Lessons Learned from Managed Care Mania

Over the last few years the cancer care community, which includes patients, their advocacy associations, oncology nurses, and oncologists, has been extraordinarily busy with the Clinton Administration's multiple initiatives that were designed to cut payments for oncology services. These payment cuts were to be made by attacking drug reimbursements without appropriate attention to the underpayment of chemotherapy administration. In addition, the ambulatory payment classification (APC) proposal came along and threatened to destabilize hospital outpatient cancer services, including radiation therapy and chemotherapy. Through a huge effort on the part of many, these threats to cancer care delivery were slowed or stopped or postponed, thereby avoiding the most serious threats to access to cancer care in the last decade.

But another threat to patient access to cancer care emerged in the last decade—managed care mania. Fortunately for some parts of the country, the managed care train never left the station. For others managed care has mangled the infrastructure of the local medical community. Clinics have gone bankrupt in parts of the West, where many are still teetering on the edge of financial ruin. The financial problems arose because too little money was infused into the infrastructure during a time of unprecedented (and expensive) medical advances in many areas of health care, including cancer treatment.

The initial impetus for managed care mania was that purchasers of insurance (employers) wanted to control rising health care costs. The business community embraced the concept, and everyone wanted to get into the HMO process. Health insurance premiums stopped growing for a few years, which pleased employers. HMOs were making money, healthy people were saving on premiums, and everyone was happy except for providers and patients with serious illness. Specialty providers continued to see annual hikes of 8 to 10 percent in their practice expense but with level or lower fees and fewer referrals. Primary care physicians were at risk for costs over which they had no control. The net result was reduced margins and collapsing earnings. In addition, no capital reserve was retained for renewal of equipment and facilities, and financial means were inadequate to maintain staff pay and benefits. The tragedy is that most of this financial instability occurred because the practices ended up in high-risk contracts and had no clue about costs. The current damages in some communities where managed care mania was most widespread are reflected in a shortage of physicians, including both primary care and specialties.

Let's not forget the seriously ill patients who have frequently suffered under these plans. These patients represent the smallest portion of the plans' members, and insurers often take their time to respond to patient complaints. People with cancer make up a significant portion of these patients. The healthy people in a plan are generally satisfied because they have not really needed health care. Healthy members often comprise more than 80 percent of the total HMO plan membership. Statistically, the healthy members' satisfaction overshadows the much smaller number of dissatisfied members with serious illness.

I have found primary care physicians to be highly dedicated and committed to doing what is right for patients. However, those with large HMO patient loads end up spending an excessive amount of time seeing healthy people for physicals and screening in order to maintain good HMO report cards. They scarcely have time to see patients who are ill. Of great concern is the fact that many primary care physicians are worried about losing their diagnostic skills. Patients with cancer need access to competent providers in order to recognize, diagnose, and receive appropriate treatments on a timely basis.

Although managed care mania has subsided in those parts of the country where it began, the damages to the health care system are still apparent. Patient confidence in managed care has evaporated, and many managed care companies are frantically attempting to change their image. Premiums are on the rise again, and providers are beginning to see improvements in reimbursements. Controlling costs by limiting access does not serve the patient with cancer and is a major roadblock to quality cancer care. Many insurers are abandoning their capitated-risk plans for more open-access systems. Let's hope the lessons learned from managed care can lead us back down the road to open access and quality cancer care with sensible attention to cost.

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