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Covering A Breaking Revolution: The Media And Managed Care

Managed care has received unduly negative treatment by the media, a prominent industry leader asserts. It is time to tell the whole story.

by Karen Ignagni

PROLOGUE: Managed care and the media are not the best of friends. Many reporters assert that health plans that tout their strengths through marketing campaigns often obscure how they actually operate: how they structure financial incentives under which physicians practice; how they limit referrals to specialists; and how they resolve patient grievances over treatment decisions. Health plans, on the other hand, criticize media coverage as biased against managed care. The fact is, they accurately assert, the traditional fee-for-service indemnity insurance model was never held up to the degree of scrutiny to which managed care is being subjected. To a substantial degree, the interests advocating on behalf of managed care and the media are both correct. In this paper Karen Ignagni, chief executive officer of the American Association of Health Plans (AAHP), suggests ways that media coverage could be improved, but she also exhorts the industry to recognize that it, too, could assist reporters in this effort. A Washington policy analyst and advocate for more than twenty years, Ignagni gets high marks as a spokesperson for managed care because she has a command of both the broad sweep and the technical minutiae of complex policy questions. Ignagni came to the AAHP (then the Group Health Association of America) in 1993 after serving as director of the AFL-CIO’s Department of Employee Benefits. Her experience at the labor federation in reconciling differences and finding common ground with employers and lawmakers serves her well at the AAHP, where health plans with disparate histories, cultures, and policy views must work together and with other managed care stakeholders to counter criticisms and advance a shared philosophy of care.
ABSTRACT: The health care revolution, an inherently complex undertaking, has been oversimplified. With the nation moving into an election year, it is incumbent upon the media, health plans, and policymakers to enlarge and enlighten the health care debate.

Back in 1777, shortly after the American colonies declared their independence, an observer reported to London that “the power of the rebellion is pretty well broken, and though ’tis probable the colonies may make some further efforts, those efforts will be feeble and ineffectual.” This, as we now know, turned out to be a premature assessment, based no doubt on a misreading of limited or obsolete data and a skewed interpretation of events still unfolding. The moral: It isn’t easy to cover a breaking revolution.

Now, fast-forward to 1997. A revolution is taking place in the organization and delivery of health care in the United States. Practically overnight, managed care has replaced fee-for-service as the nation’s health care system of choice. But whether this is a good or bad thing is still a matter of intense debate. By now the debate has settled into a familiar pattern. Critics of managed care have become adroit at selectively publicizing alleged denials of service and failures of care, which are then amplified by the media and become the basis for hastily considered legislation enacted in the name of consumer protection. Health plans, for their part, spend time debunking charges and shoring up public support. That time could be used more productively—by all concerned—to advance the horizons of health care.

There are risks in allowing the debate to continue within such narrow parameters. If the flawed assessments of 1777 had prevailed, the colonies would have lost confidence in their revolution. And if the health care debate continues to take place within the limited confines of horror stories and legislative reactions, many Americans will lose confidence in a system of care whose goal is to offer superior coverage, state-of-the-art care, unprecedented accountability, and an unparalleled commitment to continuous quality improvement—all at an affordable cost.

There is a solution. The debate needs to be enlarged. It needs to take into account the important fact that the health care revolution is a work in progress—a dynamic, evolving system, responsive both to the nation’s needs and to consumers’ expectations and capable of adapting as those needs and expectations change. The debate needs to move beyond anecdotes and the recycling of old data, to encompass broader perspectives on the pros and cons of change. But enlarging the debate will pose challenges—for the media, for health plans, and for policymakers.
The Challenge For The Media

The media, with their enormous ability to sway public opinion, are particularly challenged to put the health care revolution in perspective. Thus far, this has proved to be a difficult assignment.

Journalists who cover health care closely know that care management is essential if health care is to remain broadly accessible and affordable, and they know that the old fee-for-service system became unaffordable in large part because of its inherent inability to manage care. They know that a well-administered health plan promotes optimal patient care at affordable cost by ensuring that patients get the right care, at the right time, and in the right setting. And they know that there is more to this formula than meets the eye. They know that it requires an uncompromising commitment to preventive care, early intervention, active coordination of care, and ongoing assessment of outcomes. They know, in short, that “appropriate care” is not merely a synonym for “stinting on care.”

Yet, time after time, the media as a whole have been susceptible to critics’ charges that health plans are able to contain costs only by denying referrals, limiting access to high-cost treatments, or otherwise stinting on care. The result is to give credence to claims that eventually are proved to be unwarranted by the preponderance of evidence but in the meantime do no end of damage to public confidence. Examples abound: “drive-through” deliveries; outpatient mastectomies; “gag rules” for physicians.

“Gag rules.” It may be useful to focus for a moment on just one of these. For more than two years, health plans have been battling accusations that they use contractual clauses—gag rules—to limit what doctors can tell their patients about treatment options. Given the historical sanctity of the doctor/patient relationship, it would be hard to imagine how health plans could contemplate—let alone perpetrate—such an obvious and severe breach of ethics. Now the U.S. General Accounting Office (GAO) has come out with a report confirming that health plans are doing no such thing. Gag rules, as the GAO found, do not exist—except in the minds of critics who have no compunctions about distorting the true purpose of clauses that protect the confidentiality of financial arrangements or guard against disparagement of a plan by a physician contracting with competing plans.

Because the GAO has high credibility with the media, the gag-rule myth may finally be on its way to oblivion. But consider the damage done in the meantime. A multimillion-circulation national newsmagazine featured a muzzled “doctor” on its cover. Television
news and talk programs scrambled for new angles to explore. And when a national association of physicians weighed in, gag rules attracted the attention of lawmakers from coast to coast. At last count, thirty-two states had passed laws “protecting” consumers against this nonthreat—laws passed in undue haste and at undue cost in time wasted and in the creation of a needlessly adversarial, fear-dominated regulatory environment.1

Damage done by false charges. One can argue, perhaps, that there is no harm in passing laws affirming the inviolability of the physician/patient relationship. But harm has indeed been done. At a time of rapid change, millions of consumers are only now beginning to familiarize themselves with the system of care pioneered by health plans. Scaring them half to death about imagined or exaggerated abuses is not a promising way to build the kind of trust that results in making the most effective use of health plans’ services.

By now this has become a distressingly familiar pattern. Health plans engaged in nothing more suspect than following widely recognized professional practice norms have been accused of requiring “drive-through” deliveries, a charge not supported by the evidence. And they have been falsely accused (by critics making no distinctions between lumpectomies and radical mastectomies) of expecting all breast cancer patients to undergo surgery as outpatients.

False charges have a long half-life. Although health plans have repeatedly been able to demonstrate their commitment to high-quality care, in matters evoking so much emotion no amount of evidence can entirely erase the damage done by the original accusation. More people hear about the indictment than ever read the trial transcript.

It is this fact that makes covering the health care revolution so challenging for the media. On the one hand, health plans have no right to expect journalists to blindly cheer them on. On the other hand, journalists by now should be laboring under no illusions about the not always entirely altruistic motives of those who, for various reasons, would like to roll back the revolution. The media are, of course, free to amplify charges without first verifying them, but that’s like being free to cry “Fire!” in a crowded theater on the basis of a rumor. Given the risk of creating confusion—or
panic—there is a compelling argument for sorting out the facts first. In the case of health care, where the media function as guides to the revolution, the challenge is to create a nuanced context rather than repeatedly reducing an exceedingly complex topic to a simplistic black-and-white morality tale.

The Challenge For Health Plans

Better communication. Health plans must become better at communicating with the media and with policymakers. All too often, we speak different languages. Terms such as protocols, utilization review, and capitation—which are important and meaningful within the managed care community—are as Sanskrit to the special audiences with whom health plans must communicate. Although we cannot readily abandon our professional vocabulary, we can work harder at making it more accessible.

As part of this effort, we must try to communicate, at every opportunity, the real significance of the terminology that we tend to take for granted. Otherwise, health plans will remain trapped in an endless Ping-Pong match with critics: We say “accountability,” they say “interference.” We say “best practices,” they say “cookbook medicine.” And so on. There is more at stake here than trying to win the match. To the extent that the media, policymakers, and the public remain confused on these very basic points it becomes that much more difficult to have a genuinely useful debate about how the health care revolution should proceed.

Demonstrate improvement. There is, of course, more to communicating than simply choosing one’s words carefully. Part of the challenge facing health plans is the need to continually demonstrate that the revolution is really working—that health plans, spurred by the expectations of purchasers and consumers in a competitive environment, are continually bringing better coverage, better service, better care, and greater choice to the health care marketplace.

We can make this case with available data showing the high and increasing percentages of patients whose health plans provide them with optimal care across a spectrum ranging from cervical cancer screening to protection against recurrent heart attacks. We can make this case with representative success stories drawn from among the overwhelming majority of patient/plan interactions that result in positive outcomes. And we can make our case by inviting the media and policymakers inside—to witness, for example, how health plans working with highly qualified health professionals identify best practices and how plans partner with practitioners and patients to promote continuous quality improvement. Nothing demystifies managed care more
effectively than seeing it in action, close up.

■ Provide comparisons. Demystification should not mean oversimplification. Part of our challenge is to better equip the media and policymakers to compare the pros and cons of managed versus unmanaged care. This means going back to basics and revisiting what could have happened if no one had stepped up to the challenge of managing the organization and delivery of health care services and measuring and reporting on quality of care. As we know well, health care costs would likely have continued skyrocketing, and in the absence of any attempt to measure outcomes within and across service areas, wide variations in the quality of care would have continued to be the norm, exposing millions of patients to the risks of being uninsured, underserved, or inconsistently treated.

No matter how familiar these points may seem, it is important to remind observers that it was this spiral, rapidly spinning out of control, that provided the original impetus for the health care revolution. The exercise helps us to exorcise a false dichotomy: that managed care, with its undeniable complexity, replaced a simpler, more user-friendly arrangement in which a patient’s only task was to know whom to call when in need. That perception continues to color public opinion, playing into the hands of managed care’s critics.

■ A work in progress. Yet another part of the challenge facing health plans—and perhaps the most difficult—is to make the case that the revolution is a genuine work in progress, still perfectible and fully recognized as such. If seven of a hundred patients say that they are dissatisfied with the care they received, we have more work to do. If five of a hundred patients misunderstand a policy designed to reduce overreliance on emergency departments in nonemergency situations, we have work more to do. If even one patient disputes a coverage decision involving an experimental treatment, and the dispute is not promptly resolved, we have more work to do. By definition, a work in progress makes progress by identifying what needs to be improved and then doing it as promptly as the dictates of responsible management allow.

To illustrate, consider the current trend toward offering consumers more freedom in choosing physicians. In the early days of managed care, when information feedback systems were relatively primitive, it was difficult to know whether practitioners outside a plan’s select network were practicing in accordance with the plan’s professional norms. About the only way to guard against wide variations in practice was to steer patients to the plan’s preapproved physicians. Today, with health plans’ practice guidelines much more widely recognized and accepted, and with plans better able to
monitor the quality of care regardless of where it takes place, the earlier need for access restrictions has eased. As a result, consumers’ expectations can be met without compromising care—and it is by repeatedly achieving this standard that the health care revolution can claim to be a work in progress.

**Key tasks.** We cannot assume that this point will be self-evident to the media, consumers, or policymakers. To cut through the confusion of today’s narrowly proscribed health care debate, health plans must be prepared to do the following.

*Demonstrate leadership.* Believing as we do that government micro-management is the wrong way to provide for consumer protection, we must more actively contribute to the process of debating and defining government’s proper role.

*Sharpen the message.* Patient satisfaction statistics, although important, are ineffective at countering anecdotal allegations of mismanaged care. To help consumers to understand how health plans really work, plans need to work harder at communicating how they manage the care of chronically ill patients—which means, among other things, making a greater commitment to outcomes research and similar benchmarks of progress.

*Beware of misplaced goals.* It is only natural to want to be loved. But health plans cannot entirely escape the impersonal image that attaches to any large organization. Rather, their goal should be to be trusted, earning that trust by constantly demonstrating their ability to respond to consumers’ concerns, fears, and expectations.

*Give health care a human face.* Health plans have arguably underused their greatest resource: the men and women who are leading them and, in so doing, guiding the health care revolution. The leaders of the managed care community need to be more visible and to have a more active dialogue with the media, policymakers, and the public, all of whom are more likely to trust a clearly dedicated, plain-spoken leader than any number of position papers and progress reports.

*Emphasize ethics.* It is still not widely understood that health plans make business decisions within the context of doing what is best for patients. There is a continuing need to demonstrate that “Putting Patients First” is more than a motto—that it is a mission grounded in an explicit code of professional ethics adopted by the more than 1,000 members of the American Association of Health Plans (AAHP), whose adherence to the code is a condition of continued...
membership.

*Stay the course.* Few, if any, industries have ever been challenged to demonstrate mature leadership as rapidly as has the community of health plans. Although health plans have already amassed a remarkable record of service, in a sense we are still just getting started. We have committed ourselves to a process of continuous quality improvement, and the burden of proof is upon us to show skeptics that we are up to that task—every day, in every service we provide, and in every one of the myriad tough decisions and judgment calls that health plans must make as leaders.

**The Challenge For Policymakers**

Finally, given the nature of the health care revolution, the challenge for policymakers at both the state and federal levels is quite straightforward. In essence, they must decide whether to encourage a work in progress or put the brakes on. Pressure to roll back the revolution will continue to be intense, and the stakes have never been higher, especially with the nation moving into another election year.

Political rhetoric notwithstanding, policymakers do not have to make a simplistic choice between competition and regulation. There is room for both. The question is where the balance point should be. On the one hand, consumers have every right to expect to receive high-quality care that is appropriate to individual circumstances. On the other hand, the legislative arena is limited in its ability to dispassionately evaluate allegations of substandard care. In the absence of a mechanism outside the legislative arena where concerns can be brought and data produced, the temptation for members of Congress and state legislators is to produce measures that can lead to governmental micromanagement.

Many policymakers are well aware that arbitrary mandates—twenty-four hours in the hospital for this, thirty-six for that—not only fail to allow for case-by-case variations but perversely encourage just another form of cookbook medicine while absolving practitioners of any responsibility to keep health care accessible by practicing as cost-effectively as possible. But under pressure from constituents reacting to critics' charges, policymakers may be understandably tempted to pass legislation now, call it consumer protection, and cope with the consequences later.

*We all have a stake* in avoiding this scenario. We need to come to the debate as stakeholders with a shared interest in the future of accessible, affordable health care. We cannot afford to ignore the fact that quality, accountability, access, and cost are all tied together and need to be considered not
in isolation from one another but as a whole. We need to explore new ways to ensure consumers’ peace of mind at the same time that we promote continuing innovations in the organization and delivery of health care.

It may be asking too much to expect the health care debate to be broadened in this fashion in an election year. Perhaps 1998 will see little more than a continuation of the present debate, with all of its limitations. Rather than settling for that in advance, however, we might think for a moment about what could be accomplished by enlarging our horizons.

NOTES
3. Ibid.