

Accessible, Affordable Healthcare A Continuing Evolution

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DR. SANDRA GREENE'S comprehensive review of North Carolina's history with managed care organizations (MCOs) in this issue of the *North Carolina Medical Journal* provides an excellent overview of the major trends of the past decade. Rather than seeing the current structure of the health plan industry as a "decline" in managed care, however, I believe it is more accurate to describe it as the result of a gradual response to the demands of the market, and to the political landscape of North Carolina. The approach of health plans changed because their customers asked them to change.

As the following chart indicates, managed care—which I believe is best defined as network-based insurance products that incorporate incentives for cost-effective care—continues to replace traditional indemnity-style insurance plans. There has been no "decline" in managed care, only a shift from HMOs to Preferred Provider Organization (PPO) plans that provide simplified access to non-network physicians and specialists. This evolution is a response to consumer preference for more "open" products, and to the growing regulatory burden of operating an HMO, which has reduced the cost differential between PPO and HMO options.

North Carolina managed care membership grew rapidly in the early 1990s when MCOs exposed employers to the considerable body of evidence demonstrating that a vast percentage of our healthcare dollars is wasted through unnecessary care and indefensible variability in the delivery of care. Employers turned to MCOs to help reduce this waste, hoping to reduce their insurance premiums in turn. Through the development of networks, managed care organizations also promised to help foster price competition between healthcare providers that individual consumers had never been able to achieve.

As Dr. Greene indicates, the early results were encour-

aging, with employer premiums actually declining on average in 1994 and increasing in the subsequent years at single-digit rates. Consumers embraced the advantages of these new products: low payroll deductions, comprehensive coverage including preventive care, the absence of claim forms, and the predictability of \$10 co-payments for office visits.

Cost savings for some parts of the healthcare system, however, inevitably mean pay cuts for other parts. Providers rebelled against the new pressure on their bottom line, and against what they saw as interference with their autonomy and professional judgment. Providers responded with consolidation, which led to greater market power and the ability to negotiate higher reimbursement levels. Patients liked the low costs, but they chafed under rules that required approval to see physicians to whom they used to have direct access.

In Congress and state capitals across the country, resistance to managed care flourished and these issues became highly politicized. Scores of bills were introduced to "rein in" the alleged excesses of MCOs. Supported by arguments based heavily on emotion-laden anecdotes (however unrepresentative they may have been of the "typical" health plan member's experiences), many of these complex bills became law. Clinical evidence for or against a particular health plan practice was seldom a significant part of the debate. The resulting wave of regulatory requirements made it more difficult and more expensive to operate a health plan, and mandated payment for services such as emergency room care and longer maternity stays despite evidence that opportunities existed to find more cost-effective yet clinically sound alternatives.

These political "backlashes" were so successful because the general public did not understand the troubling variations in the delivery of care that were familiar to researchers, MCOs, and many employers. Many people were suspicious

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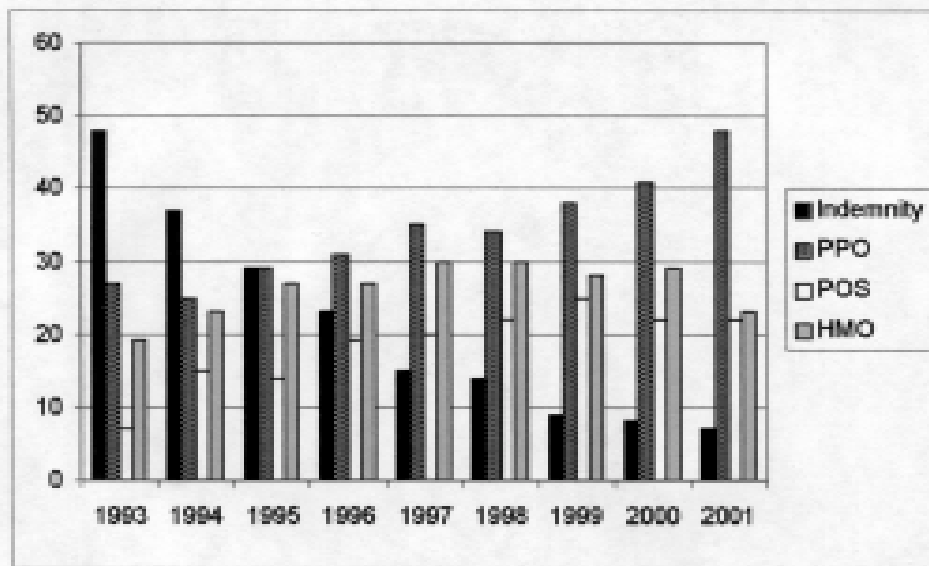


Figure. Shifts in health plan enrollment toward preferred provider organizations. PPO = preferred provider organization; POS = point of service; HMO = health maintenance organization. Source: Mercer WM. *Business and health: the state of health care in American 1998*, and Kaiser/HRET Survey, 2001.

that health plan utilization management programs were motivated more by “bottom line” thinking than by a desire to improve the efficiency of the system. This political resistance limited the ability of health plans to nudge medicine toward more evidence-based approaches.

So where does that leave our nation’s healthcare system? Costs initially constrained by managed care networks are rising sharply as laws limiting managed care and greater provider market power take hold. Employers are reeling under double-digit increases once again, and all too many businesses are reducing or eliminating health benefits in the face of a serious national recession. At best, employees can expect to pay an increasing share of their healthcare bills in the near future through significantly higher co-payments. All too many of our citizens remain unable to obtain healthcare services, an unacceptable situation in a nation as rich as ours. There are several hopeful developments that should be noted. Employers themselves have begun to lead the charge toward evidence-based medicine, such as the Leapfrog Group’s effort to make progress reducing the rate of medical errors. Importantly, employers are asking both providers and health plans to work together on this issue.

The jury is still out on so-called “consume-driven plans” that give employees more choice and more responsibility in their healthcare decisions. Making individuals more aware of the true cost of healthcare will certainly be an important achievement in itself. Public health efforts to combat obesity, improve nutrition, and increase physical activity may be greatly aided by the perception that staying healthy will keep

more money in consumers’ own pockets. Differential co-pays for specialist versus primary care visits have been in place at many health plans for several years now. Data from this experience should give us a clue about how paying more of the cost of care influences self-referral patterns in “open-access models,” including consumer-driven plans.

Some recent research indicates that the aging of the population might not cause costs to rise as much as initially feared. Whether such findings hold up remains to be seen, but we have to hope that the vast numbers of Baby Boomers becoming senior citizens in the not-to-distant future will be much healthier than seniors in the past.

The biggest challenges in healthcare are in the political arena. Regulatory intervention in the marketplace usually polls quite well, and is popular with many legislators. The complex world of healthcare, however, resists simple solutions, and unintended consequences often result from well-meaning legislation. Also, too many of these legislative “fixes” involve winners and losers — minimal or no cost savings overall and much cost shifting from a politically powerful group to a less powerful group.

We need to recognize that the various sectors of healthcare are intimately dependent on one another. When public payers like Medicare cut reimbursements to hospitals and other providers, providers push for higher reimbursements from commercial insurers to cover the shortfall. Insurance premiums rise, leading some employers to cease to provide health benefits. When patients can’t pay, hospitals and doctors are left with more bad debts and the cycle begins anew.

It’s time to end the finger pointing and the political search for the “villain” behind healthcare problems. Our nation needs to reach the “Pogo moment” when we recognize that the enemy is *us* and we all have to change our behavior. I believe that the following are among the initiatives that could bring about real, lasting improvements in our healthcare system:

- ◆ **Tort reform** could cut malpractice costs from frivolous and excessive lawsuits and reduce defensive medicine, lowering inflation throughout the system. We can’t lose sight of

the fact that victims of malpractice deserve fair compensation, but there must be more efficient ways to reach that goal than our current tort system.

◆ **A widespread movement toward evidence-based medicine is long overdue.** We simply must move toward more consistent practice of medicine based on the latest clinical evidence. Why is it so difficult for clinical discoveries to be incorporated into the everyday practice of medicine? Physicians skeptical of health plan guidelines and utilization review are challenged to acknowledge the problem squarely and present their own solutions. As noted earlier, large employers paying billions of dollars a year in healthcare costs for their workers are making this issue a top priority. Physicians and hospitals that strive to provide more efficient care should have financial incentives to encourage their efforts. For many groups, capitation proved unpopular and/or too risky. Can we develop other forms of financial incentives to help promote efficient, evidence-based care in more broadly acceptable ways?

◆ **Legislating medical practice through insurance laws** adds cost, but surprisingly little value. Recent evidence has surfaced showing that the latest available science may *not* support some of the laws that have been passed to protect patients. For example, a recent medical study concludes that short in-patient maternity stays may be appropriate in many cases. Evidence indicates that certain types of bone marrow transplants that insurers are required to cover in some states may not have been the best options for these cancer patients after all. Evidence-based medicine is a moving target, and clinicians, not legislators or lobbyists, need to lead that effort.

◆ **Staggering administrative problems** faced by physicians and hospitals are greatly exacerbated by complex legislation such as the HIPAA privacy rules. Can't we find simpler, more common-sense ways to protect patients' privacy? Health plans are looking at ways to streamline administrative burdens. NCAHP has made some steps in creating NC's first standardized credentialing application (a similar document is now required by law), and standardized forms for office assessments and medical record reviews. New technologies are emerging that could link physician offices to

insurance systems in ways that could actually improve patient service. We need to explore these new options.

◆ **Realize that government control is not a magic bullet.** The "single payer" approach to healthcare continues to appeal to some policymakers, but it's clear that the cost problems plaguing the private sector are equally evident in Medicare, Medicaid and the public employee health programs. Lower administrative costs and broadly pooled risk simply cannot overcome the underlying inefficiencies of our common healthcare delivery system.

◆ **Fraud and abuse waste valuable resources at an alarming rate.** Medicare and Medicaid fraud rules have real teeth, and are making a difference. Penalties for fraud in the commercial sector should be toughened along the same lines. While the vast majority of healthcare providers are honest, it's clear that millions of dollars are squandered on fraudulent claims every year. A strong effort must be made to separate well-meaning providers who have difficulty understanding complex and changing claims systems from those who deliberately milk the system for personal gain.

◆ **Individuals must take more responsibility for their lifestyle and utilization of healthcare resources.** Whether through "consumer-driven" accounts that create financial incentives to conserve resources, or through differential premiums for lifestyle choices, each of us must be encouraged to take the lead role in preventive care and a healthier lifestyle. Disease management programs pioneered by health plans and pharmaceutical companies should be integrated into these efforts. New companies are also springing up with the mission of helping consumers manage their lifestyles better and make more informed choices regarding healthcare utilization.

◆ **We must find better ways to spread risk.** A person's ability to find affordable health coverage is dependent on many factors, and too many people "fall through the cracks." To address this problem, we need to face squarely the huge cost of creating true safety nets and seek the broadest possible funding source to spread the cost of this serious social problem.