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EDITORIAL

Will managed care become unmanaged care?

by Janet M. Carstens

I don't get it. Do we want managed care or do we not?

Throughout the 1990s, managed care has been increasingly accepted by the purchasers of health care services as a means to control costs. Managed care leads to greater control of cost levels because it provides coordinated care to individuals through a limited provider network "team." The team component is present to ensure that individuals receive the appropriate level of care through a coordinated effort that incorporates preventive care and adheres to specific access and care management protocols. Utilization savings are achieved through the determination of appropriate care and the appropriate care settings with an emphasis on preventive services and reductions in care delivery variation. To control the cost per service, the limited provider network generally agrees to a negotiated reimbursement arrangement that often includes a risk-sharing component; this gives the providers a financial incentive to ensure that appropriate care is delivered in the most cost-effective manner.

In recent years, this increased acceptance of managed care concepts has been accompanied by relatively low health care cost trends. Now, as numerous reports emerge indicating that health care inflation and premiums are on the rise, legislation continues to be proposed that appears to make managed care more unmanaged (i.e., more similar to traditional indemnity insurance). The legislative proposals are in response to consumer demand. Although consumers like the lower prices associated with managed care, they do not like the controls and the constraints on service.

As an example, increased levels of exposure to tort liability have resulted in managed care organizations (MCOs) implementing more sophisticated review processes over coverage denials based on a determination of medical necessity. In addition, several state and federal proposals have been introduced that not only may expand this liability but would mandate creation of an external review process, which effectively shifts part of the care management team to an outside party. The more the decision about appropriate care is taken away from those participating in an individual's care management, the less coordinated—and the less managed—it becomes.

A second example relates to "any willing provider" legislation that requires MCOs to include any provider that agrees to the organization's financial terms. This requirement would interfere with the MCO's ability to establish a provider network team to coordinate care and determine medical necessity. In addition, the long-term erosion of cost savings derived from negotiated fee arrangements will be an obvious consequence. Increased (or preserved) market share is the carrot that MCOs offer to providers in exchange for discounted fee arrangements. If MCOs cannot limit their networks, they will not be able to deliver on the promise of increased patient volume. Over time, this will erode the savings achieved through the reimbursement arrangements.

A third example is legislation requiring open access to specialty services. While it is unclear whether overall costs are higher under an MCO with a primary care gatekeeper requirement than they are under an open access

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Epidemic on trial (continued from page 1)

Another key partnership in the lawsuit was with the Minneapolis-based law firm of Robins, Kaplan, Miller, and Ciresi, which had agreed to take the case on a modified contingency basis.

The case posed a significant risk. The tobacco industry was undefeated in the courts. Big Tobacco was also known for its tactics of overtly attacking its opponents. But in 1994, Blue Cross CEO Andy Czajkowski inspired the Blue Cross board to take on the lawsuit as an important means to attack the tobacco epidemic. The lawsuit's goals were to unveil the truth about the tobacco industry's manipulation of consumers, to stop cigarette makers from marketing to children, and to hold the industry financially accountable for the harm it has caused. The ultimate goal is to change the way the tobacco industry operates in Minnesota, reduce tobacco use, lower the rates of illness and deaths caused by tobacco, and cut health care costs for treating smoking-related illness.

The combination of the state, Blue Cross, and the Robins Kaplan legal team presented a strong front to withstand the legal onslaught of the tobacco industry's legion of attorneys.

Building the case against Big Tobacco

The lawsuit was filed against the six largest cigarette manufacturers in the United States: Philip Morris, RJ Reynolds, Lorillard, Liggett, and Brown and Williamson and its parent company, British American Tobacco, as well as the industry's trade group (the Tobacco Institute) and the industry's research arm (the Council for Tobacco Research).

There were two tracks to developing the legal arguments for the lawsuit: documents and damages.

For the first time, tobacco companies were required to turn over millions of internal documents to be examined for consumer fraud and antitrust activities. The legal team succeeded in obtaining through court order the index of tobacco industry documents to guide the discovery process. More than 26 million pages of memos, marketing and research plans, and other internal information were compiled at a document depository in north Minneapolis. Another 7 million pages of internal documents were compiled in England from the British American Tobacco Company. The documents represent the largest collection of information from a single industry and perhaps the most important collection on a public health issue of this century.

The documents revealed how tobacco companies manipulated nicotine to keep smokers addicted, how they marketed to children, and how they collaborated in a massive public relations campaign to counter mounting information on the hazards of smoking.

As one legal team poured over the details of the documents, another was formed to create a damages model. That team consisted of epidemiologists and biomedical statisticians.

Their first step was to identify smoking-related diseases to be built into the damages model. Smoking-related illnesses include heart disease, hardening of the arteries, emphysema, peptic ulcers, and cancers of the lung, mouth, larynx, esophagus, kidney, pancreas, and bladder. There is also a category of diminished health status — illnesses made worse because the person smokes. For example, research has shown smokers take longer than nonsmokers to recover from injury, illness, or surgery.

Blue Cross' damages model was based on 60 million medical claims from Blue Cross for these diseases for 20 years, from 1978 through 1997. This included claims from only fully insured groups and excluded self-insured members, members in Blue Cross' HMO, and fully insured individuals. The Blue Cross actuarial department was responsible for extracting and preparing the data for use by the expert teams of biomedical statisticians.

Each of the smoking-related diseases was identified in medical claims by their ICD-9 diagnosis codes. But because the claims did not record whether the person was a smoker, the damages model needed to extrapolate the percent of claims directly attributable to smoking. The percent of smokers was drawn from the Minnesota Behavioral Risk Factor Surveillance System, a telephone survey of a sample of adults conducted by the Minnesota Health Department each year for the past decade. The damages model was also adjusted for confounding factors, such as the percent of persons who were obese or had other complicating health problems.

The result was a damages claim by Blue Cross of $460 million, which we considered a conservative estimate. The state claimed $1.7 billion in damages over the same period of time.

Blue Cross as plaintiff

Blue Cross sued for damages from only fully insured group claims because they presented the strongest case that Blue

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Managed care (continued from page 2)

MCO, an open access requirement affects the ability of the MCO to coordinate and manage care.

It seems that if consumers want comprehensive and affordable care such as that associated with managed care, they must be willing to accept the controls and constraints on service associated with managed care — or be prepared to accept the high premium increases that accompany indemnity insurance.