



California Managed Health Care Improvement Task Force

Have you seen the film, *As Good As It Gets*, with Jack Nicholson and Helen Hunt? There is one scene in which a physician blasts HMOs. Even screenwriters apparently realize that HMO-bashing has extraordinary audience appeal.

This phenomenon is not lost on the Legislature, which has its bill-producing machinery in high gear. In 1996, in response to public outcry, legislation was enacted which called for the establishment of an ad hoc task force that would study the impact of managed health care in California. The task force, sometimes referred to as the "Richter Commission," after the author of the legislation, commenced work in mid-1997, and published its findings and recommendations in January 1998.

The task force consisted of 30 members, 20 of whom were appointed by Governor Wilson. The Senate and Assembly appointed five each. Membership consisted of broad representation of many interest groups, including providers, consumers, labor, business and health insurance carriers. Kaiser Permanente was represented by Steve Zarkin, Senior Vice President, Government Relations, Program Offices. Alain Enthoven, PhD, a respected economist from Stanford University, chaired the task force.

In a relatively short period of time, the task force convened and held a number of public meetings in various parts of the state. Testimony was taken from interested parties, and written comments were received from many interest groups.

The charge of the task force, in addition to studying the impact of managed health care in California, included consideration of appropriate placement and scope of regulatory oversight of HMOs and other forms of managed care in this state. Currently, managed health care plans (Knox-Keene plans) are regulated by the Department of Corporations (DOC). A number of legislators and others have questioned whether regulation by the DOC, given its other demands and interests, is appropriate given the dramatic growth and market penetration of HMOs in this state.

Key Recommendations of the Task Force

The task force report includes in excess of 100 recommendations—too many to describe in this article. Key recommendations include:

- A new state entity for regulation of managed health care should be created to regulate health care service plans which are currently regulated by the DOC, and to phase in the regulation of other entities over time. Medical groups and other

provider entities that bear significant risk should be directly regulated by the new state entity for solvency and quality. The new state entity should be either a board or an individual, appointed by the governor, and confirmed by the Senate.

- The new state entity should have several guiding principles, including overseeing one periodic solvency audit and one quality audit, upon the request of a provider group.
- Purchasers should offer choices of plans when possible.
- The California Public Employees Retirement System should conduct projects to risk-adjust premiums in California, preferably with the University of California, and the Pacific Group on Health.
- The Major Risk Medical Insurance Board should be directed to develop and modify as appropriate, every two years, a set of five standard reference coverage contracts for all product types in the small and individual markets. Standard outlines and definitions for "evidence of coverage" should be developed.
- State data collection should transition from one that is based in statute, to a regulatory approach. The state should set broad data guidelines, but give the state entity for regulation of managed care the authority to approve data elements.
- Consistent, mandatory, complaint-process standards should be developed with stakeholders and adopted for all health care service plans, including application to provider groups, non-urgent and urgent timing requirements, and periods of limitation.
- Health plan disclosure should be improved to include the scope and general methods of incentives paid to provider groups and practitioners, as well as specific methods paid or received upon request. The state should prohibit capitation of individual practitioners for a substantial portion of the cost of referrals for that practitioner's patients.
- Health plans, medical groups, and IPAs should be required to provide continuity of care with providers for chronically ill, acutely ill and pregnant patients when they involuntarily change plans, or when

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DENNIS FLATT is Vice President and Legislative Representative for Kaiser Permanente in Sacramento. He supervises government relations activities for California, representing the interests of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Permanente Medical Group.



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- a provider is terminated for other than cause, through the course of treatment, up to a maximum of 90 days or safe transfer.
- Health plans should be required to allow extended, prolonged or permanent referrals to specialists for enrollees with life-threatening, degenerative or disabling conditions that require specialized care, while maintaining coordination of services.
 - Health plans should develop alternatives to prior authorization/concurrent review, based on statistically valid patterns of care and outcomes, or professional consensus. Providers with an exemplary practice profile should care for patients with automatic plan approval for a defined scope of practice.
 - The new state entity for regulation of managed health care should convene a clinical expert panel to determine best clinical practices and standards of care, as well as when and how to reclassify therapies from "experimental" to "proven" treatments.
 - Purchasers should encourage plans to work toward credentialing and certifying medical groups and providers based on their knowledge, sensitivity, skills and cultural competence to serve vulnerable populations.
 - Women should be allowed direct access to their health care providers, including reproductive health services, in a manner

that permits and encourages coordination of services.

- Leaders of California's academic medical centers should work together to develop an authoritative projection of physician personnel (and other health professionals) needs, and a plan for adjusting education programs to meet them.

What will happen now?

As you would expect, legislators are hurrying to introduce bills that will address specific recommendations adopted by the task force. It is reasonable to expect that most if not all of the recommendations of the task force will be included in one bill or another in 1998. This does not mean, however, that Governor Wilson will look favorably on all of these bills. As a matter of fact, the governor has indicated that he will consider some of the recommendations, and not others.

From a political standpoint (and this may be the real story this year), it should be remembered that 1998 is an election year and managed care is a hot political "interest zone." Political strategists are advising candidates of both parties to include health care in their campaigns this year. HMOs are "fair game," and the issues, real and imagined, will receive considerable attention as we approach the June and November elections.

In 1998, expect the Legislature to send scores of anti-managed care bills to the governor. He will veto many, but he cannot be expected to veto all of them, particularly in an election year. ♦

Out for a Bite

"If you pick up a starving dog and make him prosperous, he will not bite you. This is the principal difference between a dog and a man."

Mark Twain