Restoring Trust to Managed Care, Part 1: A Focus on Patients

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Managed care organizations face distrust from patients, many of whom believe the organizations disregard their interests. To succeed in a market-driven healthcare system, managed care plans must work to restore that trust. A variety of strategies are presented to restore patient trust. The next 2 articles of this 3-part series will examine trust-building strategies targeted at physicians and public stakeholders.

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In the early 1990s, while I was conducting a seminar on the applicability of managed care concepts to health insurance programs in the Netherlands, 1 attendee asked, "What is the most important asset of an HMO?" After listening to my standard reply that the most important asset was the knowledge possessed by the medical director and the chief financial officer, the questioner countered with the forthrightness characteristic of Dutch executives: "I disagree. Trust is the most important asset of an insurer." In the years since then I have frequently discussed the prescience of his comment with colleagues.

Once heralded as the solution to the healthcare cost problem and a powerful tool for improving the quality of care through assuring appropriateness and efficiency, the managed care industry faces distrust from the public. From cartoons in newspapers[1] to major films such as "John Q," managed care is a prime target for critics. Managed care plans in America appear to have lost the trust of the broader public, many of their customers, the medical community, the press, and some political leaders.[2]

The problem of hostility to managed care is not new. Opposition to the prepaid group practices of the 1930s and 1940s was in many ways as severe as the current challenges facing the industry.[3,4] Earlier publications[5-8] have examined how managed care has lost public trust; this commentary is the first in a series of 3 articles that will use a framework drawn from the literature[9,10] to suggest strategies for restoring it. This report is not the first attempt to recommend strategies to restore trust, but a wider range of specific options is presented here than in previous work.[10-15] How managed care plans respond will have a major affect on the viability of a market-driven healthcare system in America.

The focus of this first article is how patient trust in managed care can be bolstered. The next 2 articles will examine trust strategies for physicians and public stakeholders.

We begin with a definition of trust. Among the many explanations, Mechanic's is succinct: "Trust is the expectation that individuals and institutions will meet their responsibilities to us."[9] The task of maintaining trust is difficult for managed care plans, because they operate in a complex web of stakeholder relationships. Plans are responsible to individual members, large and small employers, labor unions, and public payers (Medicare and Medicaid) with whom they contract as an insurer. Plans have responsibilities to their provider networks (hospitals, nursing homes, pharmacies, physicians, nurses, and other clinicians) and to industry monitoring and regulatory agencies and organizations. Further compounding the problem are the opinions of powerful secondary stakeholders, such as the media, politicians, and other policy-makers, whose criticisms often profoundly affect how the plans can do business.

Pearson and Raeke[16] found that patient trust is "a complicated, multidimensional construct" and identified 5 dimensions of trust: competence, compassion, privacy/confidentiality, reliability/dependability, and

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communication. Mechanic defined 5 similar dimensions of trust: "(1) expectations about physicians' competence, (2) the extent to which doctors are concerned with their patients' welfare, (3) physician control over decision-making, (4) physicians' management of confidential information, and (5) physicians' openness in providing and receiving information."[9]

Although these studies focused on patient-physician trust, similar dimensions can be used to examine the relationship between managed care plans and their stakeholders, which consist primarily of patients, physicians, and public policy makers. Thus, trust in managed care declines with failure of the plan to meet stakeholders' expectations about (1) the plan's competency in organizing and delivering medical care, (2) the plan's concern with their members' health and continuity of care, (3) choice of providers, (4) the management of confidential information, and (5) the plan's communication with them. Each of these failures to meet an expectation creates a trust deficit. These deficits will be examined briefly to identify areas in which managed care plans are coming up short, specifically in their relationship with patients.

THE COMPETENCY DEFICIT

Managed care plans create distrust when their operations are inefficient and fail to meet the expectations of their members. Patients often encounter long delays when seeking a visit to their primary care physician or a referral to a specialist. When member access to providers is poor, the plan appears to have broken its commitment, and distrust ensues. Poorly managed referral authorization and claims processing add to this aspect of mistrust.

THE CONCERN DEFICIT

The marketing materials of many plans emphasize preventive and primary care. Members believe that they should receive a variety of medical and health services intended to restore health in times of illness and promote health and wellness regardless of current health status. They lose trust in their plan when they find themselves being treated simply as a policyholder who submits claims. Plans make commitments to their members that they will have adequate access to care; yet when care is needed patients often regard the plan networks as too limited. Patients may find that they must travel longer distances than expected to obtain approved care. Many patients believe that managed care plans do not consider member convenience to be a priority.

THE CHOICE DEFICIT

The public perceives the managed care industry has established unreasonable limitations on choice. For too long the focus of managed care has been to limit utilization to a narrow provider network. Patients expect to have a high degree of autonomy in their selection of providers, and view the ability to change providers as one method that they have to respond to poor service. By their very nature, managed care plans tell patients that they must give up their choice and control when they join a plan, which creates a sense of distrust.

THE CONFIDENTIALITY DEFICIT

Managed care plans have more access to confidential patient information than did traditional health insurers. Plan members and the general public have concerns that plans do not understand the importance of protecting privileged information.

THE COMMUNICATIONS DEFICIT

Many plan members, providers, and the general public have an insufficient understanding of the healthcare system: the way it works, how it is financed, the roles of the various stakeholders, and what can be done to improve it. In too many plans the focus of the customer relations staff is to explain the limits and rules to patients after they need care, rather than educating them as to how they can use the plan to obtain care. Long waiting time on the phone to talk with customer service representatives and delays in feedback regarding covered services and authorization are 2 of the main issues that result in both an education deficit and a lack of trust.

It is easy to acknowledge that managed care has lost the public's trust, and to categorize the aspects of managed care that have led to this situation. But the industry must respond to this rising backlash against managed care plans, by using multiple strategies to restore trust. Each strategy can do only a small part to restore trust: only the cumulative effect

of implementing multiple strategies will improve relations with all of the stakeholders.

STRATEGIES TO RESTORE THE TRUST OF PATIENTS

To succeed in a market-driven healthcare system, managed care plans must work to restore the trust of their stakeholders. Administrators can use a variety of strategies to mitigate deficits in the areas of competency, concern, choice, confidentiality, and communications that result in mistrust of managed care. Focusing specifically on patients, here are some suggested courses of action to reduce these deficits and therefore restore trust.

Reducing the Competency Deficit

Commit to Sustained Operations Improvement. One approach to restore trust through improvements in plan competency would be to undertake a collaborative effort involving contracted physicians, managed care plan staff, and members and active patients to address operational problems, specifically referral and claims payment systems. An overhaul of these systems is necessary for most managed care companies and will ultimately result in shorter delays in referral services and claims payment, improved patient and provider satisfaction, and a decrease in administrative costs. A vast number of books and articles on business process reengineering and continuous quality improvement have appeared over the past 2 decades: it is time that managed care plans commit seriously to a sustained implementation, with openness and communication with members.

Assure the Efficiency and Effectiveness of Primary Care. One of the hallmarks of managed care is the emphasis placed on primary care. Almost all plans emphasize primary care in their marketing and member education materials. Plans constantly inform their members that their primary care provider should be their first point of contact for care, except for life-threatening emergencies. Unfortunately, a lack of trust can develop if the primary care approach of a plan is not effective or efficient. The primary care physicians of a plan must not only be competent at primary care delivery, they must believe in their role in the system or they will convey their dissatisfaction to the patient. Plans must work with primary care physicians to ensure efficient scheduling, appointments, and communications systems and that those primary care physicians have up-to-date patient education materials. Plans should encourage the use of e-mail and the Internet for patient–provider communication regarding scheduling and appointments. Plans that use nurse practitioners or physician assistants in the delivery of primary care must actively assure that these providers operate effectively within their scope of practice, and promote a team model of primary care delivery. Plans can no longer simply contract with a primary care physician or group and assume that appropriate primary care will be provided: they must assure their members that a well-functioning primary care system is in place. Plans should also examine patient-centered approaches to treatment. The patient visit re-engineering model of care can provide a needed radical change in what happens when a patient enters a health center.[17]

Improve Coordination of Care for Transitional Patients. Improved coordination of care during transitions from one managed care plan to another could increase patients' trust (and indirectly their family members' and the broader public's trust) in the managed care industry. One approach would be for competing plans in a given market to develop a set of standardized protocols concerning transfers. Case managers from the member's new plan would work with the previous plan to assure that prescriptions, durable medical equipment, and preventive services were not interrupted during the transfer. A second approach would be to allow access to the previous plan's provider network during transitional periods, with the patient responsible for a large share of any difference in costs if the former plan is more expensive.

Reducing the Concern Deficit

Assure Access to Care. Ensuring an adequate network of providers with regard to type of care, geographic location, and capacity would reduce distrust by members. Too many plans make vague assurances about access to care and then revert to the role of a health insurer when patients have access problems. Managed care has generally not expanded far into rural areas, but patients must have adequate access to appropriate care within a reasonable distance. Having many providers on lists of affiliated practitioners is insufficient and may engender distrust if plan members try to make an appointment and discover that the provider is no longer seeing new patients. All participating providers listed by a plan must have the capacity to care for more patients. Members with chronic illnesses must especially be assured access to providers who understand

and can manage these illnesses. Managed care plans must improve and maintain the continuity and comprehensiveness of care that these patients require. Contracting with larger panels of clinicians and conducting patient follow-up to assure that patients have been able to make an appointment can improve access to care.

Transform Customer Relations Into Customer-Centered Service. Unarguably, managed care plans must employ adequate numbers of customer service representatives who are experienced, well trained, empathetic, and understanding of the member's situation from the member's perspective. Unfortunately, many patients report that telephone and front office encounters with customer service representatives are discourteous and uncaring. Adequate staffing in plan-owned facilities creates improved services, which builds trust.

As part of this renewed focus on customer-centered service, patient feedback should be viewed as an essential component. Members will feel more empowered if they have a resource that allows them to voice their concerns—and will feel greater trust that the plan is concerned with their needs. Both paper and online feedback forms should be made available. Although feedback liaisons or ombudsmen are an additional cost, plan administrators might want to consider establishing such positions. Despite increased access to health-related information through the Internet, many people still prefer to talk to a live person when they have health concerns. Plans must respond to member complaints quickly and accurately, with a focus on the specific issues raised by the customer. Quick response to complaints can avoid entanglement in formal grievance processes. Members should be tapped as a source of ideas and observations for efforts to improve plan operations. Plans can capitalize on such endeavors by having their communication resources publicize when patient suggestions have been implemented.

Develop Joint Advocacy Initiatives With Patients. Managed care has legitimate policy differences with the other healthcare industries and common cause with consumers in a number of areas, but nowhere is this dichotomy more evident than with regard to the pharmaceutical industry. Certain drug industry practices delay the launch of generics; direct-to-consumer marketing imposes costs and demands on plans; and drug industry resistance to reclassify some appropriate prescription drugs as over-the-counter products raises costs for both medical services and prescriptions. Managed care companies need to publicize the problems they share with their members, emphasizing that for a number of issues they are an intermediary for the members rather than a cause of the problem.

Provide Pre-Enrollment Information to Employees With Chronic Diseases. Employers and their human resources departments should receive highly specific information about the chronic disease management protocols used by plans. This information should be provided to employees prior to their selecting a plan, so that employees will know the details of the available chronic disease services after enrollment. Such care plans would include information on all treatment options covered by the plan.

Reducing the Choice Deficit

Expand Point-of-Service Models. A major strategy for managed care plans to restore trust would be to move to point-of-service (POS) models as their primary product. Enhancing choice would not mean the death of managed care, only its revitalization.[7] The traditional closed-panel health maintenance organization with a gatekeeper primary care physician would no longer be actively marketed, although it would remain available to sponsors who were already purchasing such a plan. The POS product could be a second option.

Two possible plan designs for POS models could restore trust without significantly increasing costs. First, plans could implement co-payments for direct access to specialists. Plans could give members a choice of seeing a primary care physician gatekeeper before seeing a specialist or having direct access to a specialist for a higher copayment. Although plans might incur an additional cost by allowing patients to see a specialist without a referral, they avoid the cost of the gatekeeper visit in those cases. The additional charge would act as an incentive to minimize use, but in this model the patient would be making the decision, leading to greater satisfaction. With this model, patients choosing to see their primary care physician first may have a shorter wait at the office, also leading to greater satisfaction. Recent research demonstrates that such plan designs do not necessarily increase costs.[18,19]

A second approach would be to implement copayments for services that would otherwise be denied in a single copayment system. The most common example is the increased use of a 3- or 4-tier pharmacy benefit system. Rather than a single pharmacy copayment and a limited formulary, plans are increasingly giving members the choice of having an on-formulary generic, an on-formulary nongeneric, or a nonformulary nongeneric. Plan members are no

longer told that the drug prescribed by their physician is not covered. Instead, patients are told that all prescribed medications are covered, but the patient has a choice as to copayment level. This model could be applied to other limited areas. For example, many plans have limited or no coverage of chiropractic care or alternative medicine. Plans could levy deductible and co-payment fees to give the member choice and responsibility for payment, rather than simply refusing coverage.

Offer Member-Purchased Supplemental Coverage. Another approach to restore trust would be for plans to offer supplemental coverage paid totally by the member. Clearly defining what is covered in the sponsored-subsidized plan and the member-purchased supplement could clarify the limits of the sponsored plan and so help reduce mistrust. Members and the public will feel they have been given a clear choice to purchase in advance coverage for those aspects of care not covered by their primary plan. Two possible products in this area are supplemental provider networks and enhanced out-of-area coverage.

SUPPLEMENTAL PROVIDER NETWORKS. Rather than offer coverage for out-of-network providers as part of the employer-sponsored program, plans could offer members the option to purchase access to a supplemental network of providers that would give members deep discounts on the fees not covered by their primary plan. Although not insurance, this type of supplement would provide some degree of financial protection to members who desired out-of-network services.

OUT-OF-AREA COVERAGE. Managed care plans could offer members "vacation" or "travel" coverage. This type of product would be a type of short-term insurance (similar to car rental insurance) that members could purchase to cover out-of-network care in the event that they became ill while away from home, and needed care that did not clearly fit the standard definition of a life-threatening emergency. Such an offering communicates that the plan is concerned with consumer lifestyles and consumer adaptability. Travel insurance would essentially allow consumers to be covered in other states. Such an offering would relieve the stress involved with travel, which is increasingly a component of the lives of many consumers. Enrollees would need to be aware that out-of-network coverage is minimal under the basic package and that such an additional product is available.

Involve Patients in Provider Contracting. To be effective in assuring quality and cost containment, managed care plans must have limited networks of providers. One approach to achieve this objective while regaining patient trust would be to encourage patients to participate in the design of the care networks. Patients have knowledge about providers—for example, provider attitudes toward patients and the operational efficiency of their practices. Plans could use that patient knowledge to help shape their networks, and by involving the patients in the network redesign would include enrollees as partners, and so improve trust.

Reducing the Confidentiality Deficit

Assure Full Compliance With All Patient Privacy and Confidentiality Regulations. The implementation of the Healthcare Insurance Portability and Accountability Act (HIPAA) will require extensive revisions to all processes related to patient and member information. HIPAA was passed in part because of a concern about a lack of confidentiality in patient information. Plans that want to reduce this aspect of distrust must fully comply with HIPAA in a timely manner and communicate their compliance to the public. Compliance with HIPAA will be time-consuming and costly, but such public knowledge about compliance will greatly restore trust.[20,21]

Reducing the Communication Deficit

Educate Patients About the Effects of Overutilization. Controlling the use of specialists, antibiotic agents, advanced diagnostic tests, and experimental or cutting-edge treatment technologies are major principles of managed care. A tightly run plan reduces utilization to what is medically necessary and ensures that patients receive needed care in the most cost-effective manner possible. Unfortunately, the general public perceives this legitimate need for effective usage of scare resources as restricting access to necessary services. The industry must address this misunderstanding by clearly communicating to the public that one role of the managed care industry is to protect the public from unnecessary and dangerous care. Many plans have implemented educational programs on the overuse of antibiotic agents, but much more should be done. If the negative effects of unnecessary treatments could be explained convincingly to the public, the public's unquestioning faith in the benefits of specialists and the newest drugs might be tempered by realism. If members were to view their primary care physician gatekeeper as someone who is looking out for their best interests by not referring them to specialists and inpatient care unless absolutely required, then

perhaps one of the biggest sources of distrust about managed care could be mitigated.

Educate Members About Covered Benefits. Managed care companies have an opportunity to restore trust in their relationship with members by providing enrollees and physicians with accurate, timely, readable, and realistic information about the managed care plan coverage. This information should include notification about revisions to prescription drug formularies so that patients are not surprised when drugs are no longer covered or their co-payments increase. Plans should emphasize that the sponsor (eg, employer or government) determines what overall services are covered, not the plan. One component that leads to distrust is the term "medical necessity." Physicians, patients, and their families fear that the plan will not accept the physician's judgment as to what is medically necessary, either because of poor communication between physician and plan, or because the physician is not an aggressive-enough advocate for the patient. "Medical necessity" may appear to be a somewhat arbitrary designation, and patients can believe they will not be covered for a service if the plan does not accept the seriousness of the patient's case. Thus patients fear that they will become the victim of the failure of the plan and the provider to communicate effectively about medical necessity and that needed care will be denied. To reduce uncertainty, plan administrators should consider making public their criteria for "medical necessity."

Educate Consumers About Costs. Consumers need to fully understand the cost of the services they receive. Plans could send patients a statement of the billed charges incurred from office visits, showing the proportion paid by the plan and the proportion paid by the member's co-payment. A statement could also be provided for prescription drugs, including information on the retail price of the drug, the discounted price paid by the managed care plan, and the amount paid by the member's co-payment. Besides giving the consumer a clearer understanding of the cost of services, such communication would give the member an appreciation of the plan's ability to obtain discounts.

Develop Enhanced Communication Efforts for Patients With Catastrophic Health Problems. Most managed care plans have developed patient education and disease management programs. Unfortunately, many of these programs are not targeted at those stakeholders who are most likely to develop distrust of the managed care approach: patients with catastrophic health problems and their families. Patients undergoing transplants, recovering from severe multiple traumas, or coping with terminal cancer need to understand how their care will be coordinated and managed in advance of having conflicts with utilization control procedures. Some plans have catastrophic case managers, although the extent to which these case managers serve as patient educators varies across plans.

CONCLUSION

In this first article a variety of strategies have been described to increase trust between managed care plans and their patients. These strategies address deficits in the domains of competency, concern, choice, confidentiality, and communication. The next article will provide a review of strategies to address physician concerns related to these 5 domains of trust.

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