The HMO

More than 14 million Californians receive their health care through health maintenance organizations, and dissatisfaction with the results is growing. The response from government: lots of bills and a task force to study HMOs, but no systematic reform on the horizon.

By Sigrid Bathen

If money is a measure of the stakes in California's burgeoning managed-care system — as it usually is in political matters of any significance — then the victory party on Election Night last November to celebrate the demise of two consumer-backed health care initiatives was surely a defining moment in the health-care wars.

After spending at least $7.5 million to defeat Propositions 214 and 216, the opponents gathered early — well before the polls closed — to mark their widely predicted victory. The early evening scene on the 15th floor of the plush Renaissance Tower office building in downtown Sacramento — which houses several health care interest groups — was almost surreal, a telling measure of the special-interest clout brought to bear in the well-oiled opposition campaign by an influential and expertly organized coalition of health care, insurance and business groups.

Just past the entry to the lavish catered victory party were mounds of caviar, buckets of shrimp and elegant canapes artfully displayed on tiers of glass shelves. Nibbling away was a veritable army of health care executives rubbing shoulders with political and public relations consultants, lawyers and legislators. Well-paid public relations firms dispatched friendly staffers to minister to the reporters who wandered in, barely able to take in the scene before being offered all variety of story-gathering assistance by one charming, smiling flack after another.

Wars

Illustration by Anthony Strom

If one tired of mere appetizers, there was a full buffet and a large, circular, very open (as in free) bar. If one tired of the panoramic views from the 15th floor windows ringing the room, one could watch the panoply of wide-screen TVs with dizzying, multiple images of NBC's Tom Brokaw chronicling the early — very early in California — returns. Or segue into the adjoining room — this one devoted to the corollary, and wildly more expensive ($35-$50 million) campaign to defeat the so-called "frivolous lawsuit" initiative, Proposition 211. Lined with more wide-screen TVs displaying more multiple Brokaws, a bank of phones and computers, the second room was dominated by a towering floral centerpiece cascading over a tiered table containing a vast collection of delectable chocolate confections, each in its own paper holder.

Whatever its moral worth, it had to be the fanciest set of parties on that election night in the state capital — and a harbinger of the legislative and public relations wars to follow in the current legislative session, where at least 70 different pieces of legislation affecting managed care are grinding through the process.

A measure of the huge stakes in the debate over managed care may be seen in the list of contributors to the "no" campaign against 214 and 216 — a list which reads like a Who's Who of the health-care industry. Although it is a non-profit in a sea of "for-profit" brethren, Kaiser Permanente alone gave $800,000, and other big HMOs and insurers contributed huge sums — six-figure checks from Foundation Health Plan, Pacificare, Health Net, Foundation Health, Prudential, Aetna Life & Casualty, to name a few of the heavy hitters, poured into the coffers of the opposition campaign. Backers, principally the California Nurses Association for 216 and the Service Employees International Union for 214, spent a relatively paltry $2 million to promote two initiatives, which ended up dueling each other because the two powerful unions could not agree on one measure. They are now working together on legislation — or at least keeping their disagreements quiet.

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Combined with the huge salaries often paid to the chief executives of the big health maintenance organizations, the sheer volume and amount of contributions to the anti-initiative campaign raised a persistent, nagging question among critics of the giant managed care organizations: With all that money floating around the industry, why is patient care sometimes so bad?

"I'm not one to say that regulation is the key to everything," says Mark Hiepler, an Oxnard attorney who has won major jury verdicts and settlements for HMO patients and is a member of the Managed Health Care Improvement task force established by legislation (AB 2343 by Assemblyman Bernie Richter, R-Chico) last year. "But there must be fair and understandable disclosure. HMOs are now very secretive organizations. The consumers who make them the billion-dollar industries that they are have a right to know where that money is going, what they are really getting and how the physicians are paid.

"We go back to the fundamental ingredient," he adds, echoing the complaints of physicians and patients disgusted with the widely reported abuses of managed care, "which is the doctor-patient relationship. What has to happen is to put that relationship back on track, not drive a barrier between the two. The patient has to be brought back into the formula, because patients are losing trust. When the doctor is owned by and responsible to a third party, the patient can't possibly be at the same interest level."

The 34-year-old Hiepler, who is in practice with his wife, Michelle, has been the subject of a cover story in *Time* as well as major articles in the *Los Angeles Times, California Medicine, California Lawyer,* and many other publications. He has handled some 140 cases against HMOs, but his journey through the legal minefield of the health care industry started on a painfully personal level. His sister, Nelene Fox of Temecula in Riverside County, died in 1993 after her HMO, Health Net, denied a bone marrow transplant for metastasized breast cancer. He gained national attention after a trial in which two women — a Health Net executive and a San Francisco physician — testified that they had been granted the same treatment Fox had been denied. Hiepler won an $89 million verdict (the HMO appealed, and the case was settled for an undisclosed, but still reportedly very substantial, sum).

"They tried to deny her treatment, to send her to places where they wouldn't treat her," said Hiepler. "At the same time, they paid for a physician in San Francisco to have this procedure, and for an executive of the company. The procedure greatly extended their lives by four or five years, and they both testified for my sister." After an exhausting personal fund-raising effort, Fox finally paid for and received her bone marrow transplant. Still, she died in April 1993 at age 40, seven months after her transplant and eight months before the jury awarded her family $12 million in compensatory and $77 million in punitive damages. The two women who testified at the trial have since died, but enjoyed several years of good health, their cancer in remission.

Hiepler made subsequent headlines in the case of Joyce Ching, an Agoura, California, woman who went to her doctor complaining of abdominal pain and rectal bleeding. Despite her repeated requests, she was not referred to a specialist for three months, and was finally diagnosed with colon cancer. She died in 1994 at age 34. Hiepler sued her two Simi Valley doc-

began paying for some home health care. A year after his birth, Daniel's condition is somewhat stabilized, Hiepler says, although he faces major heart surgery, has undergone "all kinds of gastric surgeries" that might have been avoided with proper skilled care, and is nourished through a gastric tube that will remain in place indefinitely. "It was very short sighted," says Hiepler of the home health care denial. "In the end, [home care] would have saved the company a lot of money."

Monarch declined comment on the suit, but a PacifiCare spokeswoman told the Times that the family received "appropriate care" from its medical group.

The people who represent HMOs say such "horror stories" gain attention in part because of the HMOs' inability to comment. Maureen O'Haren, principal lobbyist for the California Association of Health Plans, says in many cases, privacy restrictions keep HMOs from defending themselves in the court of public opinion. "The plan cannot comment because of patient confidentiality." But HMOs also maintain some of the complaints come from a lack of understanding about how their function differs from the more traditional fee-for-service approach.

"People go into HMOs for economic reasons — low-cost sharing, low co-payments," said O'Haren. "But they [patients] expect the same sort of freedom and uncontrolled service that they got with expensive fee-for-service plans. They don't understand that the reason we are able to do that is because we weed out wasteful care."

At 30 members, the Managed Health Care Improvement task force is large, some say unwieldy. It is headed by Dr. Alain C. Enthoven, an economist and health care expert who is widely described as the "father of managed care." A former vice president of Litton Industries, he was an assistant secretary of defense under President Lyndon Johnson and has served on a variety of prestigious advisory groups on employee benefits and health care and is chairman of the Health Benefits Advisory Council for the California Public Employees Retirement System. Executive Director Phil Romero is a former Rand Corporation economist who is chief economist for Governor Pete Wilson.

"Thus far we have identified three big clusters of issues," says Romero. "One is how government should be

Attorney Mark Heipler, with now deceased sister, Nelene Fox — Photo by Kimberly Reierson

tors in a strike at the very heart of managed care — the HMO's financial incentives for doctors to stay within the reimbursement limits (known as "caps" or capitation in the industry), which critics say encourage or force doctors to delay care and avoid expensive tests and specialist referrals. A Ventura County jury awarded Ching's family $3 million in damages against the doctors, reduced to some $700,000 by California's legal limitations on malpractice awards.

But what may become Hiepler's most shocking and legally groundbreaking case is the ordeal of Leonard and Dana Wallock of Santa Barbara and their 1-year-old twin boys. Hiepler filed suit May 27 against the Wallock's HMO, PacifiCare Health Systems and Monarch Medical Alliance, and two of Monarch's physician medical directors. Using an unusual legal tactic based on a seven-year-old California statute. Hiepler is, among other things, alleging the HMO subjected the family to torture when it refused home health care for Dana Wallock, who was sent home with complications from the birth which included an open Caesarean wound, and for one of the twins, who was born with major heart defects and required round-the-clock care. The twin, Daniel, was sent home over the objections of his pediatrician.

"We were terrified and panicking," Leonard Wallock, an administrator at University of California at Santa Barbara, told the *Los Angeles Times*. "It nearly bankrupted us, and it exhausted us," said Dana Wallock. To compound their plight, the couple had already suffered the death of a child, 5-month-old Rachel, in 1995, from a neurological disorder.

"They were literally forced to go out and find people changing shifts [at hospitals] and hire them to get some kind of nursing care in the home, just to sleep for an hour or two," says Hiepler. "They were worried constantly about the child dying." In January, he said, "about six months too late," PacifiCare

organized to oversee managed care, and two is choice — how can we encourage a wider range of choice to a wider number of consumers? The third is information: Price and cost are relied upon excessively. Quality-of-care information should be more readily available."

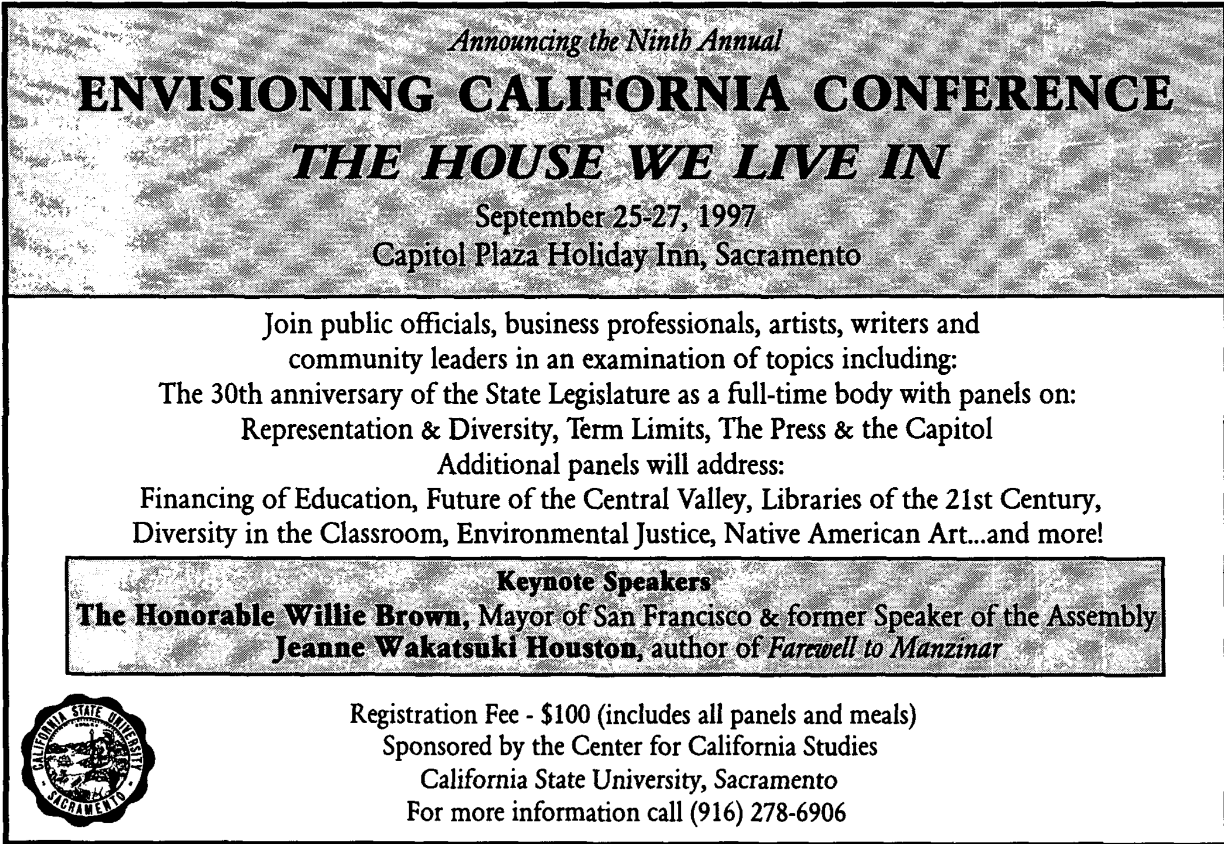
Participants in the task force include a wide range of representatives of the health care industry, from HMO executives to consumer groups. There are expected to be some significant disagreements among its members, and the task force will probably issue majority and minority reports. A major stumbling block in passage of key HMO regulatory legislation this session is the fact that the task force won't issue its final report until next January.

Several HMO-related bills before the Legislature deal with perhaps the most vexing organizational quagmire facing the task force: which government agency should regulate the industry? Since the mid-1970s, HMOs have been regulated — or left largely alone, as many critics argue — by the state Department of Corporations, which inherited HMO regulations in a political snafu because the state Department of Health (now Health Services) was in chaos, under investigation by other government agencies and the news media for a variety of bureaucratic nightmares. Controversies included a long series of "suspicious deaths" in state hospitals and alleged mismanagement of "prepaid health plans," the precursors to HMOs. California is the only state in the country where HMO regulation is not handled by an insurance or health department, or some combination of the two. The California Insurance and Health Services departments have some responsibility in HMO regulation, depending on the plan, but Corporations is the principal regulatory agency.

"The current pattern of organizational responsibility is a fragmented patchwork which has evolved almost accidentally," the California Medical Association, often at odds with HMOs, concluded in a policy statement on HMO regulation. "A rationale for organizational consistency is simply nonexistent."

Governor Wilson's choice to head the Department of Corporations, lawyer Keith Paul Bishop, in June faced a contentious and nearly unsuccessful confirmation battle in the Senate Rules Committee, where Senate President Pro Tempore Bill Lockyer (D-Hayward) held out for beefed-up enforcement measures from the governor and Bishop endured hours of grilling by senators over the agency's regulatory record. In the end, although Wilson says he planned to improve the enforcement budget anyway, Lockyer in effect forced the governor to allocate additional money in the budget to improve enforcement — and allowed Bishop to be confirmed, despite intense opposition from many consumer groups and the California Nurses Association. Saying he has made improvements in the agency's oversight of HMOs, the CMA did not oppose Bishop's confirmation. "I'm always amazed that they do as much as they do with as little as they have," said CMA lobbyist Carol Lee.

Bishop's toughest grilling came, not from members of Senate Rules, but from Senator Herschel Rosenthal (D-San Fernando Valley), author of legislation to transfer HMO regulation out of Corporations to a new HMO board in



the state Department of Consumer Affairs. "Consumer protection is an afterthought for DOC," says Rosenthal. "Its primary concern appears to be protecting the financial health of the corporations it regulates, including HMOs."

Sean Walsh, principal spokesman for Governor Wilson, scoffs at the notion that a beefed-up DOC cannot do the job of regulating the HMOs — but says the governor recognizes the need to reform some aspects of HMO regulation. "There are areas that need to be addressed," he said. "These are enormously complicated issues. Our hope is that we will have through our task force a kind of defining of the key issues and some parameters for the way health care is dealt with in this state. We need to get our arms around the sundry issues facing health care in the state and apply some of our understanding of these issues to the sundry bills that are floating around."

Walsh said Wilson is "very, very leery" of approving bills on HMO regulation — which address everything from the telephone waiting time on "hold" to the responsibility of HMOs to pay for contraceptives — without some systematic, big-picture review. "If we're not careful we could end up passing bills that are bad bills."

For its part, the HMO industry is being selective about which bills it supports. It concedes it needs to do a better job of communicating with patients, and its representatives insist they are working with legislators and are backing some of the legislation. They are, however, opposed to Rosenthal's proposed board, as well as other measures to put regulatory responsibility in the hands of the elected state insurance commissioner.

"Any regulatory agency should be headed by an appointed executive, not an elected official, and not a politically appointed board," said O'Haren.

Nobody on any side of the HMO debate believes the current, scattershot approach to HMO reform is the best way. But critics argue that the more egregious abuses of the HMOs demand more immediate attention than a year-long, 30-member task force review can offer.

"This is a piecemeal approach and we support it because that is all that's out there," says Jill Furrillo, a registered nurse and lobbyist for the California Nurses Association. "We're happy to see that many of the provisions of our initiative are included in a lot of the bills, and that those bills are sailing through, often with bipartisan support. Patients started speaking up, and legislators are starting to feel the heat."

Consumer groups say the major stumbling block to comprehensive reform is the huge influence of campaign contributions to the governor and legislators. "The HMO industry and their brethren, from hospitals to pharmaceuticals to drug distribution and medical distributors, are an obscenely powerful lobby," says CNA spokesman Charles Idelson. "One of the most unfortunate aspects of this Byzantine process is that we're forced to repair a dam that is breaking by putting fingers in the dike. Piecemeal legislation is not the best way to repair a system run amok, but the strongest approaches run into withering opposition."

Beth Cappell of Health Access, a coalition of consumer and health care groups, including the SEIU, which sponsored a package of bills called the "Patient Bill of Rights," said a coherent legislative approach aims to "right the balance" between consumers and their health plans. "A million dollars is a rounding error to these guys [HMO executives]," she says. "A lot of the things that policy wonks find ridiculous, like the right to get a phone call answered in less than five minutes so a working person can actually get through, are important to patients. There is the right not to have a doctor contract terminated [by an HMO], not to be sent home before you or your family are able to care for you, the right to a second opinion. These are pretty basic. Frankly, no one would stay in a hotel where they had to wait 45 minutes on hold to get through to the front desk. A well-run business wouldn't let it get to this point."

Although much of the health care debate has focused on consumers angered by what they perceive as shoddy, unresponsive care, perhaps the most intense — and often hushed — debate occurs among physicians, most of whom recognize that managed care is here to stay. Many are deeply troubled by what they see as devastating inroads by the demands of managed care on the sacred doctor-patient relationship. Reliable statistics are hard to come by, but anecdotal reports indicate that some doctors are opting to leave their California practices — or medicine altogether. In a study last fall of "doctor burnout" by the Sacramento-El Dorado Medical Society, those factors identified as most responsible for increasing levels of burnout were the lack of physician autonomy and managed care.

"There is a lot of criticism of the old fee-for-service days, and a lot of that is just," says Bill Sandberg, the society's executive director. "They cannot control their style of practice, as they were trained to do, and a great many of them get burnout, think of second careers, transition from a clinical to a manage-

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ment position, or go to work for the state or county, perhaps a correctional system. Many have been caught up in contractual disputes [with HMOs and/or medical groups that contract with HMOs] that have reduced their access to patients and have significantly reduced their income."

Dr. Jerome Lackner, former state health director now in private practice in Sacramento, specializes in treating alcoholics and drug addicts. At 70, he works long hours with often difficult patients, many of whom cannot afford to pay him. He treats them anyway, lives frugally, drives a 12-year-old car. An attorney as well as a doctor, he supports the concept of controlling spiraling medical costs, but like many physicians who prefer one-on-one patient care to administration or management, he is troubled by the HMOs' heavy reliance on "fiscal incentives."

"The old fiscal incentive was fee-for-service," he says. "That produced an aberrational system — inappropriate procedures, too many of them. The prepaid fiscal incentive [of managed care] is to underutilize. It is much easier to measure over-utilization than under-utilization. In over-utilization, the doctor has to bill for everything he does. If I gave everybody an EKG and a penicillin shot every time they came in, I'd stick out like a sore thumb on the computer. Under-utilization is much more subtle. There are no valid measurements for under-utilization."

While Lackner's physician lifestyle may not be typical, O'Haren insists the bottom-line issue for most physicians who oppose managed care is income. They are upset, she says, "mostly because their incomes are declining." As an example, she cited a nameless physician who is reportedly selling Amway products on the side because his annual income declined from $400,000 to $300,000 under managed care. "Are their incomes going down? Yes. Market forces are working. Before, doctors controlled all the information. They could do what they wanted, as many tests as they wanted. Most people can't set their own salaries, much as we might like to."

Ultimately, critics and advocates of managed care say many of the problems identified with HMOs are a function of their dramatic increase in prominence, forever changing the way health care is delivered in this country. "There has been a massive and very quick change in the health care delivery system," said O'Haren. "And HMOs are under siege."