the Consent Items. The only consent item was the proposed August 7, 1997 meeting minutes. Vice Chairman Kerr moved to adopt the Minutes, with minor changes [add Ms. Berte’s name to the list of August 7 meeting attendees and to delete Ms. Griffiths’ name from that list.] Mr. Lee seconded the motion which was unanimously adopted by the Task Force.

V. Action Items - 10:40 A.M.
A. Discussion/Adoption of Proposed Amendments to Standing Rule #4
Ms. Singh introduced the next order of business - to adopt Standing Rule No. 4.5 which was composed of five amendments.

Amendment No. 1
Amendment No. 1 listed and described the three components of the Report to be prepared pursuant to AB 2343 [Ch. 815, Stats. Of 1996]: I. Executive Summary, II. Main Report and III. Appendices. Amendment No. 1 was moved for adoption by Mr. Rodgers and seconded by Dr. Spurlock. Mr. Lee then moved to delete the list of and information pertaining to managed care issues not addressed by the Task Force as a component of the Main Report. Mr. Perez seconded the motion and it was adopted with 21 affirmative votes. Discussion then stemmed to include in the Executive Summary a statement indicating that the Task Force members were unable to address all issues surrounding managed care, but that does not equate that those issues any less important.

Members then discussed the option of including those letters [or minority reports] written by members re: issues addressed in the Report in the Main Report. Mr. Hauck then moved to include those letters [or minority reports] written by members re: issues addressed in the Report in the Main Report. Mr. Lee seconded the motion and it was adopted with 21 affirmative votes. Ms. Singh then reiterated that all such
letters must be submitted to her by noon on December 19 to ensure their inclusion in the January 5, 1998 meeting packet.

Mr. Perez then moved to substitute the word “may” with the word “shall” and deleting the phrase “but not limited to” regarding the composition of the Report prepared pursuant to AB 2343. Ms. O’Sullivan seconded the motion and it was adopted with 22 affirmative votes.

After some discussion, Ms. O’Sullivan then moved to substitute the phrase “the full papers that are required by AB 2343” with “the Findings and Recommendations Sections of those papers that are required by AB 2343.” Mr. Perez seconded the motion and it was adopted with 22 affirmative votes.

Mr. Perez called for the question on the main motion to adopt Amendment No. 1, as amended. The main motion was adopted with 22 affirmative votes.

Amendment No. 2

Amendment No. 2 stated that the individual components of the Main Report must be adopted by the Task Force. Mr. Perez made a motion adopt Amendment No. 2 up to and ending with the sentence ending with “set forth in Standing Rule No. 4”. Mr. Lee seconded the motion which was adopted with 18 affirmative votes.

Amendment No. 3

Amendment No. 3 stated that the Executive Summary did not require adoption by the Task Force. Mr. Perez moved to adopt Amendment No. 3 with the following revisions: delete the words “does not” and change the word “require” to “requires” to in essence, require Task Force adoption of the document. This motion was seconded by Ms. O’Sullivan. Chairman Enthoven responded to this motion by stating that he wanted the members to understand exactly what they would be voting for and what a vote would likely do to the end report. Dr. Rodriguez-Trias and Ms. Decker responded that they were in favor of the members reviewing the Executive Summary, given its importance. Mr. Perez made another motion insert the words “as to form and content” after “Task Force”. The motion was seconded by Mr. Lee and adopted with 23 affirmative votes.

The Main Motion to adopt Amendment No. 3, as amended, was adopted with 23 affirmative votes.

Amendment No. 4

Amendment No. 4 provided that the Report Appendices do not require Task Force adoption. Ms. Bowne moved adoption of Amendment No. 4 and it was seconded by Mr. Rodgers. Mr. Lee clarified that all documents that are included in the report should be made available to the members for review only and not for voting. Members then adopted Amendment No. 4 with 22 affirmative votes.

Amendment No. 5

Amendment No. 5 stated that the members would vote on language that would be used to transmit the final report to the Governor and the Legislature. Chairman Enthoven moved to remove language in the amendment that would create any ambiguity about the January 5 deadline. Mr. Rodgers moved to adopt this amendment which was seconded by Dr. Rodriguez-Trias. Members had a discussion about this change and whether it would limit them in their ability to call for additional meetings of the Task Force if they were needed. Members adopted the proposed amendment with 22 affirmative votes.

Members then adopted Amendment No. 5, as amended, with 22 affirmative votes.

Recess - 11:50 A.M.

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B. Adoption of the Standardization of Benefit Paper's Finding & Recommendations Sections - 12:05 P.M.

PUBLIC COMMENT:

1. Maureen O’Haren - California Association of Health Plans. Ms. O’Haren was concerned that the reference packages were being recommended for the individual and small group markets outside of purchasing groups. She felt that reference packages would be best for large employers and new purchasing groups. She was also concerned that the recommendations would lead to the reference packages being required in the marketplace, which would stifle innovation.

TASK FORCE DISCUSSION:

Ms. Bowne asked that the title and Recommendation 1 be changed to refer to standardized benefit format and terminology rather than standardized contracts. She also asked for clarification in Recommendation 2 that the reference contracts are optional and not required. Dr. Karpf, Dr. Gilbert, Mr. Williams, Mr. Zatkin, and Mr. Hartshorn agreed with Ms. Bowne. Mr. Ramey disagreed, stating that the contract is the only enforceable part of the transactions between the consumer and the purchasers and if it was removed the whole paper would become invalid.

Ms. Decker felt the items in the recommendations didn’t seem to fit together and would not be possible to adopt as a whole. Ms. O’Sullivan agreed and recommended keeping the contract language in the paper.

Mr. Shapiro asked whether the Task Force shouldn’t just use the standard models that CalPers, PBGH and HIPC already had available as reference packages. He stated that no one had to necessarily sell or buy these materials, but they could be used simply as a comparative tool for the buyers.

Both Dr. Rodriguez-Trias and Mr. Rodgers agreed that there is a need to separate what the consumer needs to evaluate a plan and what the employer requires to have an understanding of what is in their contract. They thought that these two issues should not be together in the same recommendation. The issue of whether certain language in the recommendation could be construed as misleading to the consumer was addressed by Dr. Northway and Ms. Finberg. Ms. Finberg stated that she feels standardization is very critical for consumers and argued to keep the word “contracts” in the recommendation.

VOTING:

Recommendation No. 1

Ms. Farber moved to adopt Recommendation No. 1 as amended to read: The Governor and the Legislature should direct the state agency (or agencies) that is (are) charged with regulating managed care to adopt a proactive policy towards the development of standard coverage models that emphasize clarity of language and structure of benefits in order to enhance comparability by purchasers and consumers. Mr. Williams seconded the motion and the motion failed with only 10 affirmative votes.

Mr. Perez then moved to adopt Recommendation No. 1, as originally proposed with minor changes proposed by Chairman Enthoven. The Chairman seconded the motion and Recommendation No. 1, as amended, was adopted with 19 affirmative votes.¹

Recommendation No. 2(a) through (d)

Mr. Perez moved to adopt Recommendation No. 2(a) through (d) as proposed. Ms. Finberg seconded the motion which was adopted by the Task Force with 19 affirmative votes.

¹ Recommendation No. 1, as adopted, reads "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."
Recommendation No. 2(e)
Mr. Perez moved to adopt Recommendation No. 2(e) with the amendment that “or” be substituted with the word “and” regarding the required publishing and providing plan comparisons to employers and consumers. Ms. Finberg seconded the motion which was adopted 16-7.

Recommendation No. 3
Mr. Lee moved to adopt recommendation 3 as originally proposed. Mr. Perez seconded the motion. After some discussion, several informal, technical amendments were accepted without objection. Recommendation No. 3 was adopted with 20 affirmative votes.2

Findings Section
Mr. Perez moved to adopt the Findings Section, as proposed. Vice Chairman Kerr seconded the motion and it was adopted with 20 affirmative votes.

Lunch Break - 1:20 P.M.

C. Adoption of the Health Industry Profile Findings Section - 2:00 P.M.
The Chairman stressed that he and his staff had taken great efforts with the Health Industry Profile paper to incorporate the views of all members. Notably, all references to any managed care corporation had been removed. The Chairman stressed that pursuant to the adoption of Standing Rule No. 4.5, only the Findings Section of this paper would be put to a vote.

The discussion proceeded and Vice Chairman Kerr moved to adopt the Findings Section of the Health Industry Profile paper and Mr. Rodgers seconded the motion.

Dr. Karpf asked that the paragraph about medical loss ratio that was in the body of the report also be included in the executive summary. The Chairman asked if there was any objection to this technical amendment - no objection was made. Thus, the amendment was accepted.

Ms. O’Sullivan was concerned that the information about the MediCal issue that was discussed in the paper required updating. She also wanted to add the fact that millions of MediCal beneficiaries were being transferred to managed care. To accommodate Ms. O’Sullivan’s concern, the Chairman proposed, without objection, to add on page 3 in the paragraph entitled “Purchasers”, “…In 1994, government sponsored programs such as MediCare and MediCal accounted for about 41% of California’s total health care expenditures of $105.3 billion. MediCal is moving increasing numbers of members to managed care with some illustrative numbers…” No objection was made and the amendment was accepted.

Members adopted the Findings Section, as amended, with 23 affirmative votes.

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2 Recommendation No. 3, as adopted, reads, “(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.”
D. Adoption of the Managed Care’s Impact on Quality, Access & Cost Findings [2:12 P.M.]

PUBLIC COMMENT:

1) **Catherine Dodd** - American Nurses Association (California). She wanted the Task Force to know that since the penetration of managed care and the downsizing of skilled nurses, there had been a dramatic change in quality in hospital care. As managed care replaced skilled nurses with unlicensed personnel, the skill mix went down in order to meet the cost demands.

2) **Beth Capell** - Health Access. Her organization had some major concerns with this paper, especially the fact that the findings rely heavily on studies paid for by the American Association of Health Plans. They also thought that the paper was internally contradictory and contradicts other Task Force papers.

TASK FORCE DISCUSSION:

The Chairman then members to commence their discussion on the Findings Section of this paper. Ms. Bowne asked that wording other than “pharmaceuticals” be used, the reason being that outpatient drugs are not a Medicare covered benefit. She suggested using the words “health prevention and promotion” or “prevention and health promotion”. Dr. Alpert suggesting changing the wording in the opening sentences to read “some change is good and necessary, change however is sometimes uncomfortable”. Mr. Perez added that he thinks using the word “negative” is not necessarily a bad thing. He thought it should be reflected to make the statements equal. Vice Chairman Kerr finally resolved this issue by suggesting deleting most of the paragraph that dealt with this positive/negative issue of change [delete the last three sentences of I. Introduction on Page 1]. There was no objection to Vice Chairman Kerr’s suggestion, thus it was accepted by Chairman Enthoven.

Ms. Bowne then moved to adopt the Findings Section with the above technical amendment and it was seconded by Dr. Karpf.

Ms. Finberg stated that she felt the paper did not go far enough in describing the impact of managed care on quality, access and cost from a consumer perspective. She did not feel that she could vote for the paper as it stood.

Dr. Alpert then moved to amend the motion to remove the word “continuity” [in the bottom paragraph on Page 1] and the words “rewarding quality” [in the continued sentence on the top of Page 2]. He felt both these words were being used in the context that they were directly attributable to managed care. Dr. Karpf seconded this motion. The amendment was adopted with 22 affirmative votes.

Both Dr. Northway and Ms. Bowne felt that there has been a decreased amount of charitable health care given to those who are uninsured. Given that the employment rate is at the lowest point it had been in a while, it is disappointing that the uninsured rate is still rising.

Ms. O’Sullivan made a motion to delete the line on Page 2 that read “lower HMO premiums mean more people can afford health care”. She felt this was a misleading sentence and it sounded like people could now afford health care who couldn’t have done so before due to slower cost increases. Dr. Conom seconded the motion. Chairman Enthoven spoke in opposition to this amendment and he cited examples of data that prove the statement in question was correct. Members discussed the pros and cons of deleting the statement. Ms. Farber agreed that the numbers of uninsured were growing and she cited several examples of that happening here in California in the Silicon Valley.

Mr. Lee moved to end debate on this issue. A two-thirds vote was needed to call the question. The motion failed.
Vice Chairman Kerr moved to substitute Ms. O’Sullivan’s amendment with the following language to read “lower HMO premiums keep coverage affordable for more people”. The motion was seconded by Ms. Decker and adopted with 23 affirmative votes.

Ms. O’Sullivan moved to move the language that deals with uncompensated care on Page 22 of the background paper to the 3rd paragraph on Page 2. Ms. Bowne seconded the motion. The motion failed 9-11.

Dr. Northway then moved to amend the first sentence in the 3rd paragraph by adding after “Despite lower overall costs generally...” “as the number of uninsured continues to be high”. Dr. Spurlock seconded the motion. Chairman Enthoven asked whether any member had data about a population survey that would show the actual number of uninsured people. Mr. William’s felt that the data would show that California would have a large population of uninsured compared to other locations. The motion was adopted with 25 affirmative votes.

Members then adopted the Findings Section, as amended, 16-4.

Break - 3:05 P.M.

E. Adoption of the Expanding Consumer Choice Findings & Recommendations Section - 3:30 P.M.

Public Comment:
1) Conni Barker - California Psychiatric Association. Ms. Barker pointed out that the doctor/patient relationship discussion in the paper did not discuss continuity of care if a doctor is removed from a panel. She asked that the Consumer Choice paper and Doctor/Patient Relationship papers be cross-referenced.

2) Maureen O’Haren - California Association of Health Plans. Ms. O’Haren was concerned with the recommendations about participation requirements in the small group market, which she felt would lead to adverse selection that could not be sufficiently compensated by risk adjustment. She was also concerned with the potential amendment that would require every HMO to be a point of service plan. She felt this recommendation would actually eliminate choice of plan types from the market place.

3) Richard Figueroa - Senate Insurance Committee. Mr. Figueroa argued for expanding the market reforms for the small group market (2-50 employees) to the mid-size (51-100 employees) market. He also argued for individual-market reforms. He supported proposed amendments that had already been made by Mr. Shapiro but were not incorporated into the Choice paper.


5) Anne Eowan - Association of California Life and Health Insurance Co. Ms. Eowan was concerned with the recommendations regarding minimum participation requirements and their potential to create adverse selection for plans. Regarding reforms in the 51-100 employee market, she stated that those employers had not requested the reforms because they are already able to negotiate their own benefit plans. She felt the recommendation would lead to less choice and to more self-insured plans.

6) Beth Capell – Health Access. Ms. Capell voiced support for the Senate Insurance Committee suggestions regarding the individual market and the market for mid-size (51-100) employers. She urged the members to consider the implications of the ERISA recommendation very carefully because without an employer mandate, ERISA reforms might lead to fewer employers offering coverage.

The members began discussing the Findings and Recommendations Section. Dr. Karpf asked the Chairman if the members could consider some issues that were not in the paper. Some of his suggested issues were point of service, and choice relating to how much a consumer is willing to pay to get a better range of choice. Executive Director Romero made a suggestion that the members not recommend a mandate on this issue that is not fully developed, but rather suggest a study or further work be done on the idea. Ms.
Finberg asked what the percentage of people in the state are who have a point of service option. Ms. Singer stated that she believed it was eight percent with the point of service and another 23 percent with PPO.

**Recommendation No. A.(1)**
Mr. Perez commented, regarding the recommendation to change ERISA, that he would not vote on an issue that would offer less choice by prizing out the employer. Ms. Bowne said that until the issue of more choice becomes mandated or there is some structural change in the system, the employer will not offer more choice to the consumer mainly because of the issue of cost. Mr. Williams stated that he felt the more choice is offered, the more it seems to be diminishing. The more people that have access to health care, the more people seem to come forward who have no health care at all. Mr. Shapiro stated his opinion that there is a problem in the market place that can be solved with choice. He thinks that there are certain risks associated with choice, but the question becomes, do you promote choice given those risks or do you not, saying the risks are too great.

Executive Director Romero compared the discussion points with some of the information in the public survey. Mr. Perez thought that it is unreasonable to put the burden of offering choice on the employer by mandating the issue. He stated there are additional costs other than those borne by the employee. There are administrative costs that will have to be covered by the employer. Mr. Zaremberg agreed with these statements and added that when you raise the costs you run the risk of reducing access.

Mr. Lee suggested a technical change to the language and Mr. Perez made a suggestion to delete some of the language. Basically, Mr. Perez wanted to strike any reference to ERISA in creating mandates for employers to offer more choice. An informal straw vote was taken on both these revisions. The vote on Mr. Lee's revision received 7 votes and Mr. Perez's revisions received 16 votes.

Mr. Perez then made a motion to delete Recommendation No. A.(1). Dr. Spurlock seconded the motion. Mr. Zaremberg made the observation that the point of contention seemed to be mandating the employer to provide more choice. He thought the Task Force might be feeling frustrated because the Congress is in a better position to deal with the issue. The motion was adopted with 22 affirmative votes.

**Recess - 4:35 P.M.**

**Recommendation A.(2)**
The second recommendation stated that the state would prohibit plans from setting minimum participation requirements for participation in their plans. The intent was that the recommendation would only be implemented to the degree that negative consequences can be avoided. Ms. Bowne wanted to make sure the members understood what the current federal law requires. The law that was passed in 1996 requires all carriers who serve the small group market to guarantee issue of their products to all small employers. Further, once the plan contracts with an employer, it must take anyone and their dependents who elects coverage. Chairman Enthoven asked that the members take a straw poll to determine whether they wanted to discuss this section of the paper. Before the straw poll could be taken, Ms. Bowne moved to delete Recommendation No. A.(2). The motion was seconded by Mr. Williams and adopted with 16 affirmative votes.

Mr. Hauck moved to adopt Recommendation No. B.(3) as proposed and Mr. Perez seconded the motion. The motion was adopted with 24 affirmative votes.

Several members made suggestions to hold off on all discussions of choice until the meetings in December. However, a majority of members chose to move on to the alternative recommendations.

**Alternative Recommendation No. 1**
The first alternate recommendation concerned guaranteed issue, plan design, disclosure, and premium
rating limitations for employers with 51 to 100 employees so that purchasing cooperatives can form in the mid-sized market. Ms. Decker made a motion to adopt this recommendation and it was seconded by Vice Chairman Kerr.

A discussion on this recommendation started with Mr. Zaremberg asking what the consequences were of this recommendation once rate bands and guaranteed issuance were applied. He asked if the consequences would be the same as those seen in the small group market. Mr. Williams felt that there would be less choice - fewer PPOs - and more self-insured employers if this were adopted. Mr. Zaremberg mentioned Mr. Kritchlow, who had spoken to the Task Force at one of their meetings, and who was in the process of starting a purchasing pool for medium sized businesses without the benefit of rate bands. He wanted to know whether it is better to have 51 to 100 employers in a purchasing pool like Mr. Kritchlow's or have them in the HIPC.

The members ended their discussions and adopted Alternative Recommendation No. 1.

Alternative Recommendation No. 2
They moved on to alternate recommendation No.2, as submitted to staff by Mr. Shapiro. This recommendation calls for the legislature to enact a law that increases consumer choice by allowing individuals to purchase coverage through purchasing cooperatives. Mr. Shapiro asked that the discussion recognize that these reforms can't be made unless certain market reforms to mitigate the risk are also passed. He suggested the second recommendation be modified to include the mitigation requirements.

Chairman Enthoven had a number of comments about this recommendation. He first wanted to stress that this is not a managed care issue. It is a broad health issue that exists with or without managed care. He had facts that premiums were on the rise due to adverse selection, which has to be paid for somehow in the market. Mr. Shapiro asked that consideration of recommendation No.2 be withdrawn.

Alternative Recommendation No. 3
Chairman Enthoven moved on to alternate recommendation No.3, which would enable agents and brokers to establish purchasing alliances through the Department of Insurance (DOI), but incorporate provisions to track and prevent risk selection. No member claimed ownership of this submittal so the Chairman moved on to recommendation No. 4, submitted by Vice Chairman Kerr.

Alternative Recommendation No. 4
Recommendation No. 4 stated that DOI would be responsible, through brokers and agents, to track and report and improve by 20 percent per year the proportion of employer clients who offer a choice of health plans. Mr. Lee suggested a technical amendment to the recommendation. He asked that DOI require agents and brokers to submit yearly reports and the DOI should do a summary report on the status and in two years time, decide whether it should be mandated or not. Mr. Williams asked how this amendment would affect the agents' fiduciary obligations to the employer. Mr. Lee stated that the amendment does not affect that issue. Dr. Karpf moved to adopt this amendment and it was seconded by Mr. Perez. The members then voted on recommendation No.4 as amended and it failed 6-1.

Alternative Recommendation No. 5
Alternate recommendation No. 5 concerned a closed panel HMO product contract that gives a consumer access to indemnity coverage after a deductible is met. Dr. Rodriguez-Trias made a motion to adopt this recommendation and it was seconded by Vice Chairman Kerr. Dr. Alpert was concerned that this recommendation would cost significantly more money. He advocated making this option available only to persons with life threatening or life disabling conditions and with the condition that the provider agrees to be paid in the same way the plan would have paid its own provider. Dr. Spurlock also liked the intent of the proposal and suggested that it be tied to dispute resolution. However, he was concerned that this recommendation would actually diminish choice for those people who are satisfied with their current HMO plan with no point of service (POS) option.
Mr. Hartshorn felt that people like choice but what they really want is control - control to change doctors. Ms. Decker wanted to point out that surveys have shown that people in POS plans are the least satisfied with their plans. They have the option of opting out and they give their plans the worst ratings. Mr. Zatkin pointed out that to carry out this opt out idea would end up costing the consumer additional funds and that would not be fair to those in the plan who were satisfied with the program. Chairman Enthoven stated that he would vote against this recommendation because he feels very strongly that people should be provided the opportunity to purchase good quality care at a reasonable price.

Vice Chairman Kerr made several suggestions to make this more appealing. First, you would have restrictions on why you would opt out. Only the most important, critical issues would be covered. Second, the providers you opt to go to would have to prove they would be able to provide better services than those in the plan that the person left. And third, the consumers would have to agree that they were going to opt out.

Mr. Perez moved to defer this recommendation until the December meeting. Ms. Bowne seconded this motion. Members adopted the motion to defer with 19 affirmative votes.

VI. Discussion Items

A. Discussion of the Provider Incentives Paper - 6:00 P.M.

Chairman Enthoven began the discussion of the Findings and Recommendations Section of the paper entitled, “Financial Incentives for Physicians in Managed Care”. He decided that the other three agenda items would address at tomorrow’s meeting. Mr. Shapiro also asked that any public comment on the paper be at the end of the discussions, if any time remained, given the amount of material still to cover in a short time span. The Expert Resource Group gave a very brief discussion of the findings in the paper. Mr. Zatkin highlighted a few of the items that reflected the previous Task Force discussions on this paper. First, all compensation arrangements contain incentives that can have positive or negative effects and there can be an infinite number of these arrangements. The second is that there is no evidence showing a relationship between specific financial arrangements and adverse outcomes. Of particular concern are incentives which place an individual or small group of health group practitioners at risk for the cost of referrals for their patients.

The ERG members recommended that health plans be required to disclose to the public the general methods of payment made to contracting medical groups in the types of financial incentives used. They recommended that this be done in clear and simple language that is easy for the consumer to understand. They also recommended a pilot project with medical groups to develop a method for disclosure and that they asked that all provider groups and health practitioners be required to disclose their method of compensation and incentives paid to their subcontracting providers. The fourth recommendation was a prohibition of certain intense incentive arrangements for individual physicians, including capitation arrangements that include the cost of services for that practitioner’s patients. Lastly, they recommended stop loss protection for all physicians under these circumstances.

Several of the members asked Mr. Zatkin to clarify some of the language in the recommendations. Dr. Gilbert asked if there was a difference between incentives tied to individual decisions versus total decisions over time. Mr. Zatkin stated that the individual is at risk for the cost of referral for that practitioner’s patients. The members had a short discussion about the Department of Corporations and their review process as it relates to small groups. Staff said that DOC does in fact look at the small groups, but they only do cursory reviews. Mr. Zatkin stated that DOC is going to have limited capacity and manpower to carry these reviews out, which was why recommendation No. 6 states that a private sector approach should be established to look at this issue and not leave it to the government to mandate.

Dr. Spurlock had some additional comments and questions regarding this ERG paper. He thought that the discussions on physicians’ services and unethical behavior was a bit fuzzy and unclear. He thought that there definitely should be some sort of system to gauge behavior and regulate it. Mr. Hartshorn
agreed with Dr. Spurlock’s comments but felt that a little more data would be helpful to be absolutely clear on the issue. Dr. Gilbert was concerned that there is no real evidence to demonstrate that adverse outcomes have occurred.

Mr. Shapiro had several recommendations. He first wanted to encourage compensation arrangements that include rewards for quality care and other non-financial factors. Second, he suggested that the federal rule that requires stop loss and surveys be applied to all commercial plans. Mr. Shapiro also pointed out the timing of payment issue that was include in the background materials but not in the recommendations. Mr. Zatkin explained that the intensity of the incentive increases the more frequently the incentive is calculated – e.g., monthly incentives are more intense than annual incentives.

Chairman Enthoven proposed taking straw polls on the recommendations to see where the members stood:

- Recommendation No. 1 obtained majority support
- Recommendation No. 2 obtained majority support
- Recommendation No. 3 obtained majority support
- Recommendation No. 4(a) obtained majority support with minor changes
- Recommendation No. 4(b) obtained majority support with minor changes
- Recommendation No. 4(c) obtained majority support
- Recommendation No. 5 obtained majority support
- Recommendation No. 6 obtained majority support
- Recommendation No. 7 did not obtain majority support

Dr. Karpf responded to recommendation No. 6 by stating some sort of regulatory body was needed to head up the committees that had been established.

Public Comment:

1) Maureen O’Haren – California Association of Health Plans. Ms. O’Haren was cautioned the Task Force members that the federal rules regarding stop loss protection only apply to plans with less than 25,000 covered lives and that the calculations involved are very complex and costly. She suggested a recommendation that the plans either do this calculation or require the stop loss protection. She also suggested that accreditation organizations such as NCQA, rather than purchasers, review plans’ incentive arrangements.

2) Catherine Dodd – American Nurses Association. Ms. Dodd asked that nursing organizations be represented on blue ribbon panels recommended by the Task Force. She also favored using incentives based on quality.

Ms. O’Sullivan made one last suggestion to add the nurses or their organization to the panels and task force asked for in Recommendation No.6. A straw poll was taken regarding this suggestion and a majority of members supported the proposed amendment.

VII. Adjournment - 7:08 P.M.

Chairman Enthoven declared that without any objection, the business meeting would be adjourned. Seeing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Stephanie Kauss, Alice M. Singh, and Teri Shaw
These minutes were not available for Task Force adoption before its last meeting on January 5, 1998; therefore this document was not formally adopted by the Task Force.

Saturday November 22, 1997
8:30 AM to 5:14 PM.
Chamber of Commerce 12th Floor Conference Room
1201 K Street
Sacramento, California

I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 8:33 A.M.
The eighth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven at the Chamber of Commerce Building in Sacramento, California.

II. Roll Call and Declaration of a Quorum - 8:37 A.M.
Task Force Administrative Assistant, Lawrence Ahn, took roll. The following members were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne, Ms. Barbara Decker, Alain Enthoven, Ph.D., Ms. Nancy Farber, Ms. Jeanne Finberg, Hn. Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffiths, Mr. Terry Hartsom, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Ronald Williams, Mr. Allan Zaremberg, Mr. Steven Zatkin, and Mr. Les Schlaegel.

The following Ex-Officio members were present: Ms. Marjorie Berte, Ms. Kim Belshe, Mr. Michael Shapiro, and Dr. David Werdegar.

III. Opening Remarks - 8:42 A.M.
Chairman Enthoven opened the meeting by stating that today’s meeting was the second in a three day series of meetings and that today’s meeting would not include any voting activities. He said that given the time constraints, members would be asked to work through the lunch hour and that lunch would be delivered. The Chairman also indicated his strong preference to end the meeting by 5:00 pm today.

Chairman Enthoven then prioritized the papers for today’s discussion in the following order: 1) Academic Medical Centers; 2) Physician-Patient Relationship; 3) Regulatory Organization; 4) Dispute Resolution; 5) Consumer Involvement, Communication, and Information; 6) Practice of Medicine; 7) New Quality Information Development; 8) Vulnerable Populations; and 9) Integration: A case Study on Women.

IV. Old Business
A. Discussion of the Academic Medical Centers Paper - 8:44 A.M.
Dr. Karpf began the discussion by proposing two changes to the paper. The first change would be on the first page where it lists the hospitals associated with Academic Medical Centers (AMCs). Dr. Karpf suggested that rather than saying “…teaching hospitals studied in this report…,” the word “listed” should be substituted for “studied” because the paper did not study all of the Academic Medical Centers in detail.
Dr. Karpf suggested a second change to the paper related to the last paragraph on page 2 under the discussion of Loss of Disproportionate Share. Dr. Karpf proposed that the language be changed to note that as Medi-Cal patients leave, traditional safety net providers have a real financial burden and are endangered. Mr. Rodgers felt that the system needed to be restructured to recognize the excellence of the Academic Medical Centers and to allow them to contract broadly throughout the system, rather than creating a mandated program for their support. Dr. Gilbert objected to the concept that AMCs are somehow “skimming” healthier patients under the managed care system; he felt skimming occurred more under the fee for service system.

Ms. Finberg stated that the issue of the effects on safety net providers goes beyond AMCs. In response, Chairman Enthoven proposed that the language read “AMCs and other safety net providers are concerned.”

Mr. Lee and Ms. Bowne felt that the report should discuss the effects of managed care on the full range of health professions education such as physician assistant programs, pharmacy programs, dental programs, nurse practitioner programs and not just physician training programs. They agreed that the paper should explicitly state that only one component of health professions education was addressed.

Mr. Lee also brought up the point that managed care should be involved in residency programs. Ms. Bowne agreed but pointed out that most health plans contract with networks. In order for residents to be placed in managed care settings, networks would need to participate in residency programs.

Dr. Werdegar felt that the paper should not mislead the readers that university hospitals are the only academic teaching centers. Chairman Enthoven agreed and proposed language to clarify the issue.

Ms. Severoni proposed a change to the language regarding Medi-Cal patients and managed care she suggested changing the word “transfer” to “movement”, because transfer does not imply a choice. This change was supported by Dr. Karpf and Dr. Spurlock. However, Dr. Northway stated that involuntary transferring of Medi-Cal patients does in fact occur in some cases. Dr. Enthoven agreed to change the language.

Dr. Northway also proposed a language change regarding the statement “Medi-Cal recipients are moved to private hospitals.” He felt that private hospitals were given a negative connotation and proposed that the language be changed to “from safety net providers to non-safety net providers.”

Ms. Farber felt that issues about experimental care and denial of access to clinical trials should be addressed in the paper. Dr. Karpf agreed that it was a very important issue but that it would be discussed with other issues.

Dr. Rodriguez-Trias and Dr. Spurlock expressed concern about sources of funding for teaching as AMCs clinical revenues decrease. Dr. Spurlock felt it was unfortunate that the Task Force had not addressed the issue of all-payer funding. Dr. Spurlock and Dr. Rodriguez-Trias further discussed deficiencies in residency training, particularly the continued emphasis on inpatient care rather than primary care, which is more the focus of practice in the managed care environment. In response, Dr. Karpf stated that primary care is one of the main services of most AMCs, which are in fact competing in the managed care environment.

B. Discussion of the Physician-Patient Relationship Paper - 9:25 A.M.

Dr. Gilbert began the discussion by proposing changes in the term “physician-patient relationship” to “provider-patient relationship.” He then clarified his intent in section E, number 4: if a consumer was assigned to see a doctor but the doctor was not available, the consumer should be informed if the consumer is re-scheduled to see another care giver (i.e. physician assistant (PA), nurse practitioner (NP)). He added, should the consumer choose or be assigned to see an NP or PA who was not available, no notification is necessary should the patient see another NP or PA. Dr. Gilbert also indicated that his recommen-
The wording in the recommendations regarding this issue was stricken from the recommendations. Dr. Gilbert ended his opening remarks by proposing that physician-extender be changed to “advanced practice nurses” which would include nurse practitioners, clinical nurse specialists and certified nurse midwives. Also, physician assistants would be called as such rather than referred to as physician extenders.

Mr. Hiepler addressed the issue of disclosure. He proposed that if anyone is capitated in a system, it should be the plan’s duty to explain those services that are capitated. Mr. Hiepler also suggested that information such as the amount of the capitation and who is capitated should be disclosed.

Ms. Singer recommended that a pilot project be conducted for working with the medical groups to determine a clear, simple, effective way to disclose compensation arrangements.

Dr. Karpf proposed two language changes. The first change, in section C “Informing Patients of All Options,” was to strike the first sentence regarding increased patient participation under managed care because he felt that all patients should participate in their own care all the time, not just under managed care. Dr. Gilbert agreed and also proposed that the second sentence be stricken. By straw poll, the Task Force agreed to remove the two sentences.

The second language change proposed by Dr. Karpf, under section E “Physician Availability,” recommended to strike “but make coordination and oversight more difficult.” Dr. Karpf felt that physician extenders help coordinate care between the provider and patient.

Dr. Karpf also brought up discussion in section three page four, regarding the information disclosed to patients. Dr. Karpf felt that the recommendation “…and medical groups to disclose to patients the number and outcomes of prior procedures…” was ambiguous and could not be supported by most hospitals. The ambiguity comes from the interpretation of outcomes because outcomes could mean mortality, morbidity or functionality. The reason that he felt that the system could not support this was because there is so much information involved and the system currently used can not store this data.

Dr. Werdegar expressed his approval of the paper’s emphasis on the patient-provider relationship and also expressed that this relationship be preserved with the recommendations made in the paper. He added that informing patients of all options, while necessary to establish a good patient-provider relationship, should be discussed in the paper regarding quality measurement.

Hn. Gallegos proposed the title of this paper be changed to provider-patient relationship instead of physician-patient relationship. He said that upcoming legislation has changed to say provider-patient instead of physician-patient relationship. Ms. Singer stated the literature used, studied specifically the physician-patient relationship and so the paper used physician-patient relationship so that the paper would be accurate.

Hn. Gallegos expressed his dissatisfaction with the language in the paper regarding advanced notice of termination of the doctor or provider to the patient. Dr. Gilbert brought up two parts for discussion in this termination issue. The first was member noticing. The second involved due process in the termination of physician contracts. Dr. Gilbert suggested something similar to current DHS policy under Medi-Cal which states that members should receive 30 days notice in advance should their provider not be available to them.

Chairman Enthoven began discussion of the issue of providing a reason for non-renewal of a provider’s contract. Mr. Williams felt that giving a reason for non-renewal would have unintended consequences and was a bad idea. Mr. Hiepler felt that some reason should be given to doctors for the non-renewal of their contracts to minimize lawsuits. Ms. Singer clarified existing law under the Knox-Keene Act, which states that there must be disclosure for termination but fails to mention anything for non-renewal. Ms. Singer
also indicated that another group is working on a compromise regarding renewal. Dr. Spurlock further proposed that the Task Force allow for the other group to settle this issue because any recommendations now by the Task Force would hinder the group’s ability to reach a compromise. Mr. Zaremberg added that when a contract is finished, there should be no reason required for non-renewal because the contract terminated on its own terms. In a straw vote, a requirement for non-renewal failed 8:16.

Ms. Bowne brought up discussion concerning the issue of continuity of care between provider and patient. Dr. Spurlock stated that patients change providers for various reasons, some voluntary and some involuntary. He proposed that language be included to distinguish these separate situations because if the patient voluntarily changes providers, this continuity of care should be not mandated. He also proposed that for those chronically ill or those who are in the second or third trimester of pregnancy at the time when a provider is terminated by a plan for other than cause, the patient should be able to continue seeing their current specialty providers for up to 90 days or term completion of postpartum care to allow for transition care. In addition, the providers who treat patients during this transition must accept the plan’s rates as payment in full, provide necessary information to the plan for quality assurance, and transfer all medical records with patient authorization.

Dr. Spurlock began the discussion of recommendation B regarding gatekeeper roles, primary care physicians and utilization review, particularly for chronically ill patients. He agreed that patients with severe, chronic, and complex illnesses should have access to ongoing care from specialists, but felt that some chronic illnesses could be appropriately treated by the primary care physician. He proposed that primary care providers be allowed to authorize extended or permanent referrals to specialists. He felt that this method would result in a discourse between the specialist and the primary care provider. Mr. Lee, Mr. Rodgers, and Ms. Finberg agreed with Dr. Spurlock’s idea but Mr. Lee and Ms. Finberg felt that the idea should be mandated rather than “encouraged.” Mr. Lee and Dr. Spurlock agreed to work out some language for voting at the next meeting.

Dr. Werdegar proposed that recommendation C “Informing Patients of All Options” be included in the physician-patient paper where freedom of communication is addressed. Mr. Lee agreed and further recommended that health plans be included in the requirement list. He also proposed that this recommendation should be restated in the consumer information piece. Mr. Lee also added the qualifying language “as appropriate outcomes are available.”

Dr. Karpf suggested language changes to allow for outcomes to be made available. He proposed the language “all presently available outcome data should be made available.” Dr. Alpert expressed his concern with the problem of practical implementation. Dr. Spurlock stated that self-reported information is biased and inaccurate and therefore cannot be used by consumers for meaningful information. Further, he stated that because there are so many different techniques in performing the same procedure, the consumer may not be able to understand all of the data and therefore this issue should be addressed in the informed-consent instead of outcomes section. Dr. Spurlock and Dr. Rodriguez-Trias proposed language to strengthen the informed consent process regarding the data collection of outcomes. Dr. Spurlock proposed that this issue be included in the paper on quality information. A straw poll was conducted and the changes were accepted.

Mr. Hiepler began discussion on recommendation D, financial incentives. Mr. Hiepler felt that since the patient pays for the procedure, the patient deserves to know the amount of the capitation and who is capitated. Also, Mr. Hiepler felt that disclosing this information would act as a safeguard against abuse. Dr. Gilbert agreed that there should be some information available to the patient such as what services the provider is capitated for and how much in terms of dollar figures. Dr. Gilbert also proposed a friendly language change of adding the word “scope” so that the new language would read “method and scope of financial arrangement.” In a straw poll, Mr. Hiepler’s recommendation was opposed 8:17 and Dr. Gilbert’s language change was accepted without objection.
Dr. Gilbert began discussion on recommendation E4. He stated that if a patient is assigned or has chosen a specific physician, the patient should be notified if he is directed to an alternative provider such as a physician assistant (PA) or advanced practice nurse (APN). Mr. Rodgers added to the discussion that Dr. Gilbert's recommendation would affect county facilities, clinics, and residency programs because there is a constant change of providers in these settings. A straw poll was done and the idea passed. Later in the discussion, Ms. O’Sullivan proposed that whenever a primary care provider (PCP) is changed, the patient should be informed of that change ahead of time, whether or not it is from a MD to a PA, or PA to PA. Dr. Gilbert and Dr. Rodriguez-Trias both agreed with this proposal.

Chairman Enthoven moved that recommendation F5 be removed since it is already discussed in the consumer information paper. A straw poll was taken and it was agreed to be dropped.

**Break - 11:00 A.M. - 11:15 A.M.**

Chairman Enthoven resumed the discussion regarding Dr. Werdegar's proposal to add a recommendation regarding confidentiality. Chairman Enthoven agreed that this was an important issue and should be included in the recommendations. Dr. Werdegar and Ms. Griffiths proposed language to address this issue. Mr. Shapiro stated that currently some health plans are asking individuals to waive their right and that was considered consent as a condition for getting medical care. He recommended that patients shouldn't have to be forced to waive their right to confidentiality for purposes not related to care. Chairman Enthoven proposed the language addition “or shouldn’t be asked to waive for purposes other than care.”

**PUBLIC COMMENT:**

1. **Catherine Dodd** - American Nurses Association of California. Ms. Dodd asked that because nurses participate in collaborative care, they should be included in the list of providers to participate in recommended blue ribbon panels. She also asked that APN's be protected by the same gag rules as physicians. She asked that the paper be more provider neutral.

   Ms. O’Sullivan agreed and proposed a language change which would not distinguish doctors in the issue regarding the formation of the blue ribbon committees. Chairman Enthoven, Dr. Rodriguez-Trias and Mr. Perez disagreed and proposed that the language read “doctors and other health care providers.” They felt that this would emphasize the idea to have other primary care providers on the blue ribbon task forces or committees. A straw poll was taken and the language from Mr. Perez was incorporated.

2. **Maureen O’Haren** - California Association of Health Plans (CAHP). Ms. O’Haren stated that there is already existing law regarding the issue of continuity of care. She stated that the law requires 30 days notification for termination but nothing for non-renewal. She also cautioned that requiring medical records be used only for health care issues would slow down the grievance process because plans would have to get the patient's consent to review the records. Ms. Griffith noted that the confidentiality language explicitly states that the provision and payment of care are included in the allowable uses.

3. **Beth Capell** - California Physicians Alliance. Ms. Capell expressed her concerns that Dr. Spurlock’s amendments regarding the continuity of care was more specific than those stated in the Knox-Keene Act which could result in some situations which might be excluded. She also encouraged the Task Force to revisit the renewal issue.

4. **Mary Griffin** - American Medical Group Association. On the issue of continuity of care, Ms. Griffin stated that medical groups are moving to “Evergreen” (in perpetuity) contracts rather than one-year contracts with their sub-contracting physicians. She explained that Evergreen contracts are less expensive for the medical groups and that they exist on a continual basis until terminated.
Executive Director Romero began the discussion by explaining that this paper is a consolidation of two earlier papers, the regulatory organization and streamlining papers. Executive Director Romero recommended that if an organization in the health industry bears financial risk, then its oversight should be consolidated in a single regulator. He also stated that the paper specifically recommends that regulation of preferred provider organizations (PPOs) and exclusive provider organizations (EPOs) be consolidated along with more traditional Knox-Keene Plans in the same organization. He stated that this consolidated regulator is responsible for quality and traditional financial regulation. Executive Director Romero stated that there were two ways to achieve this consolidation. The first method, as recommended by the paper, was a stand alone organization called the Office of Health System Oversight (OHSO). The second would be a re-configured Department of Corporations (DOC). Executive Director Romero also stated that the paper recommended a single appointed director for this new regulatory organization. Hn. Gallegos offered an alternative which was a board with a leader or chairman. Executive Director Romero asked Ms. Singer to explain the recommendation concerning the financial and quality audits. Ms. Singer explained that the paper recommended that solvency audits and quality audits be streamlined to eliminate redundancy. This would be accomplished by allowing a medical group to request that the DOC or the new regulatory authority identify organizations that could provide an audit that would be sufficient for all health plans conducting regulatory reviews. Executive Director Romero concluded his opening remarks by stating that the reason for recommending a single regulator was that a single regulator has the flexibility to adapt and encourage innovation in the marketplace.

Hn. Gallegos explained reasons for why he felt that a five member board would be more effective than a single appointee. He thought it would be difficult to find a single person qualified to take on all of the new duties. He advocated a five member appointed board with one full time appointed chairperson, similar to the Air Resources Board and Water Management Board structures. The board would have decision-making authority, not serve only as an advisory body. He felt this structure would create better opportunities for public input, accountability, and continuity.

Mr. Rodgers, Ms. Farber, Executive Director Romero, Ms. Skubik, Ms. Singer, and Chairman Enthoven discussed the issue regarding responsibilities of DHS and the new regulatory organization. It was clarified that DHS would oversee the contractual obligations and OHSO would deal with the oversight of quality.

Mr. Rodgers expressed his concern regarding PPOs. He felt there would be fewer PPOs with a consolidated regulator, which overall would limit consumer’s choice of plan types.

Comments from the members regarding a board or a single appointed leader included:

- Mr. Zatkin felt that there should be an appointed leader who can be held accountable
- Mr. Shapiro felt that there is less stability with a single director, therefore a board would be more advantageous.
- Dr. Gilbert felt that a board promotes more public involvement and that this would help in credibility.
- Dr. Alpert agreed with Dr. Gilbert in that the public accountability builds credibility. He proposed a combination of a board with one person who is identified as the chair and the other board members are decision makers rather than advisors.
- Ms. Berte felt that a board is not effective. She felt that an executive director wouldn’t be able to focus all of his/her time to running the agency. She also felt that public boards lack expertise and therefore public boards should have more of an advisory role rather than a decision making one.
- Mr. Schlaegel felt that there would be better accountability through an individual person rather than a board.
• Dr. Spurlock felt that there should be an appointed head and an advisory board. Having one person accountable would guard against board members arguing against each other and not actually achieving anything.

• Dr. Werdegar felt that the new oversight body should not be located in the Health and Welfare Agency, but should either be its own agency or an office with direct access to the Governor and with an advisory board.

In a straw vote, the Task Force approved the first sentence of recommendation 1-A, which called for the creation of a new oversight body.

Lunch - 12:45 P.M.-1:10 P.M.

Chairman Enthoven resumed the meeting by discussing the second half of recommendation 1-A. Dr. Werdegar felt that the services of the Office of Statewide Health Planning and Development (OSHPD) could be provided through interdepartmental arrangements and that OSHPD would not necessarily have to be moved. Mr. Zatkin stated that he did not see the rationale in moving OSHPD to the new oversight body unless other health-related entities that OSHPD serves would also be moved. Ms. Farber agreed. Mr. Schlaegel was concerned that unless OSHPD was moved to the new oversight body, the data needs of the new body would be overshadowed by other legislative mandates on OSHPD. A straw poll was taken to strike the second sentence in recommendation A-1, which was accepted by a majority of the members.

Ms. Berte proposed a language change be added to clarify that the Medical Board not be included in the new agency.

Dr. Spurlock requested that the language about direct regulation of medical groups and IPAs be clarified to specifically refer only to those regulations described in the rest of the recommendations, rather than creating an “open checkbook” of regulation. Dr. Northway and Mr. Zatkin agreed.

Mr. Hartshorn felt that language in the recommendation be rigid enough but also flexible enough to adapt to changes in the future. Dr. Alpert felt that the first sentence allows a general and very broad definition for who will be responsible for medical care which allows for inclusion of future definitions of care. He stated that the definition given in the Medical Practice Act in 1867 does not apply to today’s definitions.

Executive Director Romero stated that the intention of the paper was to have the OSHO fuse financial and quality audits.

Ms. Griffin stated that because medical groups are regulated by everyone that possibly could, the recommendation would result in over-regulation.

A straw poll in deleting paragraph B was not accepted.

Mr. Kerr felt that striking the paragraph would be premature because everybody has some advantages in this recommendation. He suggested that a study be done to find what is best for consumers, purchasers and medical groups and then evaluate the issue. He proposed that within one year the study be done and evaluated.

A straw poll was taken regarding Mr. Kerr’s proposal which passed.

The following were comments in the discussion of Recommendation 1-C.

• Ms. Berte felt that too many changes made could hinder the new organization so she proposed the changes be made incrementally. She also stated that streamlining and coordination must be accompanied by technological improvements.

• Ms. Bowne cautioned against putting PPOs in the same regulatory structure as HMOs because she felt that this would result in less choice and less alternatives in dispute resolution.
• Mr. Lee asked for additional language about the need to increase integration and coordination between various state agencies in order to improve the system for consumers.

• Mr. Shapiro suggested inclusion of ex-officio, non-voting members (such as the Insurance Commissioner and Director of DHS) on the proposed new oversight body’s board.

A straw poll was taken on recommendation C, which passed.

A straw poll was taken to see if the single appointed head with the advisory board was favored or an appointed board with an executive officer was favored. The appointed board was in favor 14:9.

Chairman Enthoven proposed a language change which would say streamlining “should” be done, not “could” be done. A straw poll was taken, which passed.

A straw poll was taken on the concepts contained in recommendations 4, 5, and 6, which all passed.

Chairman Enthoven, with regards to recommendation 7, proposed a language clarification “no change in jurisdiction”. A straw poll was taken, which passed.

Ms. Berte felt that recommendation 8-B had a suggestion of criticism towards counsel. Ms. Decker and Mr. Lee proposed wording changes. Chairman Enthoven agreed to change the language to clarify the concept of objectivity and continuity.

Mr. Rodgers felt that this new entity should not be a department of the state because it would be affected by hiring freezes. He felt that it should be a public entity but be protected from the rules of the state in order to operate more efficiently. Executive Director Romero expressed his concern that an entity with this much regulatory authority might need to be a governmental agency. Mr. Rodgers proposed that the entity’s governance be accountable to the public but the staff and the general processes be arranged through an authority organization. Chairman Enthoven asked Mr. Rodgers to prepare a memo on this issue.

Mr. Shapiro commented on recommendation 8-C on the language “consolidate minor amendments.” He felt that this was too vague and that the new oversight body should perhaps develop a method to consistently determine what constitutes a minor amendment. Mr. Shapiro also addressed recommendation 8-D. He stated that this evaluation had already been done. Ms. O’Sullivan recommended a friendly amendment which would strike “hire independent organizations to evaluate the use of the recent.”

The concepts in recommendations 8-A, B, C, and D, as amended, were approved in straw polls.

With the next recommendation, Chairman Enthoven proposed that health plans be able to implement, without being subject to retribution, material modifications submitted to the DOC that are stagnant for more than 60 days. Ms. O’Sullivan felt that instead of removing regulation after 60 days the delays creating the problem should be addressed. Mr. Rogers proposed that the DOC identify a reasonable time frame for reviewing each submitted modification and act within that time frame, rather than having one fixed time frame for every modification. The Task Force agreed on this concept.

Recess - 2:34 P.M. - 2:50 P.M.

D. Discussion of the New Quality Information Development Paper - 2:52 P.M.

Mr. Kerr began the discussion by stating that improved information should help consumers make better choices between health plans, providers, and treatments. He stated that it would also help providers improve quality of care, help public and private purchasers better determine value, and safeguard the public’s health. Mr. Kerr recognized that there is high cost in collecting data, so he recommended data collection only if it either helps providers improve the quality of care or helps consumers and purchasers choose quality health care. He also proposed that the state should not duplicate private sector efforts but that the state and the public sector should complement each other. Mr. Kerr ended his opening remarks by stating that the risk adjusted payment issue was dropped from this paper since it was already approved in another paper.
Mr. Kerr proposed that the larger health plans should have electronic implementation by 2002 and that smaller clinics have electronic implementation by 2004. Dr. Northway expressed his concern that this recommendation was a very expensive venture. Ms. Decker felt that electronic records would facilitate in decision making and that even if it was expensive, it would be worth taking the first steps towards implementation. Dr. Karpf agreed on the importance of electronic records but was concerned about who would bear the costs. He advocated starting with a manageable goal in which all providers could participate and then developing longer term goals.

Mr. Kerr addressed recommendation 2. He proposed legislative oversight of the process of storing and keeping data. He proposed it be done by a blue ribbon committee made of consumers, providers and purchasers.

Dr. Spurlock expressed his concerns that it would be easy to get carried away with data collection and that this could get out of hand financially. He proposed that the data stick to a certain set or number of data elements to avoid enormous amounts of data storage. He proposed that as one data element is added, one should be dropped.

Mr. Kerr stated that recommendation 5 dealt with the opportunity to make major improvements in public safety. He stated that currently, there are no minimum safety requirements in health care and that this recommendation would form a blue ribbon group to address the issue. This committee would set up time frames to implement such improvements. He recommended that a standard baseline of safety standards should be set so that all patients would receive at least an established minimum quality of care. He clarified that the intent of the recommendation would not be to entirely close down entities that failed to meet the standards, but to close down only the relevant components of the entity (e.g., revoke their ability to perform coronary artery bypass graft (CABG) surgery if they did not meet CABG performance standards). He agreed to add language to clarify this issue.

Ms. Bowne believed that this issue is not a managed care issue but a basic issue and therefore outside of the Task Force’s purview.

Dr. Spurlock felt that the key issue would be the enforcement component and questioned whether the new oversight agency should have that responsibility, but he agreed with the concept. He asked for additional language to clarify the role of accreditation organizations and suggested using process measures in addition to outcomes measures.

Dr. Alpert also agreed with the concept, but felt that there may need to be geographic variation in the standards.

Dr. Werdegar was concerned that this type of function is currently performed by DHS and should not be moved to the new oversight agency. Mr. Lee suggested that the recommendation direct the appropriate agencies to look at the issue, rather than specify which agency should have the responsibility for safety oversight. Mr. Kerr agreed to make this change.

Chairman Enthoven was concerned about creating a culture in which people would intentionally not report mistakes, in order to avoid punishment or retribution. In response, Mr. Kerr noted that one alternative would be to set the standards, monitor them, and work with violators to improve their record, rather than closing down relevant components of their business.

Ms. O’Sullivan felt that this recommendation would allow the market to work.

E. Discussion of the Vulnerable Populations Paper - 3:55 P.M.

Mr. Rodgers began the discussion by giving a preview of the issues in this paper. He stated that the majority of the vulnerable populations are in government programs. He also stated that providers were lacking in the ability to diagnose vulnerable populations.
Mr. Rodgers stated that the concept of recommendation 1 was to improve quality of care to vulnerable populations by creating a benchmark. The recommendation would require government programs to only contract with plans that have the ability to track, identify, and report performance outcomes for vulnerable populations.

Ms. Bowne agreed with the concept but she felt that having the benchmark set too high would hurt the system. She felt that having outcome data would not be possible. She expressed her concerns that the best people to treat vulnerable populations might not be able to treat them because of the inability to have outcome data. Mr. Lee agreed with the technological feasibility and proposed that some stipulation should be included with the recommendation.

Mr. Rodgers stated that technology is available to have outcome data and that some plans do track certain individuals to manage costs. He gave the examples of diabetics and asthmatics. He further recommended that withholding premiums from providers would act as an incentive to implement this tracking.

Mr. Schlaegel felt that this should happen with all populations, not just vulnerable populations.

Mr. Lee suggested that in addition to the recommendation that the state selectively contract, the state should also use incentives such as withholds and should work with other purchasers to create common tracking and reporting on performance outcomes for vulnerable populations.

In a straw poll, the Task Force approved Recommendation 1 as amended.

Mr. Rodgers began discussing Recommendation No. 2, regarding reallocation of savings achieved through managed care to insuring the uninsured. Mr. Shapiro cautioned against identifying a particular source of funding for the uninsured. Several Task Force members asked for clarification as to where these funds would go.

Dr. Northway was concerned about redirecting Medi-Cal savings without first assessing the adequacy of current funding levels for Medi-Cal.

Discussion followed concerning how to address issues that are also discussed in other papers. Task Force members were concerned about time, consistency across papers, procedural issues, and additional nuances on previous recommendations when considered in terms of vulnerable populations. Dr. Rodríguez-Triás suggested that before the next meeting staff identify which of the vulnerable population recommendations had not been addressed in other papers and include only those in the next discussion of this issue.

Ms. O’Sullivan presented an additional recommendation regarding a new annual report to the Legislature from DHS on the impacts of Medi-Cal managed care. Task Force members discussed which of the aspects of the recommendation were already required by Medi-Cal contracts and how much effort such a report might require. Mr. Lee suggested that DHS work with other organizations to create comparative data between commercial and Medi-Cal populations. Executive Director Romero proposed that this report be published biannually instead of annually. Mr. Shapiro requested that this be a public report rather than a report to the legislature. Ms. O’Sullivan emphasized that the report should be readable and readily available.

PUBLIC COMMENT:

1. Ms. Dodd - ANA, California. Regarding the New Quality Information Development discussion, Ms. Dodd urged against limiting the data set. She felt that it would be an error to require a data element to be deleted whenever a new data element is added.

2. Ms. Stephanie Munoz. Ms. Munoz cautioned against over-regulation. She stated that the government’s duty is to provide a level playing field for competition.
V. Adjournment - 5:14 P.M.

Before adjourning the meeting, Chairman Enthoven indicated that the following papers would be discussed at the November 25 Task Force meeting: 1) Improving the Dispute Resolution Process; 2) Consumer Information, Communication and Involvement; 3) Improving the Practice of Medicine; and 4) Case Study on Women’s Health.

Chairman Enthoven then adjourned the meeting after hearing and seeing no objection.

Prepared by: Lawrence Ahn
I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 8:45 A.M.

The ninth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by the Chairman, Dr. Alain Enthoven, at the Sacramento Convention Center in Sacramento, California.

II. Roll Call

Task Force Administrative Assistant Lawrence Ahn took roll. The following Task Force members were present: Dr. Bernard Alpert; Dr. Rodney Armstead; Ms. Barbara Decker; Alain Enthoven, Ph.D.; Ms. Nancy Farber; Ms. Jeanne Finberg; Dr. Bradley Gilbert; Ms. Diane Griffiths; Mr. Clark Kerr; Mr. Terry Hartshorn; Mr. Bill Hauck; Mr. Mark Hiepler; Dr. Michael Karpf; Mr. Peter Lee; Dr. J.D. Northway; Mr. John Perez; Mr. John Ramey; Mr. Anthony Rodgers; Dr. Helen Rodriguez-Trias; Mr. Les Schlaegel; Ms. Ellen Severoni; Dr. Bruce Spurlock; Mr. David Tirapelle; Mr. Ronald Williams; Mr. Allan Zaremberg; and Mr. Steve Zatkin.

The following alternate members were also present: Dr. William Duffy, substituting for Hon. Martin Gallegos, and Mr. David Grant, sitting in for Ms. Maryann O’Sullivan.

The following ex-officio members were present: Ms. Marjorie Berte; Mr. Michael Shapiro and Dr. David Werdegar.

III. Opening Remarks - 9:00 A.M.

Chairman Enthoven welcomed Task Force members and the public and thanked them for participating in the third of a series of three day meetings scheduled to ensure all papers drafted by Expert Resource Groups and staff are afforded an opportunity to be discussed before they are scheduled for formal adoption. Chairman Enthoven then introduced Task Force Executive Director Phil Romero.

Mr. Romero echoed the Chairman’s appreciation that members put some much effort into ensuring the three day meetings were productive. He then announced that Mr. David Grant would be sitting in for Ms. Maryann O’Sullivan and that Dr. William Duffy would be sitting in for Hon. Martin Gallegos.

Dr. Romero also stated the Task Force would not be voting formally on any issues today.

IV. Old Business - 9:15 A.M.

A. Discussion of the Practice of Medicine Paper (Task Force Member Dr. Bernard Alpert and Dr. Bruce Spurlock).

Dr. Alpert and Dr. Spurlock presented the recommendations from the practice of medicine paper to the Task Force. After each recommendation was discussed, Task Force members conducted straw votes.
Recommendation 1 (A,B,C, D, and E) concerned changes in the prior authorization/concurrent review process, including broader use of provider pre-credentialing and “gold carding”. 1A was revised as a directive to the Legislature and Governor to encourage health plans to adopt the noted changes, rather than encouraging the changes through purchaser contracts. 1B was not revised. 1C was revised to allow a two year probationary for health plans to assess providers for pre-authorization eligibility. 1D was revised to clarify for which conditions (those for which outcomes-based protocols have been developed and accepted) the prior authorization/concurrent review process should be eliminated. 1E was not revised. After discussion, Recommendation 1 was supported by a majority of Task Force members.

Recommendation 2 concerned changes to drug formulary management. Dr. Spurlock stated that the idea behind this recommendation was to streamline the process for the patient and the physician when they are trying to decide which drugs make the most sense for their clinical condition. It recommended that all health plans that offer prescription drug benefits and use a formulary must periodically publish their formulary list and make it available to any member of the public upon request; that health plans publish the process by which the formulary is developed and reviewed; and that when a health plan removes a drug from the formulary, they must allow the patient to continue receiving the removed drug for an ongoing condition unless the treating physician changes the prescription.

Vice Chairman Kerr suggested replacing the paper’s Recommendation 2A through 2E with Mr. Lee’s proposed Recommendation 2A through 2E (distributed to Task Force members by Mr. Lee). Mr. Lee’s proposed Recommendation 2 received majority support.

Chairman Enthoven stated that the intent of Recommendation 3, regarding liability, was that there should be one legal action and that if a determination of liability was reached, the parties should contribute to the extent of their negligence and liability. Substitute language specifying health plans, medical groups, hospitals, etc. - rather than “all entities practicing medicine” - was incorporated to avoid confusion with the issue of the corporate practice of medicine. The majority of Task Force members voiced support for the intent of Recommendation 3, with exact wording to be determined.

Recommendation 4 concerned the creation of a blue ribbon panel to study and recommend standardized definitions of terms, such as “medically necessary”, used in health coverage contracts. Mr. Grant provided Task Force members with three additions to Recommendation 4A, regarding: 1) decisions of coverage equal decisions of care; 2) benefit decision should take into account particular needs of particular populations, specifically the elderly and disabled, and focus on maximizing functional capacity; and 3) impacts on quality of care should be considered. These additions were included in the list of issues for the blue ribbon panel to consider. Recommendation 4A received majority support. Ms. Farber requested that Recommendation 4B be amended to include the new regulatory oversight agency in the blue ribbon panel. Recommendation 4B as amended was supported by the majority of Task Force members.

PUBLIC COMMENT:
1. **Ms. Maureen O’Haren** - California Association of Health Plans. Ms. O’Haren stated that health plans can only gold card somebody for those procedures for which there are clear objective guidelines in place, so she asked the Task Force to collapse Recommendations 1C and 1D. She also suggested that pre-authorization cannot be eliminated entirely because even when a physician has been gold carded, the physician needs to call the health plan to check for eligibility, verify coverage for that particular benefit, and make sure that the setting is appropriate.

2. **Ms. Beth Capell** - Health Access. Ms. Capell called the attention of the Task Force to two points: 1) practice guidelines and clinical pathways ought to be developed by practicing health professionals, including nurses; and 2) these guidelines should be available not only to the patient and the treating health professional, but also for review by consumer groups and relevant health professionals specialty associations.
B. Discussion of the Dispute Resolution Paper- (Task Force Members Mr. Peter Lee and Ms. Barbara Decker) - 2:30 P.M.

Ms. Decker began by reviewing the “essential elements” of the dispute resolution process, including the need for consumers to understand their rights and responsibilities; quick resolution; assistance in navigating the system; fairness; efficiency; and feedback loops to improve the system.

Ms. Decker and Mr. Lee then reviewed, led discussion, and conducted straw votes on each recommendation. Recommendation A1 encouraged the use of collaborative and non-repetitive processes to improve dispute resolution. Recommendation A2 encouraged voluntary adoption of the recommendations for those employer-based plans that are exempted from state regulation under ERISA. Task Force members did not object to these two items.

Section C concerned standardization of timeframes in the dispute resolution process. Mr. Lee reordered the items so that C(g) - a recommendation that where the medical group is acting on behalf of the health plan, all dispute resolution standards that would have applied to the plan now apply to the medical group - became C(a). He also clarified that the main differences between the recommendations and existing law were that in the recommendations 1) these timeframes should apply across all plan types, including PPOs and 2) plans should resolve disputes over emergency situations in 72 hours rather than 5 days. In addition, Mr. Lee stated that the intent of the recommendations is to have closure on disputes within the timeframes, except in rare circumstances. The recommendation regarding the 72 hour rule was amended to have the state regulatory agency study and consider making the shorter timeframe the standard in two years. The recommendation regarding the period of limitation within which a patient can file a grievance was amended to encourage uniformity across plans without specifying the precise length of time. Other recommendations discussed included standardization of terminology and data collection, and communication of dispute resolution processes. The recommendations concerning explanations of health plans’ decisions was amended to include language to preserve the peer review process. Task Force members did not object to any of these recommendations, as amended.

The Task Force next discussed recommendations regarding consumer empowerment. On the issue of second opinions, the recommendation was clarified to encourage second opinions within the patient’s medical group or network unless the particular expertise for the patient’s condition does not exist within the network, in which case the plan should pay for a second opinion outside the network. These recommendations as amended were accepted without objection.

Recommendation 5, concerning consumer assistance through plans, was amended to state that physicians can serve as an important patient advocate, to allow for disputes between patients and physicians. Recommendation 6 was amended to encourage member participation in the appeals process, either in person or by teleconference. Recommendation 7, regarding external sources for consumer assistance, was amended to encourage funding through private foundations and to create pilot projects. Consideration of extending the range of assistance through litigation was also added.

Recommendation G was revised to encourage formation of a collaborative process with all major stakeholders to develop an independent third party review process providing consumers and plans with an unbiased, expert review of grievances pertaining to medical necessity. Chairman Enthoven and Dr. Karpf also agreed to write a recommendation that would create a process for developing authoritative standards used in the third party review process. These recommendations were accepted without objection. Mr. Shapiro’s recommendation regarding ERISA was also accepted without objection. Mr. Gallegos’ recommendations regarding arbitration were tabled until the next Task Force meeting.

PUBLIC COMMENT:

1. Ms. Maureen O’Haren - California Association of Health Plans. Ms. O’Haren made two comments. First, she said that current law should be stated wherever it is relevant. Second, she stated that data elements should not be specified; the regulator should determine how best to provide information to
the public on grievances.

2. **Ms. Clare Smith** - California Health Insurance Counseling and Advocacy Program. Ms. Smith requested that the HICAPs be included in the dispute resolution collaborative working group.

**C. Discussion of the Consumer Involvement, Communication and Information Paper** - (Task Force Members: Ms. Jeanne Finberg and Ms. Ellen Severoni) - 4:00 P.M.

Ms. Finberg stated that many consumers do not understand what managed care is, so information should be provided to them that describes what managed care is and how it works in California. She said this information should be available in the many languages being spoken in California. Health plans should also submit to the state agency major health conditions or illnesses that require referrals to specialty centers. Data on these conditions, where the patient received care and how many of these procedures were referred, would then be reported annually. This information would give consumers an idea of what happens when an individual gets sick, where he/she can go, and what services his/her plan includes.

Ms. Finberg also discussed creating a comprehensive directory of providers and their available networks within the plan or group. This directory would be kept updated on a continuous basis and would also be available on the Internet.

Ms. Severoni stated that health plans, based on the Knox-Keene Act, need to describe the mechanism by which enrollees can express their views on public policy matters. In addition, they must establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan and incorporate these procedures into the plans’ by-laws.

Ms. Severoni recommended that plans establish a governing body composed of at least one-third members or enrollees and ensure that sufficient resources are made available to educate the enrollee board members so that they can effectively participate. This committee shall also communicate and advocate for members’ needs and serve as a resource for the governing body and plan administrators. It shall establish mechanisms and procedures for enrollees to express their views and concerns. It should include but not be limited to issues such as benefits and coverage, member communications, quality assurance, marketing and grievance resolution.

Public participation is not destructive, Ms. Farber said. There are 65 hospitals in California which have publicly elected members in their governing boards. Having the public participate has proven to be a very good morale booster. Dr. Alpert stated that about 40 percent of the medical board of California are consumers and this does work very well.

To clarify, Vice Chairman Kerr explained that plans would publicly have to disclose how many members/enrollees with no financial interest in the corporation are on their governance bodies. This information, along with other information, would be available for consumers to consider when choosing their health plan.

A straw vote was taken and all the recommendations presented by Ms. Finberg and Ms. Severoni were majority accepted by the Task Force.

**PUBLIC COMMENT:**

1. **Ms. Maureen O’Haren** - California Association of Health Plans. Ms. O’Haren questioned whether members/enrollees would read all the information that would be readily available. She stated that health plans hold some information as private property and would not want to disclose it to an enrollee. She also stated that the medical board currently has an Internet site that provides “superdirectory” information. Finally, Ms. O’Haren recommended that the Department of Corporations should also be required to indicate what action it took in response to complaints.
2. **Ms. Catherine Dodd** - American Nurse Association of California. Ms. Dodd urged the Task Force to pursue the superdirectory idea as a means of improving the market. In response to health plan claims that providing information would increase their costs, Ms. Dodd suggested that health plans stop giving away marketing materials such as pens and pencils during open enrollment events.

D. **Discussion of Integration: A Case Study of Women Paper - (Task Force Member: Dr. Helen Rodriguez-Trias) - 4:30 P.M.**

Dr. Rodriguez-Trias began her presentation stating that women are the primary consumers of health care for themselves and their families. As such they are the most affected by some of the issues around fragmentation of services, because traditionally reproductive health services have been provided as a separate part of the health care system. Thus the Task Force should encourage managed care organizations to coordinate and integrate care around the needs of its members.

Dr. Rodriguez-Trias further stated that health plans should recognize that members, women in particular, are likely to forgo care because of scheduling and confidentiality issues. Therefore, managed care organizations should address these issues systematically. Managed care organizations (MCO’s) should ensure that their primary care practitioners or teams are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. She stated that MCOs should also be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in basic aspects of gynecological care such as breast and pelvic exams, contraceptive management, and initial management of common gynecological problems.

Dr. Rodriguez-Trias also stated that women should be allowed direct access to their reproductive health providers. In addition, plans should offer coverage for a full range of reproductive health services including fertility control, sexually transmitted diseases (prevention, detection, and treatment), and family planning methods. Finally, she suggested collaboration between the public and private sector in the development of consistent standards and evidence-based, gender-specific practice guidelines.

**PUBLIC COMMENT:**

1. **Ms. Maureen O’Haren** - California Association of Health Plans. Ms. O’Haren said that current law requires health plans to provide all medically necessary services, to maintain confidentiality, and to provide a variety of family planning services, therefore the paper’s recommendations on those issues are unnecessary. She also stated that encouraging plans to provide information directly to all plan enrollees could be a costly mandate. She further argued that 93% of consumers are currently enrolled in a plan that provides some form of direct Ob/Gyn access.

2. **Ms. Betty Perry** - Older Women’s League. Ms. Perry commented that no recommendation mentioned any way to deal with the mental health needs of women.

3. **Mr. Jim Randlett** - California Association of Obstetricians and Gynecologists. Mr. Randlett argued for direct access to Ob/Gyn providers. He stated that, contrary to what Ms. O’Haren said, closer to 50% of women in California have true direct access.

**V. Adjournment [Vice Chairman Kerr] - 5:15 P.M.**

Without objection, Vice Chairman Kerr declared the Special Meeting adjourned at 5:15 P.M.

Prepared by: Enrique J. Ramirez, Ph.D.
The Task Force did not vote on these Minutes.

Friday, December 12, 1997
8:30 A.M. until 8:23 PM.
1201 K Street [Chamber of Commerce Building]
12th Floor Conference Room
Sacramento, California

I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 8:30 A.M.

The business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Sacramento Chamber of Commerce Building at Sacramento, California.

II. Roll Call

Task Force Administrative Assistant Lawrence Ahn took roll. The following Task Force members were present: Dr. Bernard Alpert; Dr. Rodney Armstead; Ms. Rebecca Bowne; Dr. Donna Conom; Ms. Barbara Decker; Dr. Alain Enthoven; Ms. Nancy Farber; Ms. Jeanne Finberg; Hon. Martin Gallegos; Dr. Bradley Gilbert; Ms. Diane Griffiths; Mr. Terry Hartshorn; Mr. William Hauck; Mr. Mark Hiepler; Dr. Michael Karpf; Mr. Clark Kerr; Mr. Lee; Dr. J.D. Northway; Ms. Maryann O’Sullivan; Mr. John Perez; Mr. Anthony Rodgers; Dr. Helen Rodriguez-Trias; Ms. Ellen Severoni; Dr. Bruce Spurlock; Mr. David Tirapelle; Mr. Ronald Williams; Mr. Allan Zaremberg; and Mr. Steve Zatkin.

The following ex-officio members were also present: Ms. Kim Belshe; Ms. Marjorie Berte; Dr. David Werdegar; and Mr. Michael Shapiro.

III. Public Comment [9:00 A.M.]

Chairman Enthoven began the business meeting stating that since a quorum was not yet present, he would take public comments at this time.

1) Ms. Maureen O’Haren - California Association of Health Plans. Ms. O’Haren addressed the Financial Incentives for Providers in Managed Health Care Plans Findings and Recommendations. She said that it would be inappropriate for the agency regulating health care service plans not to involve the plans in any sort of program as far as disclosure of incentive arrangements.

Ms. O’Haren also asked the Task Force to clarify language regarding the Financial Incentives for Providers in Managed Health Care Plans Recommendation No. 4(A) because she felt the language needed to be reworded.

2) Ms. Conni Barker - California Psychiatric Association. Ms. Barker recommended that a provision to Recommendation No. 2. (A)(1) of the Financial Incentives for Providers in Managed Health Care Plans Findings and Recommendations be added to address the need for continuity of care between a physician and a patient when a physician is removed from a HMO panel.

3) Ms. Catherine Dodd - American Nurse Association - California. Ms. Dodd suggested that the word “physician” be changed to “health care provider” throughout the paper entitled, Physician - Patient Relationship.
4) **Ms. O’Haren.** In regards to the Consumer Involvement and Information Findings and Recommendations, Ms. O’Haren said that sometimes the lack of knowledge about managed care gets confused with a lack of information about managed care. She said that enrollees do not always read the information they are currently provided, and that an educational booklet would probably not be a wise expenditure of resources.

5) **Ms. Dodd.** On the same topic, Ms. Dodd stated that consumer choice should also include the choice of a certified nurse practitioner, a certified midwife practitioner, and a clinical nurse specialist.

6) **Ms. O’Haren.** Regarding the Governmental Oversight on Managed Care Findings and Recommendations, Ms. O’Haren said that at first the new regulatory entity should regulate only health care service plans and that anything else should be considered later. She also said that in no event it would be appropriate to regulate a physician office or clinic under the same auspices.

On the Improving the Practice of Medicine Findings and Recommendations, Ms. O’Haren said that her organization opposes the proposal on eliminating prior authorization, especially for catastrophic conditions. A study of the American Association of Health Plans showed, she said, that health care premiums would increase as much as 12 percent depending on how much defensive medicine or defensive coverage decision are made because of expanded liability.

Then, referring to the Improvement of Managed Care Through Coordination and Integration: Case Study on Women Findings and Recommendations, Ms. O’Haren expressed her concern with Recommendation No. 3 which suggests that health plans be required to cover out-of-network care. She said that requiring plans to provide out-of-network care would not be consistent with current law.

7) **Ms. Dodd.** Ms. Dodd, on the other hand, suggested to the Task Force that health plans provide direct access to obstetrics/gynecologists as well as to certified nurse midwives and women’s health care practitioners.

8) **Mr. Scott Syphax** - California Medical Association (CMA). Mr. Syphax addressed the Governmental Oversight of Managed Health Care Findings and Recommendations by stating that the CMA strongly advocates establishing a new regulatory entity headed by a board or a board with a full time chief executive or chairman.

**IV. Opening Remarks** - [Chairman Enthoven] - 10:00 A.M.

Chairman Enthoven, announcing that the Task Force now had a quorum, began the business meeting by congratulating members for the tremendous amount of progress they have made to date. Chairman Enthoven said that if the Task Force stays on its projected course, it will reach majority support for close to 100 recommendations which, when taken together, will add up to a far-reaching change in the regulatory system and the general functioning of the managed care industry in California.

He also said that he hoped to have Task Force members prioritize the adopted recommendations through a Delphi-Questionnaire.

Chairman Enthoven also said that all background papers will be mailed out (via Federal Express) to Task Force members by December 22, and reminded members to fax their individual letters for inclusion in the Main Report to Deputy Director Alice Singh by noon on December 19.

The Report’s Executive Summary will contain a paragraph indicating that the Task Force could not address all issues on managed care nor would it contain a cost-benefit analysis of the recommendations. Mr. Lee further suggested that Task Force staff include all related findings in all papers.

Ms. Griffiths expressed her concern that the ways in which the Task Force papers are being drafted are sufficiently unclear and that it will affect the credibility and the meaning of the recommendations. Specifically, Ms. Griffiths cited the use of inconsistent phraseology. Thus, she asked the Task Force to use the same terms and terminology throughout the whole document or documents.
Mr. Lee raised some questions on the Public Perceptions and Experiences with Managed Care Paper. He moved that the Task Force include the Public Perceptions and Experiences with Managed Care Paper Findings in the Main Report with the caveat that it would not require a Task Force vote. His motion was seconded by Ms. Finberg.

Ms. Bowne then moved to amend Mr. Lee's motion by stating that the entire Public Perceptions and Experiences with Managed Care Paper [Findings and Background] shall be included in the Main Report. The motion to amend Mr. Lee's Main Motion was seconded by Mr. Lee and was adopted 20 to 1.

Ms. Farber asked that the results of the third sample of the public survey commissioned earlier by the Task Force be included in the Public Perceptions and Experiences with Managed Care Paper. Chairman Enthoven agreed to accommodate Ms. Farber's request, time permitting.

V. Consent Items
Mr. Rodgers moved to adopt the only Consent Item - the October 28, 1997 Meeting Minutes. Mr. Kerr seconded the motion and it was adopted unanimously.

VI. New Business - 11:25 A.M.
NOTE: Please refer to the Adopted Findings or Adopted Findings and Recommendations Sections for the text as adopted by the Task Force today. Proposed and adopted language is not included in these minutes due to time and space constraints.

A. Adoption of the Findings Section of the Academic Medical Centers Paper.
Chairman Enthoven expressed his apologies to Task Force members for not getting to them line-in line-out versions of some of the papers to be addressed at today's meeting.

Chairman Enthoven then asked members to move to the Findings Section of the Academic Medical Centers Paper. Ms. Bowne moved to adopt the Findings Section of the Academic Medical Centers Paper, and Ms. Decker seconded the motion. However, before voting on the Findings, members agreed to table the item until the arrival of Dr. Karpf, one of the document's primary authors.

When Dr. Karpf arrived, the Task Force reconvened its discussion of the document. Dr. Karpf said that this was a hard paper because there are a lot of sentiments and not as much information as one would like to have about the impact of managed care on academic medical centers. He further said that 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, he said, the cost of medical education has been supported by clinical revenues through cost shifting. Then, as pressure on reimbursement intensifies and clinical revenues are threatened, more discrete funding streams need to be identified. Dr. Karpf also stated that 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.

Several technical amendments were made to the Findings as suggested by Task Force Members, including the addition of a paragraph on medical profession education, as proposed by Dr. Karpf.

After some discussion, Dr. Rodriguez-Trias moved to adopt the Findings, as technically amended. Ms. Bowne seconded the motion and it was adopted 24 to 0.
B. Adoption of the Findings and Recommendations Section of the Financial Incentives for Providers in Managed Health Care Plans Paper.

Recommendation No. 1
Task Force members accepted several informal amendments to this recommendation, including the substitution of “with providers of health care services” with “medical groups/IPAs or health practitioners”, and to phrase the recommendation so that the information disclosed to consumers was sufficient to enable them to evaluate and compare plans.

Dr. Northway moved to adopt Recommendation No. 1, as technically amended and seconded by Mr. Peter Lee. The motion was adopted 16 to 5.

Recommendation No. 2
Several changes were accepted to this recommendation, including adding the phrase “health plans and their contracting” before the words “medical groups”.

Mr. Lee moved to adopt this recommendation as technically amended, and it was seconded by Mr. Kerr. The recommendation adopted 19 to 0.

Recommendation No. 3
Ms. Farber moved to adopt this recommendation as proposed and it was seconded by Mr. Lee. The motion was adopted 21 to 1.

Recommendation No. 4 (a), (b) and (c)
Recommendation No. 4 (a) was informally amended to: 1) delete text regarding the substantial cost of professional services; and 2) exclude from this recommendation aggregated or pooled risk adjustments of e.g., five or more practitioners.

Several informal, technical amendments to Recommendation No. 4 (b) were accepted, and Recommendation No. 4 (c) was informally amended to add that this recommendation should be administered in a manner that minimizes the administrative burden to plans and providers.

Mr. Lee moved to adopt all parts of Recommendation No. 4, as amended, and it was seconded by Mr. Kerr. The motion was adopted 20 to 0.

Recommendation No. 5
This recommendation was informally and technically amended. Mr. Lee moved to adopt the recommendation, as amended, and Ms. Bowne seconded it. The motion was adopted 20 to 0.

Recommendation No. 6
This recommendation was informally amended to delete the names of specific stakeholders to form an advisory group and instead, the advisory group is to be convened by the state agency responsible for regulating managed care and is to be composed of the major stakeholders.

Mr. Lee moved to adopt Recommendation No. 6, as technically amended and it was seconded by Ms. Bowne seconded. The motion was adopted 24 to 0.

Recommendation No. 7
Mr. Lee moved to adopt this recommendation, as proposed, and Mr. Kerr seconded the motion. It was adopted 23 to 0.

Findings Section
Mr. Lee moved to adopt Findings Section with one minor, technical amendment. Mr. Rodgers seconded the motion and it was adopted 22 to 0.
Generally speaking, Ms. Griffiths suggested that in cases where the Task Force places a new requirement on a plan that that requirement be conditioned with language stating that the requirement must be complied within the parameters of existing law.

C. Adoption of the Findings and Recommendations Section of the Physician-Patient Relationship Paper.

Recommendation No. 1
Recommendation No. 1 (a) was informally amended to add a phrase regarding existing law and to delete references to the requirement of health plans and medical groups/IPAs to write contractual arrangements, under specified circumstances.

Recommendation 1(b) was also informally amended to specify a plan's out of network or PPO rates.

Mr. Lee moved to adopt Recommendation No 1, as amended, and it was seconded by Ms. Bowne. The motion was adopted 26 to 0.

Recommendation No. 2
Ms. Bowne moved to adopt Recommendation No. 2, as proposed, and Dr. Karpf seconded.

Ms. Finberg then moved to amend the recommendation to delete the phrase “...if any, and the plan medical director that an enrollee needs continuing care from a specialist”. Ms. Severoni seconded the motion and it was adopted 24 to 0.

In addition, the recommendation was split into two sections - (a) and (b). Section (b) began with language referring to the way referrals should be conducted.

The Main Motion to adopt the recommendation, as amended, was adopted 26 to 0.

Recommendation No. 3
This recommendation was informally amended to add that if a patient is 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, etc., that the patient should be informed verbally and should consent prior to the appointment.

Ms. Farber moved to adopt the recommendation, as amended and Dr. Rodriguez-Trias seconded it. The motion was adopted 25 to 0.

Recommendation No. 4
Members agreed that the goal of Recommendation No. 4 is to improve the informed consent process and to improve the informed consent process with data. Thus, it was informally accepted that the recommendation would be amended to add a clarifier that as information relevant to the quality of care becomes available, physicians, regardless of financing or delivery system, should include all relevant information at every level of care in the informed consent process.

Mr. Lee moved to adopt the recommendation, as amended, and it was seconded by Mr. Williams. The motion was adopted 25 to 0.

Recommendation No. 5
After a lengthy debate and discussion, Recommendation No. 5 was completely re-written to read:

(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.

Mr. Schlaegel moved to adopt Recommendation No. 5(a), and it was seconded by Mr. Kerr. The motion was adopted 23 to 0.

Dr. Spurlock moved to adopt Recommendation No. 5(b), and Ms. Farber seconded it. The motion was adopted 21 to 0.

Findings Section
Mr. Lee moved to amend the Findings Section, with several technical amendments, and Mr. Schlaegel seconded the motion. It was adopted 24 to 1.

PUBLIC COMMENT:
Ms. LeeAnne Tratler - Consumer Attorneys of California. Ms. Tratler bluntly said that Recommendation No. 3 fell short of its goal - the problem is that the reference to the costly lawsuits is without empirical foundation.

She asked the Task Force to amend the recommendation to reflect a statement of intent that HMOs should be accountable. She also asked that the federal government address that problem in the ERISA statute and not to address the liability issues at this time as they are without empirical foundation.

D. Adoption of the Findings and Recommendations Section of the Governmental Regulation and Oversight of Managed Care Paper.
Chairman Enthoven said that the question “Who should lead the state’s new agency responsible for regulating managed health care – a Department Director or an appointed Board?” is a difficult one to answer and one that should not be settled by this Task Force. The Chairman cited that neither option had sufficient votes to pass and that instead, the Task Force should simply present both options in its Recommendations.

Mr. Gallegos discouraged members from this mode and instead, felt that the Task Force should vote to support one form of leadership. Chairman Enthoven said that the Findings and Recommendations Section of the Governmental Regulation and Oversight of Managed Care Paper would be discussed and voted on at tomorrow’s meeting.

PUBLIC COMMENT:
Mr. John M. Curtis - Discobolus Consulting Services. Mr. Curtis said that because of the rapid proliferation of managed health care plans, HMO’s now constitute over 90 percent of the health plans sold in California and more than 75 percent nationwide. He said that the industry clearly needs to be regulated.

E. Adoption of the Findings and Recommendations Section of the Expanding Consumer Choice Paper.
Recommendation No. 1
Mr. Lee moved to adopt Recommendation No. 1 as proposed, and it was seconded by Ms. Bowne. The motion was adopted 24 to 0.

Recommendation No. 2
Mr. Lee moved to adopt Recommendation No. 2, as proposed and Ms. Bowne seconded it. The motion was adopted 23 to 0.
Recommendation No. 3
After a very lengthy discussion, Ms. Finberg moved to adopt Recommendation No. 3 as proposed. Ms. Diane Griffiths seconded her motion. The motion was adopted 17 to 7.

Recommendation No. 4 [New]
Mr. Kerr suggested an additional recommendation to provide people with an opt-out alternative and also to stimulate competition among the health care plans to make sure plans have quality providers in their networks so that consumers will not want to opt-out. Several changes were accepted to Mr. Kerr’s recommendation. After which, Mr. Kerr moved to adopt his recommendation and Ms Farber seconded it. The motion failed 14 to 11.

After additional discussion and informal amendments were made, Mr. Lee moved to adopt Mr. Kerr’s revised recommendation, and it was seconded by Mr. Schlaegel. The motion was adopted 23 to 2.

Recommendation No. 4, as adopted, reads:
The Legislature and the Governor should convene a working group of stakeholders including health plans, providers, purchasers and consumers to examine the issue of how to increase consumer choice of provider on a cost-neutral basis.

Findings Section
Mr. Lee moved to adopt the Findings as amended and Dr. Rodriguez-Trias seconded it. The motion was adopted 24 to 2.

F. Adoption of the Findings and Recommendations Section of the Dispute Resolution Paper.
Ms. Farber started the discussion by saying that what is important in this paper is the timeframe in which a health plan has to “take up” an enrollee’s complaint. Ms. Barbara Gilmore, with the Department of Corporations, responded to Ms. Farber by saying that between the statute and the regulations, the department considers the clock to start ticking when a health plan receives a complaint, whether they receive it over the telephone or in writing.

Recommendation No. 1
Mr. Lee moved to adopt Recommendation No. 1, as proposed. Ms. Decker seconded it. The motion was adopted 16 to 0.

Recommendation No. 2
Mr. Lee then moved to adopt Recommendation No. 2, as proposed, and it was seconded by Ms. Farber. The motion was adopted 20 to 0.

Recommendation No. 3 and 3(a)
A motion was made by Mr. Lee to adopt Recommendation No. 3 and 3(a), as proposed. Ms. Farber seconded the motion. The motion was adopted 19 to 0.

Recommendation No. 3(b)
Several informal changes were accepted to Recommendation No. 3(b), including changing the language so that it was consistent with existing law and stating that in two years the state agency should recommend whether all plans should be required to respond or resolve a complaint within 72 hours instead of the five days currently required.

Ms. Bowne moved to adopt the recommendation and Mr. Lee seconded it. The motion was adopted 20 to 0.
Recommendation No. 3(c)
Mr. Lee moved to adopt this recommendation, as proposed and it was seconded by Ms. Decker. The motion was adopted 23 to 0.

Recommendation No. 3(d)
Mr. Lee moved to adopt this recommendation, as proposed and Mr. Gallegos seconded it. The motion was adopted 24 to 0.

Recommendation No. 3(e)
This recommendation was informally amended to say that health plan enrollees should be provided the opportunity to participate, at least once, in person in the grievance process.

Mr. Lee moved to adopt the revised recommendation and Chairman Enthoven seconded it. The motion was adopted 22 to 1.

Recommendation No. 3(f)
This recommendation was also informally amended to include that the patient should be notified in writing and verbally when an in-plan physician's recommendations are denied by a health plan or medical group.

Mr. Lee moved to adopt the revised recommendation and Mr. Kerr seconded it. The motion was adopted 25 to 0.

Recommendation No. 3(g)
Mr. Lee moved to adopt this recommendation with minor, technical changes. Ms. Bowne seconded the motion and it was adopted 23 to 0.

Recommendation No. 3(h) was rolled into Recommendation No. 3(e).

Recommendation No. 3(i)
A few clarifying changes were accepted to this recommendation, including language consideration of the cost, comparability and validity of complaint information to be reported and a statement that no such report should contingent upon confidential and peer review.

Ms. Decker moved to adopt this recommendation and Mr. Lee seconded it. The motion was adopted 22 to 0.

Recommendation No. 3(j)
With the informal amendment accepted to this recommendation so that it reads:

The agencies responsible for managed care oversight should provide a single statewide 800 number that seamlessly transfers the consumer to the appropriate agency. Mr. Lee moved to adopt the recommendation and it was seconded by Mr. Kerr. The motion was adopted 21 to 0.

Recommendation No. 4
Mr. Lee moved to adopt Recommendation No. 4 and Ms. Bowne seconded it. The motion was adopted 22 to 0.

Recommendation No. 5
Dr. Rodriguez-Trias moved to adopt Recommendation No. 5, as proposed, and Ms. Bowne seconded it. The motion was adopted 23 to 0.

Recommendation No. 6
Mr. Lee moved to adopt this recommendation, as proposed. Ms. Bowne seconded the motion and it was adopted 26 to 0.
Recommendation No. 7
Several changes were accepted to this recommendation, including the addition of several “appropriate activities” for the accessibility of consumer information. Mr. Lee moved to adopt the recommendation and it was seconded by Ms. Decker. The motion was adopted 20 to 1.

Recommendation No. 8
Several changes were accepted to this recommendation, including the statement that the state agency responsible for regulating managed care should be directed to establish and implement by January 1, 2000 [instead of “establish within two years”] an independent third-party review process.

Mr. Lee moved to adopt this recommendation, as revised and Ms. Farber seconded. The motion was adopted 20 to 1.

Recommendation No. 10
Mr. Lee moved to adopt this recommendation, as proposed and Ms. Decker seconded it. The motion was adopted 23 to 1.

Recommendation No. 9
Chairman Enthoven then announced that the Task Force would address next the Arbitration Standards issue [Recommendation No. 9]. Mr. Gallegos explained why he thought the Task Force should recommend arbitration standards. He said that it is important for the Task Force to deal with dispute resolution and that the area of binding arbitration cannot be neglected. Based on the proposal, arbitrators would be independent. A few technical changes were accepted to the recommendation.

Mr. Lee moved to adopt recommendation No. 9(a), and Mr. Gallegos seconded it. The motion failed 13 to 6.

Mr. Hiepler moved to adopt Recommendation No. 9(b), and Dr. Rodriguez-Trias seconded the motion. The motion failed 15 to 5. However, Mr. Rodgers proposed an amendment to this recommendation to delete the word “independent” from “arbitration systems” and moved to adopt the recommendation as revised. Ms. Bowne seconded the motion and it was adopted 20 to 2.

Mr. Gallegos moved to adopt Recommendation No. 9(c) and Ms. Griffiths seconded it. The motion failed 14 to 4.

Ms. Farber moved to adopt Recommendation No. 9(d), as amended to include patient and physician personal and confidential information to be excluded from an arbitration award notice. Ms. Finberg seconded the motion which was adopted 16 to 2.

Alternative No. 1
Mr. Hauck moved to delete Alternative 1. Multiple Task Force members seconded the motion, and it was adopted 16 to 4.

Alternative No. 2
Mr. Hauck moved to adopt Alternative No. 2 and Mr. Schlaegel seconded it. The motion was adopted 18 to 7.

New Recommendation
Mr. Hiepler then moved to adopt a recommendation stating that all health plans should be able to make arbitration optional to enrollees. Mr. Lee seconded the motion and it failed 12 to 11.

Findings Section
Mr. Schlaegel then moved to adopt the Findings Section, as proposed. Mr. Lee seconded it and the motion was adopted 23 to 0.
G. Adoption of the Findings and Recommendations Section of the New Quality Information Development Paper.

Chairman Enthoven announced that a new version of this document, dated December 12, 1997, was now available to Task Force members. Chairman Enthoven said that Mr. Kerr had made some technical amendments to Recommendation No. 5 and the changes are reflected in the new version of this document.

Recommendation No. 1
Several changes were accepted to this recommendation, including the provisions that: 1) the state agency responsible for regulating managed care should approve all data requests and make specific findings on costs and benefits; and 2) that the agency should coordinate data requests to avoid duplication.

Mr. Lee moved to adopt the recommendation, as revised and it was seconded by Ms. Decker. The motion was adopted 21 to 0.

Recommendation No. 2
Several changes were also accepted to this recommendation including the addition of a statement that the regulatory authority should strongly encourage and help provide leadership and coordination regarding the issue of electronic medical records. Further, the system of electronic medical records should be phased-in with a target date of 2002-2004.

Dr. Rodriguez-Trias moved to adopt the recommendation, as amended and Ms. Decker seconded the motion. The motion was adopted 19 to 2.

Recommendation No. 3
This recommendation was moved for adoption by Mr. Lee with a provision regarding cost to be added. Ms. O’Sullivan seconded the motion and it was adopted 17 to 1.

Recommendation No. 4
This recommendation was moved for adoption by Mr. Lee with a provision regarding cost to be added. Chairman Enthoven seconded the motion and it failed 15 to 6.

Mr. Kerr moved that this recommendation be granted reconsideration and Ms. Finberg seconded the motion. The motion failed 15 to 4.

Due to the lateness of the hour, Chairman Enthoven said that Recommendation No. 5 and the Findings Section would be discussed at tomorrow’s meeting.

VII. Public Comment
Ms. Stephanie Munoz. Ms. Munoz addressed the subject of academic medical centers and said that the funding for these centers comes from the community with its will that “excellence in medicine is the highest expression of human endeavor and from the [medical] residents and the [medical] resident’s future patients.”

She asked the Task Force to consider asking the state to broker health insurance so that “those $5,000, which have already been paid by every insured person in 1991, 1992 and 1993 could be available to pay the medical expenses of those who need tertiary hospital care in 1994.”

VIII. Adjournment
Without objection Chairman Enthoven adjoined the first of a two-day meeting at 8:23 P.M. The Chairman also stated that Saturday’s meeting would start promptly at 8:00 A.M.

Prepared by: Enrique J. Ramirez, Ph.D., and Alice M. Singh
The Task Force did not vote on these Minutes

Saturday, December 13, 1997
8:30 A.M. until 5:05 P.M.
1201 K Street [Chamber of Commerce Building]
12th Floor Conference Room
Sacramento, California

I. Call to Order [Chairman Alain Enthoven, Ph.D.]
The business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Sacramento Chamber of Commerce Building at Sacramento, California.

II. Roll Call
Task Force Administrative Assistant Lawrence Ahn took roll. The following Task Force members were present: Dr. Bernard Alpert; Dr. Rodney Armstead; Ms. Rebecca Bowne; Ms. Barbara Decker; Alain Enthoven, Ph.D.; Ms. Nancy Farber; Ms. Jeanne Finberg; Hon. Martin Gallegos; Dr. Bradley Gilbert; Ms. Diane Griffiths; Mr. Terry Hartshorn; Mr. William Hauck; Mr. Mark Hiepler; Dr. Michael Karpf; Mr. Clark Kerr; Mr. Peter Lee; Dr. J.D. Northway; Ms. Maryann O’Sullivan; Mr. John Perez; Mr. Anthony Rodgers; Dr. Helen Rodriguez-Trias; Mr. Les Schlaegel; Ms. Ellen Severoni; Dr. Bruce Spurlock; Mr. David Tirapelle; Mr. Ronald Williams; Mr. Allan Zaremberg; and Mr. Steve Zatkin.

The following ex-officio members were also present: Ms. Kim Belshe; Dr. David Werdegar; and Mr. Michael Shapiro.

III. Opening Remarks [Chairman Enthoven]
Chairman Enthoven announced that a quorum was present. He also announced that the Findings and Recommendation Sections for the following papers were adopted at yesterday’s meeting: 1) Physician-Patient Relationship; 2) Financial Incentives for Providers in Managed Care; 3) Academic Medical Centers; 4) Expanding Consumer Choice with Health Plans; 5) Improving the Dispute Resolution Process in California’s Managed Care System. In addition, Recommendations 1-4 in the New Quality Information Development Paper were voted on. Chairman Enthoven added that Task Force members had voted yesterday to allow the Public Perceptions and Experiences with Managed Care paper to be included in the main report without the requirement that it be adopted by the Task Force.

IV. Old Business

NOTE: Please refer to the Adopted Findings or Adopted Findings and Recommendations Sections for the text as adopted by the Task Force today. Proposed and adopted language is not included in these minutes due to time and space constraints.

A. Adoption of the Findings and Recommendations Section of the New Quality Information Development Paper.
Chairman Enthoven reiterated that members already voted on Recommendation No.s 1 through 4 and that today’s discussion would begin with Recommendation No. 5.
Recommendation No. 5
Several informal changes were accepted to this recommendation regarding the basic safety of patients. Mr. Lee moved to adopt the recommendation, as revised, Dr. Rodriguez-Trias seconded it. The motion was adopted 24 to 0.

Recommendation No. 4
Ms. Decker moved to reconsider Recommendation No. 4 which had failed the day before 15 to 6 (December 12, 1997). Ms. Finberg seconded the motion. The motion failed 15 to 5.

Findings Section
Mr. Lee moved to adopt the Findings Section and Dr. Rodriguez-Trias seconded the motion. Mr. Zatkin then moved to amend the Findings to include language clarifying that because each data element is included, providers are hampered in their ability to deliver excellent care by limited data to support evidence-based medicine. Dr. Rodriguez-Trias seconded the motion as it was adopted 25 to 0.

The motion to adopt the Findings, as amended, was adopted 26 to 0.

B. Adoption of the Findings and Recommendations Section of the Governmental Regulation and Oversight of Managed Care Paper. - 9:00 A.M.

Streamline Regulatory Oversight - Alternatives
Executive Director Romero presented three alternatives for the creation of a new regulatory organization. Alternative I makes the scope of this organization Knox-Keene plans only. Alternative II is a phase-in approach for the regulation of Knox-Keene and non Knox-Keene regulated plans. In essence, starting from Alternative I, Alternative II calls for the Governor and the Legislature to successively, over the course of several years, consider expanding the scope of this organization to include first, segments of the industry not currently directly regulated like medical groups, then later PPO’s and finally individual providers and facilities. Alternative III includes the new agency’s immediate regulation of all health care companies involved in insurance and delivery functions.

Alternative II
Task Force members accepted several informal amendments to this alternative. Ms. Bowne moved to adopt this alternative and it was seconded by Mr. Lee. The motion was adopted 20 to 6.

As adopted, Alternative II reads as follows:

(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 the 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 like medical groups, then later PPO’s and finally individual providers and facilities. Alternative III includes the new agency’s immediate regulation of all health care companies involved in insurance and delivery functions.

(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.

Alternative III
Ms. Farber then moved to adopt Alternative III, as proposed. Dr. Rodriguez-Trias seconded the motion and it failed 7 to 19.

Alternative I
Alternative I was deleted by members via a straw poll.

Amendment to Alternative II
Dr. Spurlock moved to amend newly adopted Alternative II. The amendment suggests that the Governor and Legislature should study within one year the feasibility and benefit to consolidating the review functions of all governmental agencies.” Mr. Lee seconded the motion which was then adopted 25 to 0. Mr. Lee then moved to adopt Alternative II, as amended, and Mr. Clark Kerr seconded it. The motion was adopted 22 to 1.

Provide Appropriate Leadership
After some discussion, members agreed to leave both alternatives in the document. Alternative I proposes that the new oversight organization be led by an individual while Alternative II proposes that the organization be led by a part-time board comprised of appointed members.

Dr. Karpf moved to adopt the use of generic language regarding the name of the new state agency throughout this and all other papers. Ms. Griffith seconded the motion and it was adopted 26 to 0.

Appropriate Principles for Regulation
Ms. Severoni moved to adopt this recommendation as proposed and it was seconded by Ms. Bowne. The motion was adopted 27 to 0.

Streamline Regulation of Medical Groups/IPAs
Ms. Severoni moved to adopt this recommendation and Dr. Karpf seconded the motion. It was adopted 22 to 0.

Streamline Solvency Audits
A technical change was accepted to this recommendation, and Mr. Perez moved to adopt the recommendation. Mr. Kerr seconded the motion. Ms. Decker then moved to amend subsection C to add language stipulating that the oversight agency should convene a stakeholder working group to develop acceptable solvency standards and financial documentation. Dr. Rodriguez-Trias seconded the motion and it was adopted 23 to 0. The motion to adopt the recommendation, as amended, was also adopted 23 to 0.

Disclosure
Mr. Lee discussed a possible recommendation he included in a memo to members, dated December 10, that suggested the following: 1) full disclosure of all survey process, methodologies and investigative results. Data collection, protocols and results should be publicly available. 2) Private data collection standards, protocols and results of data collected must be available to the public at no or low cost to the extent that data satisfies public oversight requirements. 3) The collaboration with private entities about State regulatory bodies should not limit or impede that public processes by the way the State determines which data should be collected and how quality should be monitored. 4) The State agency responsible for managed care oversight should ensure that any privately collected results satisfy established requirements.
Mr. Perez moved to adopt Mr. Lee's recommendation. Ms. Farber seconded Mr. Perez's motion and it was adopted 27 to 0.

Streamline Quality Audits
Members accepted informal changes to subsection B to say that: when standard data is not available, a health plan may use other information to ensure high quality care when appropriate audits of medical groups contract for quality third-party organizations that meet standards the state agency responsible for regulating managed care establishes. Mr. Perez moved to adopt the revised recommendation and it was seconded by Mr. Rodgers. The motion was adopted 26 to 0.

Promote Inter-departmental and Private Sector Coordination and Eliminate Redundancy
Ms. Decker moved to adopt these recommendations, with an informal change to phrase the recommendation so that it avoided duplication. Dr. Karpf seconded the motion and it was adopted 25 to 0.

Meet the Challenges Presented by Accelerating Industry Change (a) through (d)
Mr. Kerr moved to adopt these recommendations and it was seconded by Ms. Severoni. The motion was adopted 25 to 0.

Meet the Challenges Presented by Accelerating Industry Change (e)
Mr. Rodgers moved to adopt this recommendation with a clarifier that the recommendation applies to new product material modifications. Dr. Gilbert seconded the motion and it was adopted 22 to 2.

Findings Section
Mr. Perez moved to adopt the Findings Section and Dr. Karpf seconded it. The motion was adopted 24 to 0.

C. Adoption of the Findings and Recommendations Section of the Practice of Medicine Paper.
Recommendation No. 1 (a) through (d)
Several informal, technical changes were made to these recommendations. Dr. Alpert moved to adopt these recommendations and Ms. Decker seconded the motion. Mr. Perez then moved to amend recommendations (b) and (d) and to add a new (f) see the adopted recommendations for the actual text. Ms. Bowne seconded the motion which was adopted 28 to 0. The recommendations, as amended, were also adopted 28 to 0.

Recommendation No. 1 (e)
Several informal changes were accepted to this recommendation, including added language clarifying when the state agency responsible for regulating managed care should consider making the necessary changes towards the modification of the prior authorization/concurrent review process recognizing exemplary care a requirement of a health plan licensure or accreditation.

Mr. Lee moved to adopt the recommendation and Mr. Gallegos seconded it. The motion was adopted 27 to 0.

Recommendation No.s 2 (a) (1) through (4) and (6) and (b)
Again, several informal changes were made to this recommendation. Changes included adding a reasonable cost factor to periodically published formulary lists and a provision to allow a patient to continue receiving a drug removed from a plan’s formulary unless the drug is no longer considered safe and effective for the patient’s condition based on medical evidence.

Mr. Lee moved to adopt these recommendations and Mr. Gallegos seconded it. The motion was adopted 28 to 0.
Recommendation No. 2 (a) (5)
This recommendation was derived from part of No. (a) (2) and was moved for adoption by Ms. Farber. Dr. Spurlock seconded the motion which was put to a roll call vote.

The results of the vote were as follows:

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The motion failed 12 to 13.

Recommendation No. 3 (a)
This recommendation was discussed and debated. Ms. Griffiths moved to adopt the recommendation and it was seconded by Ms. Finberg. The motion failed 13 to 14.

Dr. Spurlock moved to postpone further consideration of Recommendation No. 3 and it was seconded by Mr. Perez. The motion failed 15 to 11.

Recommendation No. 3 (b)
Dr. Alpert moved to adopt Recommendation 3 (b) and Recommendation 3 (a) with the deletion of the reference to MICRA. Mr. Schlaegel seconded the motion and it was put to a roll call vote.

The results of the vote were as follows:

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The motion failed 15 to 13.
Mr. Hiepler then moved to adopt a new Recommendation No. 3 that read The Task Force recommends that the Governor and the Legislature of the State of California urge the President and Congress to evaluate ERISA statute and ask that it be revised to allow the relevant providers to be responsible and liable for damages to the extent the providers contribute to adverse outcomes that can be proven by law. Ms. O’Sullivan seconded the motion which failed 15 to 3.

Recommendation No. 4
Several informal amendments were made to this recommendation, including the substitution of the proposed subsection (b) with language supplied by Dr. Karpf regarding an expert review panel for experimental treatments. Mr. Perez moved to adopt the recommendation and it was seconded by Mr. Lee. The motion was adopted 20 to 1.

Findings Section
Mr. Hiepler moved to adopt the findings minus Subsection E [on page 3] and Subsection C [on page 7] and Mr. Perez seconded it. Ms. Finberg then moved to delete Section I. C. [on page 2 of the findings]. Mr. Lee seconded it and the motion failed 13 to 10.

Ms. O’Sullivan then moved to delete the following sentence under Subsection C [on page 2] However, Congress and the California Legislature should not be medical practice team members. Ms. Griffiths seconded the motion and it failed 14 to 10.

Ms. Griffiths then moved to amend the same sentence to read However, neither Congress or the California Legislature nor health plan executives should be medical practice team members. Mr. Lee seconded the motion and it was adopted 16 to 2.

The Findings Section, as amended, was adopted 23 to 1.

D. Adoption of the Findings and Recommendations Section of the Consumer Involvement, Communication and Information Paper.

Consumer Information:

Recommendation No. 1
Several informal changes were accepted to this recommendation and it was moved for adoption by Mr. Lee. Ms. O’Sullivan seconded the motion and it failed 11 to 12.

Recommendation No. 2
Ms. Decker moved to adopt this recommendation with a minor, technical change [change the reference to DOC to the state agency responsible for regulating managed care]. Ms. Griffiths seconded the motion and it was adopted 20 to 0.

Recommendation No. 3
Mr. Lee moved to adopt this recommendation with the word “physician” changed to “medical centers” regarding the place a patient receives care. Dr. Rodriguez-Trias seconded the motion and it was adopted 22 to 0.

Recommendation No. 4
Mr. Hiepler moved to adopt Recommendation No. 4, as proposed. The motion was seconded by Ms. Farber and adopted 19 to 12.

Recommendation No. 5
Mr. Kerr moved to adopt this recommendation as technically amended and Ms. Decker seconded it. The motion failed 13 to 10.
Mr. Lee then moved to adopt just the first paragraph of Recommendation No. 5, as it relates to the research and report of the feasibility of creating a “Super Directory” of physicians and other primary care providers. Mr. Tirapelle seconded the motion and it was adopted 23 to 0.

**Recommendation No. 6**
Mr. Perez moved to adopt Recommendation No. 6, as proposed. Mr. Kerr seconded Mr. Perez’s motion which was adopted 17 to 1.

**Recommendation No. 7**
Mr. Perez also moved to adopt this recommendation, as proposed. Chairman Enthoven seconded the motion, and it was adopted 22 to 0.

**Recommendation No. 8**
Ms. Farber moved to adopt Recommendation No. 8, and it was seconded by Chairman Enthoven. The motion was adopted 17 to 2.

**Consumer Involvement:**

**Recommendation Nos. A (1) through (3), B (1)**
Ms. Griffiths moved to adopt these recommendations and Dr. Rodriguez-Trias seconded the motion. The motion was adopted 20 to 0.

**Recommendation B (2) through (5)**
Mr. Lee moved to adopt these recommendations, as proposed, and it was seconded by Mr. Perez. The motion was adopted 22 to 0.

**Findings Section:**
Mr. Kerr moved the adoption of the Findings Section and it was seconded by Mr. Lee. The motion was adopted 19 to 0.

**E. Adoption of the Findings and Recommendations Section of the Vulnerable Populations Paper. Assurance of Access, Quality, Benefits and Consumer Protection:**

**Recommendation Nos. 1 through 14 (except 11)**
A motion was made by Ms. Farber that recommendations No.s 1 through 14, except 11, do not require adoption to be included in this paper. Dr. Rodriguez-Trias seconded the motion. The motion was adopted 21 to 0.

**Recommendation No. 11**
Mr. Rodgers then moved to adopt Recommendation No. 11 as an addition to Standardizing Health Insurance Contracts Recommendation No.s 2(b) and 3(b). The motion was seconded by Mr. Perez and was adopted 20 to 0.

**Recommendation No. 15**
This recommendation was informally revised to read that the Task Force should encourage purchasers to explore the feasibility of tracking vulnerable populations and that the state should explore the feasibility of: 1) providing specific incentives for plans under specified circumstances, and 2) developing performance outcomes for all vulnerable populations.

Mr. Lee moved to adopt the recommendation and it was seconded by Dr. Rodriguez-Trias. The motion was adopted 21 to 0.
Recommendation No. 17
This recommendation was informally changed to encourage DHS and others to continue to study and pilot the feasibility of integration of acute, chronic and long-term care services.

Dr. Karpf moved to adopt the revised recommendation and it was seconded by Ms. Griffiths. The motion was adopted 22 to 0.

Recommendation No. 19
Recommendation No. 19 was moved for adoption by Mr. Rodgers and seconded by Ms. Farber. The motion was adopted 23 to 0.

Recommendation No. 20
Ms. Decker moved to adopt Recommendation No. 20 and Dr. Rodriguez-Trias seconded it. The motion failed 9 to 13.

Ms. Farber then offered a substitute. Her amendment suggested that the State mandate a study to evaluate the impact of early discharge and recidivism. Ms. Farber then moved to adopt this substitution. The motion was seconded by Ms. O’Sullivan and failed 10 to 8.

Recommendation No. 18
Mr. Lee moved to adopt the following new recommendation: The State should require health plans compliance with non-discriminatory and accessibility standards as a condition of retaining State licensure. The motion was seconded by Ms. Finberg and failed 12 to 6.

Application of Recommendations to the Medi-Cal/Medicare Populations:

Recommendation No. 1
Several informal changes were accepted to this recommendation, and it was moved for adoption by Mr. Lee. Dr. Rodriguez-Trias seconded the motion and it failed 11 to 6.

Recommendation No. 2
This recommendation was informally revised to add a clarifier that resources should be provided by the Governor and the Legislature to implement this recommendation. Ms. Finberg moved to adopt the revised recommendation and it was seconded by Mr. Lee. The motion was adopted 17 to 2.

Recommendation Nos. 3 and 4
Recommendation No. 4 was revised to change the “annual” report to a “periodic” report. Mr. Lee moved to adopt the recommendation and it was seconded by Ms. O’Sullivan. The motion was adopted 16 to 4.

Future Reallocation of Health Care Costs Avoided through Managed Care or Other Funding Sources to Improve the Quality of Access to Care for Vulnerable Populations:

Recommendation No. 1
Ms. Bowne moved to adopt this recommendation and it was seconded by Ms. Decker. However, after some discussion, members and the Chairman agreed that this issue should be addressed in the Chairman’s Letter. Therefore, the motion was withdrawn.

Findings Section:
Mr. Lee moved to adopt the Findings Sections, as informally revised, and it was seconded by Mr. Schlaegel. The motion was adopted 22 to 0.
F. Adoption of the Findings and Recommendations Section of the Integration: A Case Study on Women Paper.

Recommendation Nos. 1 through 5(b)
Mr. Perez moved to adopt these recommendations and it was seconded by Mr. Kerr. The motion was adopted 22 to 0.

Recommendation No. 5(c)
This recommendation was informally revised to state that plans should be required to allow women direct access to their reproductive health care providers.

The motion to adopt the revised recommendation was made by Ms. Finberg and seconded by Mr. Lee. The motion was adopted 18 to 0.

Recommendation Nos. 7 and 8
These recommendations were informally revised and moved for adoption by Mr. Perez. Mr. Lee seconded the motion and it failed 8 to 8.

Findings Section
Mr. Perez moved to adopt the Findings Section and it was seconded by Mr. Schlaegel. The motion was adopted 19 to 0.

V. Adjournment [Chairman Enthoven]
The Chairman congratulated members for a job well done and without objection, Chairman Enthoven adjournd the meeting at 5:05 P.M.

Prepared by: Enrique J. Ramirez, Ph.D. and Alice M. Singh
Managed Health Care Improvement Task Force
January 5, 1998 Final Business Meeting Minutes

The Task Force did not vote to adopt these Minutes

Monday, January 5, 1998
1:00 P.M.
1201 K Street, California Room
California Chamber of Commerce
Sacramento, California

I. Call to Order [Chairman Alain Enthoven, Ph.D.] - 1:05 P.M.
The 12th and final Business Meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. Roll Call and Declaration of a Quorum - 1:10 P.M.
The following Task Force members were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Nancy Farber, Ms. Jeanne Finberg, Hon. Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffiths, Mr. Terry Hartshom, Mr. Bill Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O’Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Mr. Les Schlaegel, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ronald Williams, Mr. Allan Zaremberg, Mr. Steve Zatkin.

The following Ex-Officio Members were also present: Ms. Kim Belshe, Ms. Marjorie Berte, Hon. Herschel Rosenthal, Mr. Michael Shapiro, and Dr. David Werdegar.

III. Opening Remarks [Chairman Alain Enthoven] - 1:15 P.M.
Chairman Enthoven took this opportunity to thank the members and the Task Force staff for all the hard work that was accomplished over the holidays. He also reported to members that they should have all the components of the main report at this time. If there were any questions about the publication of the report, they should be directed to the Sacramento Task Force Staff.

Senator Rosenthal, who had requested the opportunity to make a brief statement to the Task Force, was introduced by Chairman Enthoven. He began by thanking the members and staff for their hard work and diligence and stated that he was disappointed, but not surprised with the final Task Force report. He felt that the report falls short of what is needed by consumers and was driven mostly because of the make up of the members. He felt that if the membership had been dominated by legislative appointees instead of gubernatorial appointees, the outcome would have been significantly different.

Senator Rosenthal highlighted three points to the members. First, that the Task Force report was not comprehensive. There were a number of HMO bills that were put on hold until the Task Force made its final recommendations, whose issues were not subject to the Task Force’s recommendations. He suggested that the Task Force’s Statement on Ongoing Legislation, as adopted August 7, 1997, be included with the Report’s transmittal letter.
Secondly, he anticipated industry opposition to the recommendations based on the absence in the report of cost benefit analyses. He said that this opposition should not be used to stall legislation.

Finally, he had joined Assembly Member Gallegos in a press conference earlier today to present a health care initiative [a proposal to amend the State Constitution]. He said he sees this as a “last resort” and would instead, like to negotiate the passage of pending and vetoed legislation.

A. Executive Director's Report [Phil Romero, Ph.D.] - 1:30 P.M.

He began by complimenting the Task Force members on a job well done. Although there were many differing opinions regarding the issues, members were still able to produce over 100 recommendations that Executive Director Romero felt would help restore people's trust in the health care system.

Although there were several issues that the Task Force did have the time to explore, such as the issue of cost, Executive Director Romero felt that some of the highlights of the recommendations included the following: Risk Adjustment, Disclosure and Standardization Reference contracts, Improving the Grievance Process, Continuity of Care, Pre-authorization, and Consolidating the Regulation and Quality of Care. He felt that the members should be proud of the package of recommendations, which he believed would greatly help the Governor, the Legislature and the leaders of the private organizations.

Executive Director Romero directed the Task Force to take note of the blue survey brief describing the Task Force's survey's findings for public distribution. He next introduced Professor Helen Schauffler, Director of the Health Insurance Policy Project of the University of California Berkeley, who served as the Principal Investigator for the scientific public telephone survey that the Task Force commissioned to determine the state-wide experience of Californians related to managed care. Today's presentation focused on the results obtained from the survey's third sample of 1200 insured Californians with serious medical conditions or hospitalizations within the last year.

Professor Schauffler thanked Task Force members Mr. Lee and Chairman Enthoven for the work that they had done to independently confirm the scientific validity of the survey results and confirmed that the rigorous methodology employed had enabled survey results to stand up to intense national scrutiny. She then briefly reviewed where she had left off with her presentation of the first two samples (1200 insured Californians and 1200 insured Californians with problems) and then described the major findings of this third and final directed sample of the seriously ill. She clarified that the purpose of the survey was not to determine satisfaction levels, but rather to identify what percentage of Californians had personally experienced specific problems related to their insurance and managed care in the last twelve months in order to inform the policy makers about systemic problems experienced across the state. Dr. Schauffler further explained the methodology used to determine the seriousness of the problems experienced in terms of productivity loss, financial loss and increased levels of disability that consumers attribute to problems they experienced with managed care.

The first slide showed that overall, 76 percent of Californians stated that they were satisfied with their health plans, even if they had experienced a problem in the last year. To put this figure in context, Dr. Schauffler stated that the Pacific Business Group on Health (PBGH) sets a benchmark goal of satisfaction for all health plans with whom they contract at 80 percent satisfaction rates among their employees. Anything lower than that PBGH considers the health plan not to be performing acceptably. With the statewide California survey showing a rate of 76 percent satisfaction rate, she stated that that would not meet the benchmark standard set by some of the largest employers in the state, noting however that there is variation among specific health plans within the state-wide Task Force survey, since health plan and insurer names were collected in the telephone interviews.

The focus of the majority of the slides in Dr. Schauffler's presentation was the experience of California adults with serious medical conditions who were hospitalized in the last 12 months with a specific health conditions. The results of these findings were organized into three sections: differences in health status,
types of managed care and type of chronic condition. The difference in health status was also broken down into three separate categories: those with serious conditions who had not been hospitalized in the last year, those who were hospitalized but had no serious condition, and finally, those who had a serious condition and had been hospitalized in the last year.

This third sample of the survey found the rate of satisfaction was highest for those who were hospitalized but have no chronic condition and lowest among those who have a chronic condition and have been hospitalized.

Ms. Farber questioned Dr. Schauffler about whether the slides showed the number of people who were satisfied with their health plan and thought it was excellent. Dr. Schauffler responded that the slide did not break the information down that far but she would be happy to provide that information to the members at a later date.

The survey specifically explored whether individuals had personally experienced one of 13 specific in the last 12 months. The highest rates of problems were reported among those who had chronic conditions and had been hospitalized. Among Californians who were hospitalized and had been diagnosed with one of the serious medical conditions explored in this third survey sample (such as cancer or heart disease), 17% reported not receiving the most appropriate care; 17% reported delays in getting needed care; 9% reported being denied care their doctors had recommended; 8% reported problems with referrals to specialists; 20% reported being treated insensitively or staff not being helpful and 14% stated a problem with billing or claims payments. They also reported the highest percentage of having their conditions worsened as a result of their problems with their plans.

Dr. Spurlock asked if Dr. Schauffler had done any analysis to see if there was any independent predictors of health status of any of the problems. An analysis of the general population was done and there are several independent predictors. But Dr. Schauffler had not prepared that specific analysis for this meeting.

Chairman Enthoven asked Dr. Schauffler whether she thought that people had made a clear distinction between their health plans that the medical care they were receiving. Dr. Schauffler believed that they understood the questions that were being asked and what they related to. She felt that given her extensive experience with conducting national and California health surveys, which gives her an understanding of public's ability to differentiate between insurance and care issues, that even if the questions had been broken down differently and people had been asked specifically about either their health plans/coverage or their medical care, the survey results would have come out very much the same.

With regard to how problems were resolved, the group that had both serious chronic conditions and were hospitalized were the most likely to solve their problems in the last year. The group of people who were hospitalized only were most likely to be satisfied with the resolution of their problems. In this third sample, only 19 percent found their problems to have been solved at a satisfactory level. Dr. Schauffler stated that given this low rate, she hoped that some of the recommendations that the Task Force would make regarding grievance procedures would help improve this.

In terms of health plans, the group/staff model HMOs (e.g. Kaiser) had the highest levels of satisfaction ratings: 83% were satisfied even though 33% still stated they had a problem in this model type. The IPA network model HMOs showed the lowest levels of consumer satisfaction, with only 75 percent. Breaking down problems among the different types of managed care, problems related to receiving appropriate care were predominantly reported for HMOs, whereas billing problems were most common in the PPO indemnity insurance. Members of IPA/network model HMOs reported the highest incidence of problems with delays of care, referrals to specialists and change of doctors, followed by the group HMO’s.

The survey was also able to break down information by the chronic and serious conditions. Some of the specific problems broken out by disease type were lack of choice, access to appropriate care, insensitive staff, lack of understanding of benefits, being denied care or treatment and billing issues.
In conclusion, Dr. Schauffler stated that the survey data confirmed a broad state pattern of much of what was presented by members of the public during extensive public testimony received at the Task Force public hearings. She also stated that her assessment was that the recommendations of the Task Force would largely address many of the systemic problems detailed in the scientific survey findings.

Dr. Schauffler took several questions from the Task Force members. Mr. Williams wanted some clarification about the percentage of people who had claimed satisfaction with their health plans. Mr. Lee spoke briefly about the satisfaction and problem rates studied in the survey and encouraged the task force members representing the health plans to look at the data and use it to better understand and respond to the issues raised as problematic. Mr. Zaremberg asked if the information given in the survey was going to be cross-referenced to make it easier to understand and respond to. Dr. Schauffler showed several places in the survey analysis where this was already the case and further reassured the Task Force that this large data set would be available to the public and researchers for continued analysis as well as market research and health policy development.

Ms. O'Sullivan directed a question to Chairman Enthoven regarding a sentence relating his feelings about the survey in his personal letter to be included in the main report. Chairman Enthoven confirmed that the sentence was inaccurate and that his only concern with the survey was that the press was not reporting in enough detail and that therefore the results could be misinterpreted by the public. Given that he had worked hard on the design of the survey, he had no problem with the results or methodology, but rather that survey results are based on the public's perceptions of the problems they had experienced rather than by expert's review of medical evidence. He agreed with Task Force Policy and Research Deputy Director Skubik that follow-on research that would include medical chart and case review (such as that conducted by the National Medical Outcomes Study) should be considered to determine the difference between what the public perceives as problems and problem rates as determined by independent analysts. Ms. O'Sullivan requested that Chairman Enthoven's letter be corrected to state that. Chairman Enthoven committed to do so. Chairman Enthoven suggested that such independent review should ask: Do they really need the referral? Does their health status warrant a referral? Dr. Schauffler responded that the survey was not created to make such distinctions, but it still had tremendous value as a tool for researchers and policy makers to better understand the discontent within the public related to managed care.

Dr. Spurlock stated that the system needed to be set up in a way that these issues were taken seriously. People should be able to get the care they need, but checks and balances are needed in the system that would allow a lot of the work to be done at the primary care level to appropriately save health care resources, instead of being unnecessarily referred to specialists. Mr. Hiepler asked Dr. Schauffler about the availability of this rich data set for the public and she reassured him that it would be available through the University of California, Berkeley as a solid resource for research and policy development for years to come.

Chairman Enthoven and Executive Director Romero thanked Dr. Schauffler for her solid work.

IV. Consent Items - 2:30 P.M.

The next order of business was the adoption of the Consent Items [business meeting minutes from the November 21 and 25 meetings]. Chairman Enthoven called for a motion to adopt the Consent Items. Mr. Perez made the motion to adopt the Consent Items and it was seconded by Dr. Armstead. The Consent Items were adopted unanimously.

V. New Business - 2:35 P.M.

A. Adoption of the Task Force's Executive Summary

Chairman Enthoven stressed to members that they are simply asked to discuss and adopt the Executive Summary based on the document's form and its' consistency with previously adopted recommendations.
Mr. Lee made a suggestion that the members deal with the first two pages of the summary first and then move on to the rest of the document. Mr. Lee then suggested that the term “managed care” be defined in the summary’s introduction. Without objection, the Chairman accepted Mr. Lee’s suggestion.

Mr. Williams suggested that an opening statement be added under “II. Findings and Recommendations” that would state that the following findings and recommendations are summarized and that an effort to be succinct, some unintended changes to their meanings may have occurred. The statement should also encourage readers to interpret the Task Force’s work by reviewing adopted findings and recommendations included in the Main Report. Mr. William’s suggestion was accepted by the Task Force without objection.

Dr. Spurlock suggested that the second paragraph of the Executive Summary be deleted and replaced with a paragraph defining managed care, as offered by Mr. Lee.

Mr. Lee also made the suggestion in the last sentence of paragraph no. seven on page one of the draft Executive Summary to delete “Knox-Keene regulated health care service plans affect quality and cost” and replace it with “the full range of managed care plans, whether or not regulated under the Knox-Keene Act, affect quality, cost, and how these entities can best be regulated.” Mr. Lee’s two suggestions were accepted without objection.

Ms. Finberg requested that staff include in the Executive Summary Appendix the employment affiliations and appointment categories of each member. Ms. Alice Singh, Deputy Director for Legislation and Operations, said that staff had appointment category information for gubernatorial appointments only, but that they would request that same information from legislative appointment coordinators. Deputy Director Singh also asked members to forward any employment changes to her within the next week. Ms. Finberg’s suggestion was accepted without objection.

Mr. Lee also proposed to substitute the last sentence in paragraph no. 2 and all of paragraph no. 3 on page 2 of the Executive Summary [as it refers to the uninsured] with his proposed language [Mr. Lee supplied members with his written suggested changes to the draft Executive Summary during the meeting]. In response to Mr. Lee’s proposed language, Ms. Belshe suggested that the reference to the management of any savings to the medical program be deleted.

Mr. Lee’s suggestion was accepted without objection.

Mr. Lee also suggested that paragraph no. 5 of the Executive Summary be replaced with his language, as it relates to the Task Force’s inability to review cost implications associated with each recommendation.

Mr. Williams objected to Mr. Lee’s proposal and said that it should remain as proposed. At this time a straw poll was taken in favor of deleting the original language and substituting it with Mr. Lee’s proposed changes. Only 11 members supported replacing the original language with Mr. Lee’s language, so the change was not accepted. Further, Mr. Shapiro raised objections to using the language that singles out “information” as a “cost producing long-term benefit”, and discriminating against other recommendations.

Referring to paragraph no. 5 on page 2 of the Executive Summary, Mr. Perez proposed to delete the last sentence that read, “The costs of the Task Force recommendations should be evaluated and weighed against their benefits before being implemented.” A straw poll was taken and only 10 members agreed to delete this sentence. Therefore, the sentence, as proposed, remained.

In that same sentence, Ms. O’Sullivan suggested adding the word “unnecessary” to before “costs”. Mr. Williams objected. A straw poll was taken and only 12 members supported Ms. O’Sullivan’s suggestion. She then suggested that the same sentence end with “recommendations”. Chairman Enthoven objected, and a straw poll was taken with only 3 members supporting Ms. O’Sullivan’s second suggestion.
Mr. Shapiro made the suggestion to remove the word “considered” from the same sentence. A straw poll was taken and only 14 members supported this change; thus, the changes was not accepted. Ms. Finberg asked that the words “before being implemented” be removed from the sentence. A straw poll was taken and 11 members supported Ms. Finberg’s change. The change was not accepted. Mr. Shapiro suggested adding the words “long-term” before “costs”, adding “and benefits” after “costs” and deleting “their benefits”. A majority of the members supported this change and it was accepted (pg. 82).

Break - 2:50 P.M.

After the break, Chairman Enthoven announced that Ms. Severoni won the contest of naming the new state agency responsible for regulating managed care. Ms. Severoni suggested the names “California Managed Care Authority” or California Office of Health Care Oversight”. Members cited earlier, however, that a majority of members previously objected to any name with the word “Authority”. A majority of members preferred that no name be proposed. Therefore, the Chairman agreed to delete any reference in the Report to the “California Managed Care Authority” or California Office of Health Care Oversight”.

Mr. Hauck moved to adopt the Executive Summary, as amended, and it was seconded by Mr. Rodgers. Ms. Farber raised her concern that the summary of recommendation no. 1(f) of the adopted Findings and Recommendations Section of the paper entitled, “Improving the Delivery of Care and the Practice of Medicine” did not accurately reflect the recommendations she moved for adoption on December 13. Deputy Director Singh indicated that she compares all adopted recommendations with the pertinent transcripts for accuracy. Chairman Enthoven agreed to have staff re-check the transcript prior to final publication of the Executive Summary, but reiterated that the recommendation itself could not be changed if it is consistent with the transcript. Ms. Farber said that she wanted noted in the record that her request to change the recommendation to reflect her original intent was not honored. [Note, after staff review, the recommendation in question as summarized in the Executive Summary was stated verbatim as provided in the Adopted Recommendations and the transcript].

Dr. Rodriguez-Trias said that Recommendation 5(a) of the Integration and Coordination of Care - Case Study on Women’s Health summarized Findings and Recommendations needed to be changed to delete the words “obstetricians & gynecologists” and replace them with “reproductive healthcare providers”. Ms. Sara Singer and Deputy Director Singh confirmed that the term had been simplified by staff for easier readability, but that Dr. Rodriguez-Trias’ term was the correct term of art used in the adopted Recommendations. Therefore, Chairman Enthoven accepted this change without objection.

Ms. O’Sullivan asked that as requested in by Catherine Dobbs of the ANA, throughout the report the word “physician” be changed to “providers”. The Chairman said that this change was currently underway.

Ms. O’Sullivan then moved remove footnote no. 1 on page 3 of the draft Executive Summary and instead, place it in the document’s text. Ms. Bowne seconded this motion and it was adopted 28 to 0. Ms. Finberg made a suggestion to move footnote no. 2 on page 4 into the document’s text. There was no objection to this suggestion.

Mr. Kerr asked that a change be made to the last sentence of paragraph No. 1 of the summarized Public Perceptions and Experiences with Managed Care Findings [page 15 of the draft Executive Summary] to list first the type of managed care plan consumers were enrolled in and then to list the health status, etc. Mr. Kerr’s suggestion was accepted without objection.

The Executive Summary, as amended, was adopted 24 to 0.

B. Discussion of the Report Transmittal Statement - 3:45 P.M.

Mr. Perez suggested that the Task Force next consider the Report Transmittal Statement [Item No. V. C.] as opposed to the discussion of the Chairman’s Letter [Item No. V. B.] Seeing and hearing no objection, the Chairman moved to the discussion of the transmittal statement.
Chairman Enthoven moved that Option C be adopted for inclusion in the Report Transmittal Letter. The motion was seconded by Ms. Decker. Option C read:

While few, if any, members of the Task Force agree with all of the recommendations. A majority of the Task Force joins in recommending this package and functioning of and acceptability of managed health care in California.

Ms. Bowne spoke in opposition of Option C. She viewed it as a managed care with one plan and three option. Mr. Williams also spoke in opposition to Option C, because it did not address the recommendations' lack of a cost-benefit analysis. Option C was adopted 19 to 6.

C. Discussion of the Chairman's Letter - 3:50 P.M.

Mr. Hauck said that the Chairman should reserve the right to state whatever he chooses in his official letter as Task Force Chairman.

Members agreed not to comment on the Chairman's Letter.

Ms. O'Sullivan then asked that the discussion of the Report Transmittal Statement be re-opened. She had a change that she wanted to make to it. Specifically, Ms. O'Sullivan moved to append language to the Statement from the adopted Executive Summary, as it related to the evaluation and weighing of long-term costs and benefits of Task Force recommendations. Ms. Finberg seconded the motion. Mr. Zaremberg then moved to amend Ms. O'Sullivan's motion to add a phrase that members were unable to analyze those costs. Mr. Williams seconded Mr. Zaremberg's motion to amend. Before a vote was taken on Mr. Zaremberg's motion, Ms. O'Sullivan withdraw her original motion. Discussion on the Report Transmittal Statement ceased.

D. Discussion of the Proposed Liability Statement - 4:10 P.M.

Chairman Enthoven prefaced the next order of business by saying that the statement was placed on the agenda as a result of Ms. Griffiths' request and his receipt of letters from her and 15 additional members. The Task Force Bylaws stipulate that an item can be added to the agenda if it is requested by 16 or more members. Ms. Bowne expressed her disappointment that she did not learn of the request until it had been made and honored.

The proposed statement read:

All entities which contribute to medical decisions affecting health care should be accountable for their impact on medical decisions.

Dr. Gilbert, who had originally supported the statement, now felt that there needed to be modifications made to it. Specifically, he felt that all of his health care decisions are made in the same way with the same amount of seriousness given to them, whether he is acting as a physician or as a director of a medical center. He stated that he could longer support the statement as proposed.

Chairman Enthoven and Deputy Director Singh reminded members that since this statement failed during the December 13 Task Force meeting and reconsideration was not requested at that time, the statement, if adopted, could not be included in the Main Report as an official Task Force recommendation. Instead, if adopted, it would be placed in another portion of the report - most likely in the Chairman's letter. Mr. Perez responded by saying that if there was a possibility that this statement could be considered for inclusion somewhere in the report he was willing to go through the efforts of discussing it, otherwise he didn't see the reason to waste further time and effort.

Ms. Griffiths responded to Chairman Enthoven's statement by saying she was shocked that he was not willing to accept this statement as a potential item for inclusion in the Task Force recommendations. She was under the impression that in their earlier conversations, this statement would be contemplated as an
additional recommendation. Chairman Enthoven stated that he took their conversations to mean that the statement could be possibly included in the Chairman’s letter or the Transmittal letter.

Mr. Hiepler thought that the statement, although watered down, should be at least discussed. He thought the Task Force would be doing a great disservice if they did not even attempt to address this issue. Mr. Zaremberg did not think the language was benign at all and it was subject to interpretation, and Mr. Zatkin agreed with the later statement. Dr. Alpert thought that the members should acknowledge that the issue of accountability was at least considered and looked at.

Dr. Gilbert then suggested that Ms. Griffiths’ statement be amended to read:

All entities which contribute to medical decisions effecting health care should be accountable in proportion to their involvement in the medical decision and subject to recovery limits that are otherwise applicable to medical decisions.

Ms. Griffiths asked Dr. Gilbert whether he intends for the entities to be automatically accountable or whether he intends for the Governor/Legislature to study this issue. Dr. Gilbert said that the entities should be accountable and that this issue should not require any prior study.

Dr. Alpert suggested that the words “including individuals” should be added after the word “entities”. His suggestion was accepted with no objection.

Deputy Director Singh conducted a straw poll on the support for the original medical liability statement, as presented by Ms. Griffiths. Only 14 members supported the statement.

Deputy Director Singh then conducted a straw poll on Dr. Gilbert’s amended statement. The poll revealed support of only 11 members.

Searching for a compromise, Dr. Alpert asked the members to turn to the personal letter written by Chairman Enthoven to Governor Wilson. Dr. Alpert suggested using portions of this letter that addressed the issue of accountability to address the issue of medical liability. Specifically, Dr. Alpert recommended the following statement in place of Ms. Griffiths’ statement:

The Task Force feels 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. The Task Force agrees that there must be some form of accountability. He felt that the wording used in Chairman Enthoven’s letter was more balanced. Chairman Enthoven’s only objection to this was that the whole paragraph be used and that his words not be taken out of context.

Mr. Hiepler moved to adopt the statement as Dr. Alpert had suggested and this motion was seconded by Mr. Perez. Mr. Perez then moved to Call the Question [to end the discussion and take a vote] and it was seconded by Ms. Farber. The motion to Call the Question failed with 17 votes [20 votes were required to adopt the motion].

Before the formal vote was taken, Chairman Enthoven clarified that although the statement included words from his letter, he did not accept ownership of the statement.
Members requested that a roll call vote be taken on the revised statement. The results were as follows:

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Deputy Director Singh announced that the motion to adopt Dr. Alpert’s statement failed 14 to 15.

Ms. Griffiths then requested that the document signed by the 15 members in support of the original medical liability statement be included in the Task Force Main Report with the other letters submitted by Task Force members. Chairman Enthoven stated that without objection, he would honor Ms. Griffiths’ request.

**VI. Public Comment**

There were no members of the public that wished to speak.

**VII. Adjournment - 4:30 P.M.**

Before adjourning the meeting, Chairman Enthoven asked members to join him in thanking Deputy Director Singh for her job as Task Force Parliamentarian. Deputy Director Singh also asked members to join her in thanking the California Chamber of Commerce for graciously allowing the Task Force to use its conference room for the past 10 months.

Chairman Enthoven then declared that without any objection, the Task Force’s final Business Meeting would be adjourned. Hearing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Stephanie Kauss and Alice M. Singh