

# **Benefits and Costs of Consumer Protection Proposals in California**

## *An Analysis of Selected Recommendations of the California Managed Health Care Improvement Task Force*

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## **Executive Summary**

In 1996, Governor Wilson and the California Legislature established the Managed Health Care Improvement Task Force to inform state leaders about the health industry in California; the impact of managed care on quality, access, and cost of care; issues of special concern to consumers; and the appropriate role of government in relation to managed care. The Task Force consisted of 30 members and 7 non-voting, ex-officio members. The members represented health care service plans, purchasers, plan enrollees, providers, and consumer groups. In January of 1998, the Task Force released its findings and recommendations.

The Henry J. Kaiser Family Foundation requested that Price Waterhouse assess the potential impact of selected Task Force recommendations in the areas of access to care and specialists, information disclosure, and dispute resolution. This report presents the results of the Price Waterhouse analysis which examined selected recommendations in each of these areas.

## **Methodology and Considerations**

The Task Force made 77 multi-part recommendations on many issues, including: expanding consumer choice of health plans, improving the delivery of care and the practice of medicine, minimizing risk selection strategies, and improving the dispute resolution process in California’s managed care system. For the purpose of our analysis, we selected recommendations in each of these areas based on the following characteristics: materiality and force of law, as well as concreteness and clarity. We selected only those recommendations that appear to materially increase plan costs or improve access to care. Since Task Force recommendations varied in strength—some seeming to be mere suggestions while others indicating that plans should be required to adopt certain practices—we chose those that appear to carry the force of law. We also eliminated recommendations that were not specific enough for analysis.

The manner in which the Task Force recommendations are interpreted and made operational could significantly impact costs and benefits for enrollees. The Task Force recommendations are frequently stated in general terms and are not specific with respect to details about how terms are defined or how changes would be implemented. In almost every case, the recommendation could be defined or operationalized in a way that would be administratively burdensome for plans. Alternatively, the recommendation could be implemented in a way that would make it ineffective and not very helpful to enrollees. We have tried to base our estimates on a reasonable interpretation of each recommendation and in a way that is consistent with views of the Task Force members we interviewed.

Our estimates are based on information from previous studies, interviews with experts and stakeholders, and illustrative calculations based on reasonable assumptions. We also had to exercise judgment and professional opinion in making our estimates. Our estimates should be viewed as suggestive of the likely order of magnitude of the costs involved, rather than as precise point estimates. Moreover, we have not chosen to give “high” and “low” estimates because we are even less certain about the range of our estimates.

We based our estimated premium increases on a monthly premium per member per month of \$120.00, an amount we view as a reasonable estimate of a typical HMO premium in California. This per member per month amount of \$120 corresponds to a premium of \$153.60 for the single adult and \$353.28 for a family (any unit with more than one person—couples with/without kids and single-parent families).

## **Direct Access to Care and Specialists**

In most HMOs, care must be coordinated through a primary care physician and referrals to specialists are required. However, under certain circumstances, policymakers and consumer advocates have urged that exceptions be made. To address some of the

concerns regarding access to providers, the Task Force made recommendations concerning extended referrals and continuity of care.

*Extended Referrals.* The Task Force recommended that health plans be required “to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and that is life-threatening, degenerative, or disabling may receive an extended, prolonged, or permanent referral to a specialist.” The Task Force further indicated that these referrals should be made in such a manner that maintains coordination of services.

By having extended referrals, those with chronic, serious illnesses would be able to see a specialist multiple times through only one referral from a primary care physician. The enrollees would be saved the burden of additional doctor visits and may receive care more regularly and promptly from the appropriate specialist. Reducing the number of visits that are not essential may be particularly valuable to patients with disabling conditions.

Overall, this recommendation would appear to have a very small impact on direct costs. Under the recommendation, extended referrals are limited to a very specific population of enrollees that likely already have frequent visits to specialists; however, these visits now often require a referral from the primary care physician for each visit. With extended referrals, the patient would see the same type of specialist as would be the case without extended referrals. Furthermore, coordination of services with the primary care physician is recommended. We estimate that the increase in premiums would be about 0.05 percent, or about six cents per member per month, as a result of direct costs.

*Continuity of Care.* The Task Force recommended that health plans and medical groups/Independent Practice/Physician Associations (IPAs) be required “to enable consumers who are undergoing a course of treatment for a chronic, acute, or disabling condition (or who are in the second or third trimester of pregnancy) when they involuntarily change health plans or when a provider is terminated by a plan or medical group/IPA (for other than cause) to continue seeing their current providers, at the patient's option, until the course of treatment (or postpartum care) is completed, up to a maximum of 90 days or until the patient's condition is such that the patient may be safely transitioned to a new provider.” The Task Force added that providers continuing to treat such patients should be required to accept the plan's out-of-network rate for such care as payment in full.

This recommendation would provide a select group of seriously ill (or pregnant) enrollees with the comfort of continuing with their current physicians for up to 90 days (or until the termination of pregnancy). These enrollees would be able to continue with their physicians who would be knowledgeable about the particulars of their cases and their medical histories at critical times. Thus, they would not have to rebuild relationships with new physicians and would be able to easily continue with the same treatment regimen.

Direct costs of the recommendation are somewhat limited because providers are required to accept the plan's out-of-network rate. The recommendation also limits costs by restricting continuity of care to a specific population. We estimate that the direct costs associated with the continuity of care recommendation would result in increases in premiums of 0.10 percent, or about twelve cents per member per month.

## **Information Disclosure**

Disclosure of appropriate and standard information would benefit consumers in several ways. First, enrollees would be able to make better decisions regarding their health insurance coverage and health care. If consumers receive clearly presented information that enables them to easily compare plans, they would be able to choose the best plan for their medical needs. If enrollees fully understand their coverage, they would be able to utilize their benefits most effectively. Second, enrollees may receive better quality health care. Requiring plans to disclose information may encourage them to improve their standards of care. To be competitive, plans may need to improve the types and number of benefits they offer. They may also restrict certain practices, such as some types of financial incentives given to physicians which make it more difficult for patients to receive referrals to specialists. Third, enrollees may benefit from lower premiums. By having standard information about each plan, enrollees would be able to determine the value of the plans. Thus, some plans may be forced to lower premiums to remain competitive.

*Plan-Oriented Recommendations.* To enable consumers to evaluate and compare health plans, the Task Force recommended that health plans be required to release publicly specific information regarding their methods of payment for their contracting providers of health care services and the types of financial incentives used. The Task Force also recommended that the state entity(ies) for regulation of managed care create a standard product description in a format to facilitate comparison of health plans by consumers. The Task Force further recommended that the state entity(ies) for regulation of managed care develop standard reference health plan contracts in each of the HMO, POS, PPO, and indemnity product lines and that plans publish and provide upon request clear and concise comparisons between any of the products they offer in the small group market and the reference contracts. We estimate that the direct cost per member of plans complying with this recommendation would be about three cents per month, or an increase in premiums of only 0.03 percent. (In its recommendations, the Task Force used the term "state entity(ies) for managed care" rather than the Department of Corporations (DOC), since the Task Force indicated that "a new state entity for regulation of managed health care should be created to regulate health care service plans currently regulated by the DOC and to phase-in the regulation of other entities over time....")

*Provider-Oriented Recommendations.* The Task Force recommended that provider groups and health practitioners be required to disclose "the scope and methods of compensation and financial incentives they receive, upon the request of a patient" and "the methods of compensation and incentives paid to their subcontracting providers."

We estimate the direct cost of providers complying with this recommendation to be about three cents per month or an increase in premiums of about 0.03 percent.

*Process-Oriented Recommendations.* In an effort to improve oversight of the information disclosure process, the Task Force recommended that California transition from a statutory approach to a regulatory approach for the state's data collection. The Task Force recommended that the state set broad guidelines but that the state entity for regulation of managed care have the authority to determine data elements for collection. Any change in data elements required would result in short-run costs for plans; however, in the long run, costs due to any specific change would diminish. The Task Force also recommended that components of electronic records be phased-in with a target date of 2002-2004, depending on available resources, and that strict provisions for patient confidentiality be included. Because the Task Force indicated a timeframe of several years and that the phase-in should be based on "available resources," we conclude that the Task Force did not intend to impose any additional costs.

### **Third-Party Review**

To provide consumers with an adequate external appeals process, the Task Force recommended that the state regulatory entity for managed care be directed to establish and implement by January 1, 2000 an independent third-party review process. The review process is to provide consumers and health plans "with an unbiased, expert-based review of grievances pertaining to delays, denials, or curtailment of care based on medical necessity, appropriateness, and all 'experimental-investigational treatments.' "

Peace of mind for enrollees could likely be a benefit of formal external appeals. As a result of knowing that external appeals processes are available, consumers may have more confidence that their plans would provide necessary care. Enrollees may also benefit from improved internal appeals processes since plans may strengthen their internal processes to reduce the number of external appeals. Ultimately, third-party review may provide enrollees with needed care that may have otherwise been denied. Furthermore, third-party review would likely reduce the number of lawsuits, thus saving enrollees and plans litigation expenses.

Direct costs would be derived from the administrative expenses involved in processing appeals. We also expect that plans would incur costs from overturned plan denials. Overall, we estimate that direct costs of third-party review would yield a cost of about three cents per member per month, or an increase in premiums of 0.03 percent.

### **Indirect Effects**

As discussed above, the selected Task Force recommendations, if enacted into law, would have direct effects on health plan premiums. In addition, the recommendations could also have indirect effects of two major types.

- *Loss of management efficiency* refers to the reaction of plans to the enactment of managed care legislation. Specifically, plans may decide to deny care less frequently, especially when the savings are not great enough to offset the costs of fighting appeals. The net effect of this type of behavior is higher utilization of services, lower discounts from providers, and higher premiums.
- *Adverse selection* refers to the fact that managed care legislation that increases premiums may drive out some of the healthier enrollees, leaving a sicker, more expensive pool. The effect would be even higher premiums.

We estimate that the indirect effects of the selected Task Force recommendations are small in magnitude—an increase in premiums of 0.28 percent in addition to the increase due to direct effects. This makes sense because the magnitude of the indirect effects would probably be related to the magnitude of the direct effects which are small in magnitude.

The indirect effect with the largest potential impact would probably be loss of management efficiency. We estimate that HMOs in California currently reduce costs by 25 percent (relative to fee-for-service plans) through case management and provider discounts. If these savings are reduced by one percent, the effect would be an increase in premiums of about 0.25 percent, or 30 cents per member per month. The effects of adverse selection would be related to the decline in managed enrollment caused by an increase in premiums. Because the increase in premiums is estimated to be so small in magnitude, the effect of adverse selection would increase premiums by only about 0.03 percent, or about four cents per member per month.

## **Conclusion**

The direct effects of the selected Task Force recommendations would be very small in magnitude (see Table A)—ranging from an estimated 0.15 percent for the two access to care provisions to only 0.03 percent for third-party review. The combined direct effects from all of the selected recommendations would also be rather modest. We estimate the combined effect at less than one-quarter of one percent, or an increase of 28 cents per member per month.

**Table A****Estimated Direct Costs of Selected Task Force Recommendations**

<b>Recommendation</b>	<b>Cost Per Member Per Month</b>	<b>Percentage Increase in Premium</b>
<b>Access to Care and Specialists</b>	\$0.18	0.15%
<b>Information Disclosure</b>	\$0.07	0.06%
<b>Third-Party Review</b>	\$0.03	0.03%
<b>Total</b>	<b>\$0.28</b>	<b>0.24%</b>

Source: Estimates by Price Waterhouse.

These effects are only part of the story. Indirect effects, such as loss of management efficiency and adverse selection, must be estimated and added to the direct effects in order to obtain an overall estimate of costs from the Task Force recommendations. We estimate that these indirect effects alone would increase premiums by about 0.28 percent, or 34 cents per member per month (see Table B, middle panel).

**Table B****Potential Increase in Health Plan Premiums  
Due to Implementation of Selected Task Force Recommendations**

<b>Type of Premium</b>	<b>Cost Per Month</b>	<b>Cost Per Year</b>	<b>Percentage Increase in Premium</b>
<b>Direct Costs</b>			
<b>Member</b>	\$ 0.28	\$ 3.36	0.24%
<b>Single Adult</b>	\$ 0.37	\$ 4.44	0.24%
<b>Family</b>	\$ 0.85	\$10.20	0.24%
<b>Indirect Costs</b>			
<b>Member</b>	\$ 0.34	\$ 4.08	0.28%
<b>Single Adult</b>	\$ 0.43	\$ 5.16	0.28%
<b>Family</b>	\$ 0.99	\$11.88	0.28%
<b>Total Costs</b>			
<b>Member</b>	\$ 0.62	\$ 7.44	0.52%
<b>Single Adult</b>	\$ 0.80	\$ 9.60	0.52%
<b>Family</b>	\$ 1.84	\$22.08	0.52%

Source: Estimates by Price Waterhouse.

After accounting for both direct and indirect effects, we estimate that implementation of the selected Task Force recommendations would lead to an average increase in premiums of about 0.52 percent, or slightly more than one-half of one percent. Stated in terms of premium dollars, the increase would be about 62 cents per member per month, or less than \$8 per year, for managed care plans that are subject to the recommended changes. As shown in Table B above, these increases translate into an increase of about 80 cents in the monthly premium for the single adult plan, or less than \$10 per year. The corresponding increases in the monthly costs for family plans would be \$1.84 per month, or about \$22 per year. These increases would vary by plan depending on whether the plan was affected by the Task Force recommendations or not. As discussed above, many plans already have implemented one or more of the changes that were recommended by the Task Force.

These modest costs must be balanced against the benefits of new regulations on health plans in California. If the selected Task Force recommendations were implemented, enrollees would have better access to providers, more information about plans and providers, and the right to appeal plan decisions through an independent third-party review process. Competition between health plans might also be improved as a result of more information being provided to consumers in a standard format. Some enrollees could reap large benefits from the ability to appeal to an independent third party when expensive treatments are denied. Furthermore, other enrollees who are not directly affected by the changes might still benefit by having the assurance that unfavorable treatment decisions would be subject to third-party review. Although we have not quantified the benefits, the benefits are likely to vary considerably across plans and enrollees. Many plans already confer many of the benefits on enrollees. Moreover, some enrollees in plans that do not currently comply with the Task Force recommendations may not value the additional benefits. From an economic viewpoint, the Task Force recommendations are worthwhile only if the benefits from more regulation outweigh the additional premium costs due to more regulation.

The full report is available online in PDF. The report can also be ordered through the Kaiser Family Foundation publications request line at (800) 656-4533. Ask for report #1416.