The Managed Care Backlash And The Task Force In California

Lessons for consumers, physicians, health care workers, health plans, and politicians from California’s task force on managed care.

by Alain C. Enthoven and Sara J. Singer

PROLOGUE: California represents a lively laboratory, in which issues that eventually concern the whole nation are worked through in a colorful, often contentious fashion. This is certainly true of managed care. The state has felt its share of the “backlash” against managed care on the part of consumers and others. In response to a rising chorus of concerned voices, California Governor Pete Wilson (R) and the state legislature appointed a thirty-member task force to examine “the appropriate role of government in guaranteeing the highest standards in quality of care.” The task force issued its final report in January 1998. True to the combative nature of the managed care debate there, some legislators and consumer advocates scored the report as “disappointing” and “weak,” while the governor praised it and quickly signed into law several of its 100 recommendations, and many managed care companies gave it their grudging approval. Many of the recommendations put forward by the governor’s task force were similar to those advanced in the final report of President Clinton’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

In this paper Alain Enthoven, the task force’s chairman, and Sara Singer, its staff director, present their interpretation of the task force’s work. Enthoven is the Marriner S. Eccles Professor of Public and Private Management at the Graduate School of Business, Stanford University, in Stanford, California. He holds degrees in economics from Stanford, Oxford, and the Massachusetts Institute of Technology. Singer directs the Health Care Management Program at the Stanford Graduate School of Business. She holds a master of business administration degree from Stanford.
ABSTRACT: Signs of a managed care backlash in California are increasing. This paper reports and interprets the recently completed work of the California Managed Health Care Improvement Task Force, focusing on the managed care backlash and the state’s regulatory response. Although cost containment was a contributing factor, the causes of and solutions to the backlash differ among consumers, physicians, health care workers, politicians, and health plans. The recommendations of the task force could improve the market for health insurance. However, lasting solutions to the profound problems causing the backlash will require fundamental cultural and systemic change.

Signs of a managed care backlash in California abound and, if anything, are increasing as politicians and the media join in. During 1990–1997 the California legislature passed eighty-nine laws reforming managed care, including legislation pertaining to access, disclosure, mandated benefits, patient billing and claims practices, provider contracting, solvency and regulation, and managed care in workers’ compensation. In 1996, ballot propositions 214 and 216, which would have established substantial provider protections, received respectively 42 percent and 39 percent of the popular vote. In 1997 alone ninety managed care bills were introduced.

The California Managed Health Care Improvement Task Force—a thirty-member ad hoc body composed of equal representation from health plans, employers, plan enrollees, providers, and consumer advocacy groups, charged by the legislature to provide information about the impact of managed care and by the governor to recommend solutions to the state’s managed care problems—concluded its deliberations in January 1998. This paper offers lessons and insights from the task force’s experience, focusing on the managed care backlash and the state’s regulatory response.

Cost Containment’s Contribution To The Backlash

The managed care backlash coincides with managed care’s success in halting the explosive growth of health care expenditures in the 1980s. This success is attributable to managed care subjected to strong price competition by employers.

The numbers. In the 1980s national health expenditure growth was straining public finances, taking money out of real wages, and pricing coverage out of reach for millions of people. From 1985 to 1992 national health expenditures grew 10 percent per year and increased their share of gross domestic product (GDP) from 10.2 percent to 13.3 percent. National health expenditures accounted for 13.6 percent of GDP in 1993. In 1996, largely because of the impact of managed care and the prosperous economy, health expenditures fell to the same proportion of GDP as four years earlier. Membership in health maintenance organizations (HMOs) nationally increased
from 36.5 million in 1990 to about 67.5 million in 1996, or to approximately one in four Americans.\(^5\)

Managed care did even better in terms of cost containment in California into 1998. Premiums for large purchasers and purchasing groups doubled between 1987 and 1992; from 1992 to 1998 health care premiums were flat. California Public Employees Retirement System (CalPERS) premiums were about the same in current dollars in 1997 as they were in 1992 for essentially the same standard benefit package and a somewhat older population; inflation-adjusted, they were down about 13 percent. Most other large California employment groups saw similar savings.

In 1985 there were 6.2 million HMO members in California; by 1996 there were fourteen million.\(^6\) By 1996, of persons having employment-based coverage, 63 percent were in HMOs, 7 percent were in point-of-service (POS) plans, 23 percent held preferred provider insurance, and only 7 percent still held traditional fee-for-service indemnity coverage.\(^7\)

- **The impact.** After years of fast-paced growth, bringing the rate of growth of health care expenditures down to the growth rate of GDP was bound to cause wrenching change for all involved. However this was done (through price-competitive managed care, price controls on HMOs, a Canadian-style single-payer system, or any other model), effective cost containment would have reduced the incomes and autonomy of health professionals and deprived patients of some of the access and freedom they previously enjoyed.

Most people see cost containment as necessary to maintain or expand access to coverage. Intensified efforts may be required if health care costs rise again. Already, employers nationwide are experiencing an upturn in prices for 1999.\(^8\)

**Consumers**

- **Problems contributing to the backlash.** Over the past decade large numbers of consumers have been converted—often involuntarily—from the freedom of fee-for-service indemnity coverage to the limitations of HMOs, often without much explanation of the relationship between the limitations and cost containment. Because employers typically pay all or most of the premium, consumers have not felt personally involved in premium costs. They do not commonly perceive that premiums ultimately come out of their wages.\(^9\) So to consumers, replacement of fee-for-service, indemnity coverage with HMO coverage is viewed as a “takeaway” with respect to choice.

To find out what California consumers thought about managed care, the Managed Health Care Improvement Task Force commi-
sioned Helen Schauffler of the University of California, Berkeley, and the Field Research Corporation to conduct a survey of insured Californians. The survey asked consumers if they were satisfied and whether they had experienced any problems with their health insurance in the past year (Exhibit 1). It examined all forms of health insurance: group/staff-model HMOs (entirely Kaiser Permanente in the sample); independent practice association (IPA)/network HMOs; preferred provider insurance plans, commonly known as preferred provider organizations (PPOs); and fee-for-service (FFS) indemnity plans (mainly Medicare beneficiaries).

Of all consumers, 42 percent said that they had had one or more problems with their health plan in the past year. Forty-one percent of consumers in PPOs had problems; 47 percent of IPA/network members and 34 percent of group/staff HMO members had a problem.

The survey was not able to evaluate the merits of consumer-reported “problems.” For example, some consumers experienced difficulty with referral to specialists, but in at least some cases, managed care might have been doing the right thing. Studies and expert opinions suggest that Americans have overused specialists. Expert evaluators may not have agreed with the patients that they did not receive appropriate care. In addition, problems related to plans’ not covering important benefits are largely out of the insurers’ control and are related to decisions made by purchasers. Moreover, 24 percent of those who were very satisfied also experienced a problem, which suggests that many of the “problems” were not major. Only 8 percent of the population both had problems and claimed to be dissatisfied with their health plan. Still, 8 percent of the insured population in California is a very large number, and many of these persons are very vocal about their problems.

The problems associated more often with HMOs (not receiving

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**EXHIBIT 1**

Prevalence Of Insured Californians’ Problems With Their Health Insurance In The Past Year, By Type Of Health Plan, 1997

<table>
<thead>
<tr>
<th>Problems</th>
<th>IPA/network</th>
<th>Group/staff</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan not covering important benefits needed</td>
<td>16%</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Difficulty with referral to specialists</td>
<td>14%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Didn’t receive most appropriate or needed care</td>
<td>14%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Misunderstanding over benefits or coverage</td>
<td>11%</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>Forced to change doctors</td>
<td>9%</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Problem with billing, premium, or claims payment</td>
<td>15%</td>
<td>6%</td>
<td>18%</td>
</tr>
</tbody>
</table>

**SOURCE:** Managed Health Care Improvement Task Force Public Survey, University of California, Berkeley/Field Research Corporation, 1997.

**NOTES:** IPA is independent practice association. PPO is preferred provider organization.

* Persons in this type of plan are statistically significantly more likely to report this problem than are persons in other plan types.
appropriate or needed care, having difficulty with referral to specialists, and being forced to change doctors) are not surprising, given the limits and restrictions that HMOs impose and the complexity of the product they provide. Members of fee-for-service PPOs had different types of problems (problems with billing, premium, or claims payment and misunderstandings over benefits and coverage), which reflect a different organizational model.

Despite these problems, the survey found that most people were satisfied or very satisfied with their health plan: 83 percent for group/staff-model HMOs, 75 percent for IPA/network-model HMOs, and 74 percent for PPOs. There was no evidence that fee-for-service PPO coverage is more satisfactory. Numerous other surveys have found Californians to be very satisfied with their HMOs.12

Kaiser Permanente members surveyed were the most satisfied. They also were among the least dissatisfied (tied with PPO members with 8 percent dissatisfied). Eleven percent of IPA/network members were dissatisfied. High satisfaction and low dissatisfaction rates among Kaiser members are interesting, given that Kaiser offers a more limited choice of doctors than the large IPA/network HMOs offer. One explanation may be that such restrictions are less important to Kaiser members. On the other hand, many IPA/network members and their doctors are recent, often involuntary or reluctant, converts from FFS indemnity insurance. In making the transition, they may have lost freedoms they valued but whose cost they or their employers were not willing to pay. For example, when asked by the task force’s public survey about their willingness to pay for direct access to specialists, although 44 percent of the general population said that they favored the policy, only 15 percent would be willing to pay more than $20 per visit for it.13

To determine whether the high level of satisfaction is merely the result of the fact that most people are healthy, the survey specifically sampled persons who were hospitalized or had a serious chronic condition, in addition to the general insured population. It found that those who met both criteria were even more satisfied than the general insured population was for all types of plans (Exhibit 2).

**EXHIBIT 2**
Proportion Of Californians Satisfied With Their Health Plan, By Type Of Plan, 1997

<table>
<thead>
<tr>
<th>Consumer group</th>
<th>IPA/network</th>
<th>Group/staff</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured population</td>
<td>75%</td>
<td>83%</td>
<td>74%</td>
</tr>
<tr>
<td>Chronic conditions/hospitalized</td>
<td>77</td>
<td>90</td>
<td>84%</td>
</tr>
</tbody>
</table>

**SOURCE:** Managed Health Care Improvement Task Force Public Survey, University of California, Berkeley/Field Research Corporation, 1997.

**NOTES:** IPA is independent practice association. PPO is preferred provider organization.
Studies indicating that patients with more contact with their physicians are more satisfied may explain these results.  

More chronically ill patients (44 percent), hospitalized patients (55 percent), and chronically ill and hospitalized patients (53 percent), however, reported problems with their plans (all types) than their healthy counterparts did. For example, such patients were more likely to report denials of treatment and being forced to change medications (Exhibit 3). Some increase in problems might have been expected, given these persons’ increased interaction with the health care system and therefore greater opportunity for problems. Persons who were chronically ill and hospitalized in the past year also were more likely to report that the primary problems they had with their plans led to a worsening of their condition and to permanent disability. Higher satisfaction rates may be attributable to lower expectations among high utilizers. The disparity between the percentage of consumers citing problems and those citing dissatisfaction raises questions about the relevance of satisfaction ratings in determining whether plans are providing high-quality care.

Resolution of the backlash by consumers. In our judgment, the managed care backlash will not dissipate until several fundamental problems related to consumers are resolved.

Consumers' demands. First, Americans must reconcile their demand for lower costs with their demand for unlimited care. As consumers who pay health insurance premiums, we demand lower prices. Taxpayers demand that the health care system get its costs down because so much health care is funded by government. But when we (or our loved ones) become ill, most of us would spare no expense to obtain the best medical care technology available. Our predominant institutional arrangements have disconnected people from the financial consequences of their health care decisions.

This problem cannot be resolved unless consumers perceive a

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**EXHIBIT 3**

Prevalence Of Californians’ Problems With Health Insurance In The Past Year, 1997

<table>
<thead>
<tr>
<th>Problem</th>
<th>General population</th>
<th>Chronic condition only</th>
<th>Hospitalized only</th>
<th>Chronic condition and hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced to change medication</td>
<td>4%</td>
<td>9%</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>Being denied care or treatment</td>
<td>3</td>
<td>6</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Doctors, nurses, or staff insensitive</td>
<td>11</td>
<td>10</td>
<td>15</td>
<td>20%</td>
</tr>
<tr>
<td>or not helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem with billing, premium, or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>claims payment</td>
<td>13</td>
<td>12</td>
<td>27%</td>
<td>14</td>
</tr>
</tbody>
</table>

**SOURCE:** Managed Health Care Improvement Task Force Public Survey, University of California, Berkeley/Field Research Corporation, 1997.

a Californians in this circumstance are statistically significantly more likely than the general insured population is to report this problem.
direct personal interest in economical medical care. Otherwise, they
have no reason to accept any limitations. To accomplish this, con-
sumers must know what their health care costs are and that premi-
ums come out of their wages. Employers should require employees
to pay the full premium difference (risk-adjusted if possible) for a
more expensive health plan. Only 7 percent of employers do so now. This would encourage consumers to seek value when pur-
chasing coverage and create pressure on health plans to offer high-
quality care for the lowest possible price. A limit on tax-free em-
ployer contributions might help employers to overcome employees’
resistance to employers’ offering a contribution set at the tax-free
limit and requiring employees to pay the difference in premiums.

Although cost-consciousness in consumers’ choice of health
plans will foster competition and reduce price, alone we believe it
will be insufficient to appease the backlash. HMO enrollees pay
little at the point of service (usually a $5 or $10 copayment for a
physician visit and nothing for hospitalization) and therefore have
little or no incentive to accept less-costly care. One physician who
testified at a public hearing to the task force described the problem.
He spoke of a patient who wanted a test that he (the physician) did
don’t think was necessary and therefore did not order. His patient
went away angry. The RAND Health Insurance Experiment results
suggest that patients might respond differently if they were re-
quired to pay part of the cost of tests and procedures that now are
covered in full. More importantly, other physicians in this situation
may simply give their patients what they want rather than exercising
their judgment in a way that helps to reduce overall health expendi-
tures (and losing patients in the process).

*Clarity in insurance rules.* Second, there needs to be much more
clarity regarding the “rules of the game” when it comes to insurance.
The mind-boggling complexity of health insurance contracts re-
quires special rules to make sure that buyers and sellers agree that
what is being sold is what is being delivered. The industry, the
purchasers, or government must define terms and set standards,
such as the meaning of *emergency* and *available services*. Toward this
end, the California task force recommended that a working group of
stakeholders seek to agree on a definition of *medical necessity* and that
a clinical expert panel be convened to determine when treatments
should be considered standard care rather than experimental. The
task force also recommended the development and use of standard
reference contracts and product descriptions to simplify choices for
consumers and to facilitate comparisons. It recommended that
plans be required to make available significant up-to-date and spe-
cific additional information on access to providers, referral patterns
to specialty centers, plans’ or medical groups’ written treatment guidelines or authorization criteria, and covered drugs. Finally, it recommended that dispute-resolution processes should be consistent across plans. Each of these recommendations would help to simplify consumers’ interactions with health plans.

Safety valves. Third, in our judgment, there need to be safety valves. One form of safety valve would assure consumers that they could seek care from the providers of their choice, albeit at an added out-of-pocket expense, as in POS plans. Health plans with POS options are very desirable. However, cost-sensitive consumers also should have the option to purchase less expensive closed-ended products, if this is their preference. Another form of safety valve is through the dispute-resolution system, which should provide access to expert independent review, as the task force recommended. However, to deter abuse, financial thresholds for the amount at issue and consumer sharing in the cost of the process are necessary.

Increased choice. Fourth, more consumers should be given a wide range of choice of plans, such as those in the Federal Employees Health Benefits Program (FEHBP) and CalPERS. According to one survey, persons in managed care who did not have a choice of plans were 57 percent more likely to be dissatisfied with their insurance plans; 22 percent were very or somewhat dissatisfied with their insurance plans, compared with 14 percent of persons with a choice. Different health plans have different operating rules, some of which will be burdensome to some and acceptable to others. Persons with preferences will be happier with their choices. Moreover, if consumers do not have a choice of plans, market forces will not be able to pressure the plans with unpopular practices to change.

Many consumers in California today have no choice of plans, and few have a full range of choices. According to KPMG Peat Marwick data, 46 percent of employees whose employers provide coverage have no choice of plans. Taking into consideration the choices offered to both spouses increases the amount of choice. The task force’s public survey found that approximately 25 percent of California consumers who knew the number of choices they were offered reported that they had no choice of plans, including choices offered to either spouse. A reasonable minimum choice set might be two HMOs and one plan that offers open access to providers of the member’s choice (such as POS or PPO). Three health plans would provide choice for persons who need or want the less costly format of a closed-ended HMO and would require all of the plans to compete head-to-head on price. Recognizing its importance, the task force sought ways to expand consumer choice of plans but found it very difficult to identify specific ways of implementing that
choice. In the end, the task force recommended only that more employers voluntarily offer individual choice of health plans. The task force considered requiring employers to offer individual choice. However, to compel choices at the state level would require changing the federal preemption of state law under the Employee Retirement Income Security Act (ERISA) of 1974. Task force members were appropriately concerned that as long as employer-sponsored insurance remains voluntary, compelling individual choice may reduce small employers’ willingness to offer coverage. Expanding choice of plans in the small-group market requires pooled purchasing arrangements such as the Health Insurance Plan of California (HIPC).

Improved resolution of problems. Fifth, there must be improvement in the areas identified by the survey as problems for consumers, such as being forced to change doctors because a medical group and a health plan could not agree on a contract. The industry should be proactive in the early identification and resolution of such problems; where it is not, government should threaten or enact legislation to resolve them. The task force made numerous recommendations to address problems identified by its public survey. To dispel mistrust, the task force recommended disclosure of the scope and general methods and incentives paid to contracting physicians. However, the task force did not recommend disclosure of the specific amounts providers are paid, considering this to be personal information. To ensure continuity of providers, the task force recommended the establishment of rules providing for limited continuity of providers in the case of involuntary plan changes and persons who are chronically or acutely ill or pregnant. To ensure that consumers are not forced or pressured to change prescription drugs, the task force recommended that if a drug is removed from a plan’s formulary, consumers be allowed to continue to receive it for an ongoing condition if their doctor continues to prescribe it. Ensuring that providers have the right incentives to factor in the effectiveness of the drug and the costs of changing drugs for patients will require that formulary decisions be made by committees of the doctors who are treating the patients, at risk for the cost of care, including drugs. To ease the referral process, the task force recommended that patients with chronic conditions be given standing referrals to appropriate specialists. Also, the task force recommended that plans be required to
allow women direct access to their reproductive health providers in a manner that permits and encourages coordination and integration of services.  

Physicians

- **Problems contributing to the backlash.** Although many physicians in many medical groups in California have embraced managed care, recognized the need for cost management, and accepted responsibility for it, many others regret the demise of FFS indemnity insurance and their transition to managed care. Outside the group/staff models and some of the multispecialty groups in network models, most physicians have been driven to HMOs for financial survival. Specialists in particular fear a loss of income as a result of managed care.  

Under managed care, physicians have suffered a loss of autonomy and authority. In some arrangements, apparently unqualified third parties tell them what they can and cannot do. In addition, some physicians object to compensation arrangements based on capitation because such arrangements place physicians in the uncomfortable position of rationing care. However, by not organizing and managing care themselves, doctors created a vacuum into which health plans have moved. As a result, health plans are performing functions that upset both physicians and patients.

Physicians in IPA/network HMOs face maddening complexity. In California, they typically contract with fifteen different managed care plans, each of which may establish its own referral requirements and employ formularies not developed by the treating physicians. This makes it impossible to master all of the rules and procedures that apply. Physicians in IPA/network HMOs typically face more interference in medical decision making from utilization managers than do physicians in Kaiser Permanente, who monitor their own utilization. Physicians deal with IPA/network insurers at arm’s length, if not as adversaries.

This adversarial relationship has been reflected in attempts to write contracts that forbid doctors from disparaging the health plan to their patients. Yet physicians are the key decisionmakers and caregivers, and they talk to their patients about managed care. No contract clause or threat will be sufficient to change their attitudes, which they inevitably will convey to patients and others. In addition, physician associations have contributed to the development and support of anti–managed care legislative proposals.

- **Resolution of the backlash by physicians.** The best resolution of the physician backlash, in our judgment, would be for physicians to accept the inevitability of cost containment and take re-
ponsibility for managing quality and cost. In our opinion, it is very important to create managed care arrangements that are acceptable to physicians and that can win their loyalty, commitment, and responsible participation. Physicians need to become actively involved in continuous quality improvement, including evaluation of practice variations, identification and promulgation of best practices, and monitoring of compliance, in partnership with professional managers who can assist them. To the extent that physicians are not willing to accept these responsibilities, someone else will have to do so. Because physicians generally were not selected or trained for management or teamwork, the major cultural change required will take some time.

Assuming that physicians accept this responsibility, medical groups will need to grow and merge into larger, stronger organizations that can accept full risk capitation and responsibility for management of all care. Groups of treating physicians must design drug formularies, practice guidelines, referral procedures, and disease management programs and contract for hospital and other services; they also must take responsibility for the consequences of these processes. Given this level of responsibility and risk, medical groups will need to be overseen directly for solvency and quality, as was recommended by the task force. On the other hand, health plans will have to delegate more and more responsibility to medical groups, while they focus on marketing, enrollment, risk management, reinsurance, out-of-area claims payment, and other administrative functions.

This delegation of responsibility from health plans to medical groups must lead to simplification of health plan relationships. This would be achieved if medical groups contracted exclusively with one plan (the Kaiser Permanente model) or concentrated most of their business in one plan (for example, Kelsey-Seybold in Texas), if medical groups contracted with fewer plans with which they act in partnership, or if medical groups assumed total risk and responsibility for care-delivery decisions and contract with health plans for administrative services only.

Health Care Workers

An important part of the backlash comes from nurses and other health care workers for whom managed care means cutbacks in jobs, tougher resistance to wage demands, and demands for productivity improvement. Of course, much of this is the inevitable product of any cost containment effort and also is the result of the Medicare prospective payment system (PPS) and Medicaid selective contracting, which also have put pressure on providers to reduce costs.
Dissatisfaction with managed care among health care workers is a powerful component of the backlash because their unions are an important constituency of California Democrats. The two defeated California propositions, 214 and 216, were sponsored by nurses’ and service employees’ unions. Democrats’ legislative agenda bears a strong resemblance to them. Democrats in California have introduced provider protection bills both in the Senate and the Assembly that would restrict a health plan’s ability to terminate a health care provider from the plan without cause and require HMOs to disclose to providers their economic profiling activities. If passed, these bills would make it more difficult for health plans to be selective in their networks, would increase litigation, and would raise costs.

Democrats in the legislature are in a bind because uncurbed health care expenditures would cost jobs, increase the number of uninsured persons, reduce the number covered by Medicaid, and cut into other public programs. Task force members were quite sensitive to this and reluctant to lay cost burdens on small employers. The task force approved no provider protection recommendations.

In time, the intensity of the backlash brought on by health care professionals will abate as displaced workers find new jobs. Also, as the population grows and ages, displaced workers will be absorbed back into health care. Indeed, there were reports in California of a nurse shortage even as a very public dispute between Kaiser and its nurses’ union continued.

Politicians

An estimated 202,000 Californians contacted an elected official about a problem with their health plan in the past year. In view of this, it is not surprising that managed care has become a hot political issue. Several of the task force’s recommendations could help to address the backlash and consumers’ complaints to politicians.

First, the task force recommended creating a new regulatory agency more specialized and expert in health care. The existing regulatory agency, the Department of Corporations, is the general business regulatory agency, and its leaders lack health care expertise. An agency specializing in managed care makes sense given the size, complexity, and high degree of public interest in managed care in California. This agency could regulate more effectively and proactively lead a problem-solving effort.

Second, legislators should consider implementation of recommendations from the task force intended to make the process work more smoothly; to reduce causes of friction; and to encourage consumers to go to their health plan with their problems, or through a well-designed dispute-resolution process, instead of to their legisla-
tors. For example, to expand consumers’ choice of plans and diminish dissatisfaction, the task force recommended expanding small-group market reforms to groups up to 100 so that pooled purchasing arrangements could grow in this larger market.42

Long-held expectations about the quality and cost of the U.S. health care system will not change without strong leadership from politicians. Political leaders should use their “bully pulpits” to call for patients to take greater responsibility for their health and the cost of care; to set realistic expectations; to acknowledge the appropriateness of some limitations; and to counsel patience.

Health Plans

HMOs are not helpless victims of the managed care backlash. Rather, at times they seem to be their own worst enemies. Judging from the testimony the task force received, some health plans have been insensitive and unresponsive to consumers and have treated employers instead as their primary customer. Patients complained to the task force that many health plans, for example, failed to give clear and convincing explanations for denials of care. Health plans should involve consumers in a process of continuous quality improvement. The task force called for greater participation among the members in plan design of health plan policies and practices.43

Some plans have resisted market-improving legislation, in part because they may benefit from market imperfections that allow them to attract healthy populations while avoiding the sick. The task force recommended that the major payer groups and agencies adopt risk-adjusted premiums (as demonstrated by the HIPC) and that the adjusted payments flow through to at-risk providers.44

Many health plans have antagonized physicians rather than finding ways to win their cooperation. Many plans have done a poor job of recognizing and responding to consumers’ and patients’ concerns by failing to provide innovative products with attributes that are desirable to consumers. To address these deficiencies, the task force recommended that health plans be required to provide continuity with providers for patients undergoing treatment; continuity for patients with drugs that have been removed from a formulary; standing referrals for the chronically ill; and greater consumer involvement in plan governance and practices.45

Although this behavior may not be true of all health plans and not always true of any of them, such resistance, lack of responsiveness, and antagonistic behavior reflect negatively on the industry. The industry needs to be proactive in the early identification and resolution of problems. For example, the task force heard early and often that interference by insurers was a major problem for doctors and
patients. The task force recommended that the industry resolve this problem by devising ways to make a transition away from prior authorization and concurrent review by making greater use of provider precredentialing, practice guidelines, clinical pathways, retrospective review, and outcomes-based data in utilization monitoring. Health plans and providers alike must assume greater responsibility for managing care. Plans have some incentive to avoid the negative consequences of antagonizing consumers, including loss of business and new legislation. To the extent that health plans do not regulate themselves, legislation will be appropriate.

**Americans need to reconcile** their views as taxpayers and premium payers with their views as patients who want no limits on the care they or their loved ones can receive. Consumers need to have realistic expectations regarding what patients can have in a cost-contained health care system. Physicians need to decide to organize into groups and accept responsibility to manage quality and cost. Once they have done so, they need to get involved in quality improvement and cost reduction, including analyzing practice variations, identifying best practices, and ensuring that the great majority of patients are treated according to them. This would constitute a major cultural change for medicine. Then, more simple and collaborative relationships must be developed between health plans and medical groups, in which physicians do more to organize their own work.

If implemented, the recommendations of the California Managed Health Care Improvement Task Force could make the market work better for consumers. However, they may not alleviate the backlash, which we believe stems from more profound sources. Solutions to these problems will not be easy or quick, and they will likely not take the form of legislation but rather will require fundamental cultural and systemic change.

The authors’ work on this paper and on the California Managed Health Care Improvement Task Force was supported by a grant from the California HealthCare Foundation. The complete task force report can be found at www.chipp.ahw.net/mctf/front.htm.

**NOTES**

1. Task force recommendations do not carry the force of law, nor is their implementation by either the public or private sector assured. However, the recommendations have been influential in framing both public and private debate. As of the writing of this paper, three laws based on task force recommendations have been passed in California. A fourth recommendation has been directed by the governor to the Little Hoover Commission, the state’s standing body for evaluation of reorganization plans, and if not rejected by the legisla-
ture, will become law 1 August 1998. Many bills proposing task force recommendations are under consideration.


4. Ibid.

5. *InterStudy Competitive Edge* (Bloomington, Minn.: InterStudy Publications, 1996).


13. Task Force, “Public Perceptions and Experiences with Managed Care.”


22. Ibid.

23. K. Davis and C. Schoen, “Managed Care, Choice, and Patient Satisfaction,” Kaiser/Commonwealth National Health Insurance Survey (New York: Com-
monwealth Fund, August 1997).
25. Ibid.
26. Ibid.
27. Ibid.
30. Task Force, “Improving the Delivery of Care and the Practice of Medicine.”
31. Task Force, “Physician-Patient Relationship.” On 30 April 1998, the governor signed into law A.B. 1181 (Assemblywoman Martha M. Escutia [D] and others) requiring health plans to provide for ongoing specialty referrals and specialists as primary care physicians for patients with certain chronic and acute conditions.
32. Task Force, “Integration and Coordination of Care: Case Study on Women’s Health” (5 January 1998). On 16 April 1998 the governor signed into law A.B. 12 (Assemblywoman Susan Davis [D] and others), enabling direct access to obstetrical and gynecological services.
33. Recent indications suggest that doctors nationwide have not suffered an actual loss of income but rather fear a loss of income and perceive that they must work harder to earn the same amount. See P. Kilborn, “Doctors’ Pay Regains Ground Despite Effects of HMOs,” New York Times, 22 April 1998, A1.
40. Task Force, “Public Perceptions and Experiences with Managed Care.”
41. Task Force, “Government Regulation and Oversight of Managed Health Care.” On 1 May 1998 the governor proposed to the Little Hoover Commission to form a new Department of Managed Health Care, which was established 1 July 1998.
45. Task Force, “Physician-Patient Relationship;” “Consumer Information, Communication, and Involvement;” and “Improving the Delivery of Care and the Practice of Medicine.”
46. Task Force, “Improving the Delivery of Care and the Practice of Medicine.”