
Chapter

1

**ROLE OF MANAGED CARE IN
THE U.S. HEALTHCARE SYSTEM**

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INTRODUCTION

Managed care is an approach to the delivery of healthcare services in a way that puts scarce resources to best use in optimizing patient care. Managed care principles are the basis for effective administration of pharmacy benefits. While it is true that a small portion of prescription drugs, less than 15%, is purchased through unreimbursed cash transactions, this amount is negligible and dwindling. The tenets of managed care, described below, have transformed the U.S. healthcare delivery system. The healthcare delivery revolution grew rapidly, especially in densely populated geographic regions following the passage of the Health Maintenance Organization (HMO) Act of 1973. However, rudimentary yet impressive managed care initiatives could be found in the United States almost 100 years ago. Managed care developed in response to unmet economic and social needs. Managed care is neither a singular process nor a static event. Rather, managed care is chimeric and dynamic, and is a highly regionalized—even local—phenomenon that is molded by territorial demands. The impact of managed care is both historic and immutable, yet even today, with the early growth of consumer-driven healthcare, managed care continues to morph, embracing vestigial elements of fee-for-service pharmacy. Managed care struggles to balance quality of care with cost efficiency, and it continues to evolve in an attempt to meet the needs of private and government plan sponsors as well as patient-members.

This chapter briefly explains the genesis, evolution, and fundamental features of managed care within the U.S. healthcare delivery system. By understanding the nature and purpose of managed care delivery and its financial principles, the reader will be able to identify, and perhaps forecast, future evolutionary states of managed healthcare pharmacy benefits.

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While *managed* care implies a certain genetic structure, fundamental traits may be expressed or repressed to accommodate current and near-term market needs. Recognizing this element, the reader should bear in mind that although this chapter defines managed care from a classical, genealogical perspective, various types of organizations are, by definition, managed, yet may appear and function quite differently.

MARKET EVENTS SUPPORTING THE DEVELOPMENT OF MANAGED CARE IN THE UNITED STATES

At the beginning of the 20th century, health insurance was virtually nonexistent in the United States. Very early managed care plans developed in isolated pockets in the early and mid-twentieth century, often provided by an employer as an employee benefit (e.g., Western Clinic, Tacoma, WA, in 1910; Blue Cross and Blue Shield organizations during the 1930s; Kaiser Foundation Health Plans in 1937; Health Insurance Plan of Greater New York in 1944).¹ Broad medical insurance coverage is generally assumed to have begun with indemnity insurance post-World War II. Pilot HMO projects began in some progressive cities in the late 1960s and more broadly after the HMO Act of 1973 signed by President Richard Nixon, which provided funding for federally qualified HMOs. It is alleged that Paul Ellwood, MD, a Minnesota physician who found himself in Washington as a healthcare policy consultant, created the term *health maintenance organization (HMO)* as an egalitarian membership health promotion and delivery system that encouraged wellness and health prevention in addition to comprehensive acute and chronic care.

Throughout the second half of the twentieth century, Americans began to consider health insurance as a necessity rather than a luxury. Although many consider access to appropriate health care a right of citizenship, the United States is the only developed industrialized nation that does not provide universal health insurance coverage on a federal level to all of its citizens. The federal government does offer coverage to those over the age of 65 and the disabled through the Medicare Program and to the needy through a partnership arrangement with states through the Medicaid programs. The Medicare Modernization Act of 2003 added outpatient prescription drug coverage for Medicare beneficiaries through the establishment of Part D. As a result, the vast majority of Americans have some type of medical and pharmacy benefits. Tragically, there remain 46.6 million Americans, or 15.9% of the population, who had no healthcare coverage in 2005.² Health insurance coverage has become a highly coveted employee benefit as well as an emotionally-charged political issue. Often the ability to obtain health insurance is a reason people seek employment until they qualify for Medicare benefits or can self-insure.

FUNDAMENTAL CONCEPTS OF GROUP INSURANCE

Individuals who self-insure pay cash from their personal funds for all healthcare needs and services. Most individuals cannot afford to personally pay for surgery, chemotherapy, and expensive imaging studies. The group health insurance concept is built on a large group of

individuals pooling a fixed amount of money (premiums) to pay for defined healthcare services needed by members of the group. Actuaries statistically forecast the anticipated healthcare needs of the group and the costs associated with their provision. The actuarial projections become the basis for determining the premium that must be collected in order to fund reimbursement for the covered services. The group may purchase reinsurance from an insurance carrier to protect themselves from extraordinary catastrophic claims. The group insurance concept allows covered healthcare costs and financial risk to be spread over an entire membership group, such that the *per capita* costs are reasonable and manageable.

In addition to paying a monthly premium, individuals who use covered healthcare services usually pay an out-of-pocket user fee in the form of a fixed copayment, a percent coinsurance, and/or a deductible amount. Copayments, coinsurance, and deductibles call for a portion of the actual costs for healthcare services to be paid by the individual using the services as a method of sharing the financial risk. Copayments, coinsurance, and deductibles also may be used as a tool to encourage individuals to use only necessary medical resources. Copayments and coinsurance are further discussed in Chapters 2 and 4. Healthcare services that are not a covered benefit are either payable in full by the individual receiving the service or end up being written off as a bad debt by the providing institution.

From the 1960s through the 1980s, the predominant type of group health insurance was indemnity insurance. The benefit design of indemnity insurance typically required covered individuals to pay 20% of billed charges after satisfaction of an annual deductible. The indemnity insurance company paid the 80% balance. This 80% balance was paid out of the pooled insurance premiums collected on behalf of the eligible group insurance members. The 20% coinsurance paid by the individual spread the financial risk between the group member and the insurer. It also discouraged the use of unnecessary medical resources. Often there was a cap or out-of-pocket maximum on the amount individuals had to pay in the event of an expensive healthcare catastrophe.

As a result of the 1973 HMO Act, managed care insurance became an option in many cities by the mid to late 1980s. Managed care was an evolutionary step beyond indemnity insurance that expanded the financial risk-sharing beyond member individuals and their insurance plans. For the first time it required healthcare providers—physicians, hospitals, pharmacies, and others—to also accept and share financial risk. In addition to expanding risk-sharing, managed care developed programs for greater integration of administrative claims, communication among healthcare providers, and the introduction of wellness and prevention programs. Finally, managed care became much more explicit in defining the benefits that were covered and those that were not as well as the rules patients had to access covered benefits.

GROWTH OF MANAGED CARE

Healthcare is a competitively market-driven industry in the United States. Similar to other markets, health insurance changed in response to current or anticipated customer desires and unmet needs. Both health insurers and HMOs (especially the federally qualified plans)

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became subject to state and/or federal regulations and oversight. The primary forces that continue to influence the evolution of healthcare delivery and insurance in the United States are local and national competitive market and healthcare policy issues.

In the 1980s and 1990s, the cost of covering the increasing number of both private commercial members, state Medicaid eligibles, and federal Medicare beneficiaries continued to climb without restraint. The 1990s saw most traditional healthcare insurers develop *de novo* managed care plans or modify existing indemnity products by introducing managed care tools such as utilization review and quality measurement.

Additionally, in the spirit of the original HMO concept of comprehensive services and preventive medicine, healthcare policy leaders believed that a managed healthcare plan could better coordinate healthcare delivery, manage resource utilization, and implement preventive care and disease management systems superior to fragmented indemnity insurance.

Managed care offered to solve two fundamental societal health issues: rising healthcare costs, and fragmented healthcare delivery.

1. Managed care promised cost savings for healthcare purchasers compared to traditional indemnity insurance. Under traditional indemnity insurance, healthcare resource utilization was uncontrolled, and resources were prescribed and consumed at the caprice of physicians and patients. Physicians were not at financial risk, and often did not consider the cost of the resources they ordered. Conversely, managed care had a defined, inclusive list of covered benefits and services, and used financial incentives to influence physicians and patients to follow health plan policies and procedures and use resources in a cost-effective manner. Whereas traditional indemnity insurance accepted and paid fee-for-service claims from any provider, managed care only paid claims submitted by contracted healthcare providers willing to accept discounted reimbursement. Managed care plans monitored and controlled health resource utilization, and prevented over- or unnecessary utilization by requiring prior authorization for non-emergency surgeries and expensive drugs or procedures.
2. Managed care offered an integrated financing and delivery system that included preventive care and coordinated chronic care for members. By processing all covered health encounter claims, health plans were able to monitor an individual's total healthcare experience, and coordinate care when appropriate. The comprehensive claims database also allowed health services researchers to measure clinical and economic outcomes, and recommend improvements in the delivery of quality care.

Thus, it was concern over rising costs and the desire to better manage both healthcare delivery and health outcomes that drove the growth and acceptance of managed care by private and public purchasers and by healthcare policymakers. In general, managed care was successful in accomplishing these two objectives when compared with traditional fee-for-service medicine and indemnity insurance. In the 1990s, a managed prescription

drug benefit could reduce pharmacy costs by 10% to 40% compared with an unmanaged pharmacy program, depending upon the aggressiveness of the pharmacy benefit management. Managed care systems incorporated tools that coordinated care in a cost-efficient manner through:

- Implementation of population-based healthcare screening programs
- Use of disease and case management
- Development of an integrated database that allowed the measurement of and reduction in practice variation
- Use of health outcomes research to identify the most cost-beneficial expenditure of healthcare resources

Today, a dizzying array of managed care organizations and benefit designs are managing the cost and care of almost 85% of the U.S. population, notwithstanding the 46 million uninsured. **Figure 1-1** illustrates the rise in U.S. healthcare expenditures (in millions of dollars) from 1975 to 2005.³ From the mid-1980s onward, managed care began to replace indemnity insurance. The graph shows the cost of healthcare has continued to spiral upwards, seemingly undaunted by the growing presence of managed care. However, what is not known is what the expenditures would have been if managed care had not been introduced.

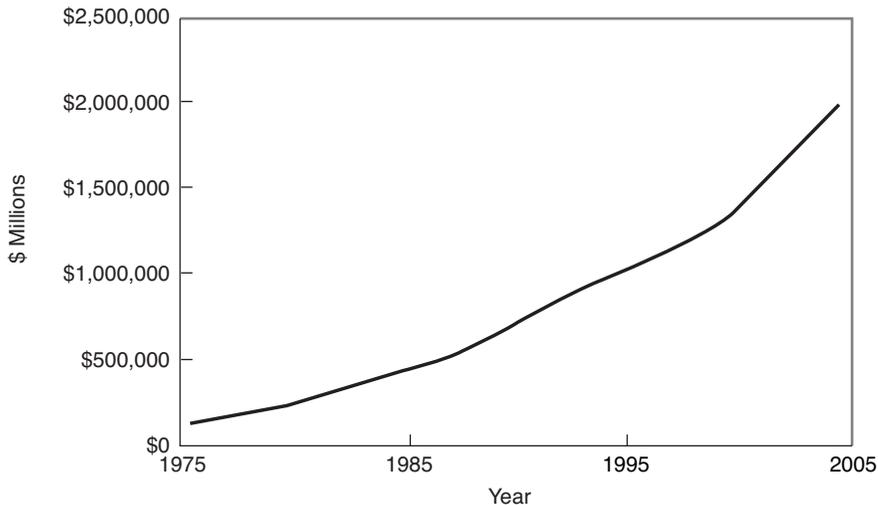


FIGURE 1-1 U.S. Healthcare Expenditures 1975–2005 (Millions of Dollars).

Data are from the CMS U.S. Health Expenditures 1960–2005. Available at http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage. Accessed 26 May 2008.

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MANAGED CARE TERMINOLOGY

A new lexicon of terms accompanied the growth of managed care, some of which are not universally accepted and require further definition. We have already introduced the term *health maintenance organization (HMO)* to refer, in general, to a managed care health plan. Two decades ago, we more easily categorized HMOs as one of four discrete types, or models, using classical definitions⁴:

1. *Staff model*: The staff model HMO owns healthcare facilities (e.g., physician offices with pharmacies, hospitals), and healthcare professionals are salaried employees. Staff model HMOs have high control and lower costs, but offer fewer choices of providers for members. Although several staff model plans flourished in the 1980s and 1990s, most are no longer in existence.
2. *Group model*: Pure group model HMOs contract with a large multispecialty physician group. Physicians are employed by the group practice but not the HMO. Kaiser Permanente and Geisinger Health Plan are examples of group model HMOs.
3. *Network model*: In a network model HMO, the HMO contracts with more than one multispecialty group practice. Health Insurance Plan (HIP) of New York was an example of a network HMO.
4. *Independent practice association (IPA) model*: This popular HMO model contracted with many independent community-based physicians (individual physicians as well as group practices) to provide care.

The greater level of control of staff in group model plans often resulted in lower costs but with reduced freedom of choice of providers and benefit levels for members. In contrast, the network, and especially the IPA model HMOs, offered more choice but because they were able to exert a lower level of control over providers and members, often had higher costs. Therefore, plan purchasers had to choose between lower costs and greater freedom of choice. In this book, staff and group models are often combined together as similar “closed” models that use a limited number of defined, and owned or affiliated, medical groups, often with employee providers and owned facilities. Similarly, network and IPA models are often combined together as “open” models that generally contracted with a broad array of independent community-based providers or large medical groups and rarely owned facilities. The general relationship between level of control, benefit richness, and cost is shown in **Figure 1-2**.

By the late 1980s, many HMOs began offering plans with more options with broad provider networks, often at a slightly higher cost. An example of such a plan is a Preferred Provider Organization (PPO). Some HMOs combined a higher benefit/higher cost option with a lower benefit/lower cost plan, called a Point-of-Service (POS) plan. A POS gave the member the choice within a single plan to access more HMO benefits (at a lower copayment) or PPO benefits (at a higher copayment). Plans with similar names often have very different levels of benefits covered within a broad cost structure. Plan sponsors desired more choice of benefits and larger community-based providers, and favored open

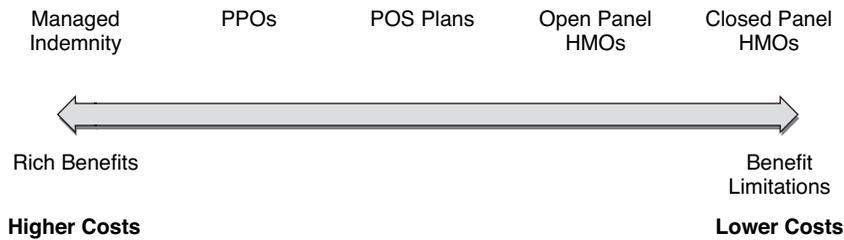


FIGURE 1-2 Continuum of Cost and Control Among Managed Care Organizations.

model plans (network and IPA HMOs) more than closed model plans (staff and group HMOs). Today, it is rare to find a pure HMO model plan, as most are hybrids that offer a broad array of health benefit programs (often called “products”) under one company. Additionally, another type of specialized organization exists that exclusively manages pharmacy benefits called *pharmacy benefit managers (PBMs)*. They are discussed in depth in Chapter 3. This range of control, costs, and level of benefits of HMOs and other insurance products are illustrated in Figure 1-1.

We use the terms *managed care organizations (MCOs)* and *health plans* interchangeably to refer to a managed care delivery system that is not a pure PBM. We will use the term *PBM* when we wish to address only pharmacy benefit management organizations.

In addition to the health benefit programs offered to employer groups and corporations, often termed *commercial plans*, many managed care organizations developed an array of product offerings:

- Managed Medicaid and Medicare programs
- Individual products offered to an individual or family
- Department of Defense TRICARE programs

Entities that purchase healthcare benefit products are often termed *plan sponsors*, as they may design, select, and purchase a program on behalf of their employees (for commercial purchasers) or beneficiaries (for state Medicaid programs, or the Centers for Medicare and Medicaid Services, [CMS], for Medicare programs). The terms *payer* or *payor* or *third party payor* is often confusing, and may refer to the MCO or health plan, or the plan sponsor (employers, Medicaid, or CMS [for Medicare]). We will use the term *payor* to refer to plan sponsors.

Individual patients who enroll in a commercial plan are termed *subscribers*. Often dependent family members are also covered under the policy. Together, subscribers and covered dependents are collectively termed *members, covered lives, or enrollees* of a health plan. Patients and dependents that are enrolled in Medicare programs are termed *beneficiaries*. Patients who are covered by state Medicaid programs are termed *eligibles*. Managed

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behavioral or mental health organizations call their members *clients*. Healthcare professionals, including physicians, pharmacists, and nurses, are generally referred to as *providers*, and pharmacies are often called *pharmacy providers*.

COMPONENTS AND ATTRIBUTES OF MANAGED HEALTH CARE

While all managed care organizations are slightly different in their version of managed care, three seminal tenets embody the philosophy of all healthcare that is “managed.”

1. First, managed care is a subscription, partially pre-funded healthcare delivery system with explicitly defined contributions and covered benefits. Through a contract filed with state regulatory agencies, the health plan or PBM defines what benefits are and are not covered, the premium cost to the plan sponsor and members as well as individual member deductibles, benefit caps (maximums), copayments, or coinsurance amounts to be paid whenever a specifically covered healthcare service (e.g., prescription, physician visit, surgery) is accessed.
2. Second, all stakeholders and participants of the managed care system (healthcare providers as well as health plans, plan sponsors, and individuals) are financially and contractually linked so that each participant shares in the financial risk, and has the ability to have some level of control or influence over the use and cost of covered services.
3. Managed care controls overall costs by controlling the supply and demand of all healthcare resources. The supply of all resources is controlled through defined benefit limitations, and contracts with all providers of products and services, including all hospitals, physicians, pharmacies, vendors, and other providers. The demand of all healthcare resources is influenced by requiring a member to pay a copayment or coinsurance amount whenever a resource is accessed.

In-patient hospital benefits, outpatient medical benefits, and pharmacy benefits are the three largest cost centers for health plans. Hospital and outpatient medical services (including physician, dental, diagnostic, and other services) are generally managed under the medical benefit, whereas the pharmacy benefit is generally managed separately. Infused drugs are often managed by the pharmacy department but may be a financial component of the medical benefit. Specialty pharmacy benefits are discussed in Chapter 22. Pharmacy benefits can be managed internally by a health plan pharmacy department, externally by a separate PBM, or the pharmacy benefits can be jointly managed by the internal health plan pharmacy department with assistance by an external PBM (discussed in Chapter 3). The reader is also referred the glossary of managed care terms on the Academy of Managed Care Pharmacy Web site (<http://www.amcp.org>).

The legal contract between a health plan, MCO, or PBM, and the purchasing plan sponsor is often called the *Certificate of Coverage (CoC)*. *Evidence of Coverage (EoC)* is another similar term. The CoC explicitly defines what benefits are included in the contract, what benefits are excluded by the contract, and the manner in which the member

must access covered benefits (e.g., by using only a participating provider with payment of a defined copayment). This is called the *benefit design*. One MCO may offer numerous benefit designs to accommodate the needs of various plan sponsors. Indemnity insurance coverage of the past had few coverage limitations, which produced higher and less predictable costs. By contrast, managed care covers selective, appropriate healthcare services to meet member needs. These services focus on the fundamental healthcare needs of members. Not all healthcare services may be covered, particularly those that are highly discretionary. Some services may be covered with a high copayment or coinsurance.

The CoC is a legal document and is filed with the regulatory authority that would be a state agency for a state chartered plan or CMS for a Medicare program. As the CoC may be a cumbersome legal document, health plans often provide members with both the CoC and a simplified summary of benefits and instructions on how to access covered services. Chapter 4 addresses the contractual relationship between the health plans and plan sponsors.

HOW MANAGED CARE ORGANIZATIONS MANAGE FINANCIAL RISK

A fundamental cost management strategy of managed care is to use financial risk-sharing to influence the behavior of all stakeholders in the healthcare delivery system to make cost-effective decisions. All providers of care (physicians, hospitals, pharmacies, etc.) must accept discounted reimbursement rates and often have financial incentives to influence cost-effective decisions. Physicians may receive incentives for achieving performance standards (Pay for Performance), and members pay lower copayments to access lower cost drugs or those known to produce valuable outcomes for patients with chronic conditions. Equipment vendors offer competitive bids to acquire contracts. Drug companies offer discounts and rebates in exchange for preferred formulary coverage (discussed in Chapter 15). Plan sponsors pay a premium for defined benefits, and member must pay a copayment whenever care is accessed. The financial risk-sharing mechanisms are summarized in **Table 1-1**, and the relationship among the stakeholders is illustrated in **Figure 1-3**.

TABLE 1-1 Examples of Managed Care Financial Risk-Sharing Mechanisms

Managed Care Stakeholder	Financial Risk-Sharing Mechanisms
Physicians	Discounted reimbursement (capitation, discounted fee-for-service); performance incentives
Hospitals	Discounted reimbursement (contract and case rates; per diem rates)
Pharmacies	Discounted reimbursement; generic dispensing incentives; drug formulary; quality, step, and other edits; prior authorization of certain drugs
Plan Sponsors	Premium increases for excessive costs
Members	Premium share payments; copayments and coinsurance

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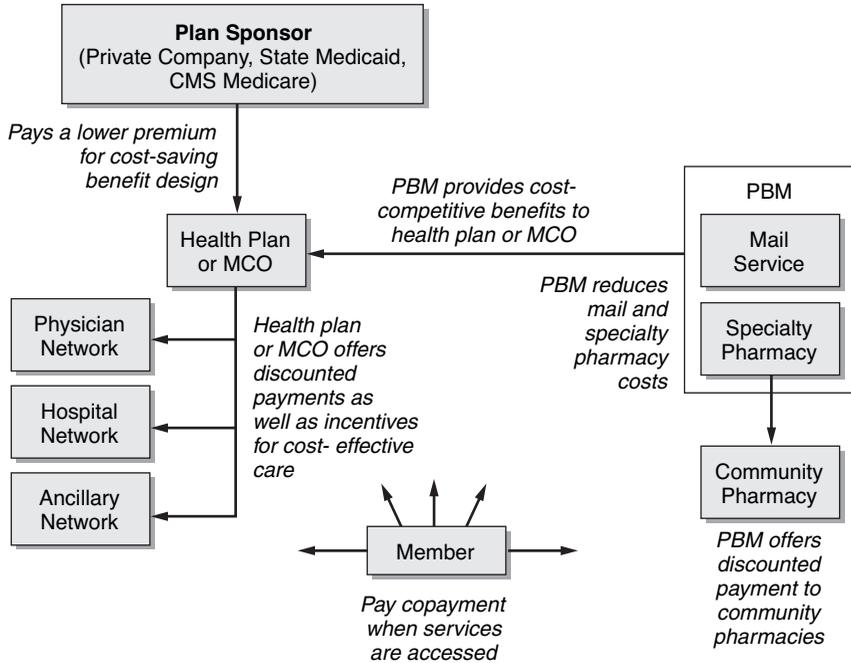


FIGURE 1-3 Managed Care Flow of Money and Financial Risk-Sharing Relationships.

UNDERWRITING TO FORECAST PLAN SPONSOR FINANCIAL RISK

Managed care organizations statistically examine the defined population they are expected to provide with health benefits coverage in order to forecast how much it will cost to provide the expected level of resource utilization. Through this analysis, called *underwriting*, the health plan or insurer can forecast the financial cost (risk) the health plan may incur to provide the medical and pharmacy benefits that are defined in the benefit product the plan sponsor decides to purchase. Based upon the projected financial risk, the health plan or insurer can determine the monthly fee (premium) the plan sponsor and members will pay as well as the copayment or coinsurance the members will pay to access covered health services. The group members covered by the plan are referred to as the *risk pool*. The value of a large population risk pool is that the costs generated by healthcare claims (e.g., high cost, high prevalence diseases, health wellness programs, rare diseases, transplants, catastrophic claims) may be spread over the entire risk pool for a lower *per capita*, or per-member cost, although costs depend upon the benefit design. The benefit design is developed to share the financial risk with the plan sponsor through premiums as well as

members through copayments, coinsurance, and deductibles, and to encourage the cost-effective use of healthcare resources.

Health plans assess the financial performance (profitability or loss) of each plan sponsor contract. Health plans divide the total healthcare expenditures by the total premium income for a specific plan sponsor to determine the *medical loss ratio (MLR)*. For example, if \$100 is taken in as premium, and \$90 is spent on medical services, the MLR is 90% (and the health plan saved 10%, part of which is kept as profit or retained earnings for non-profit organizations]). An MLR of 90 or better is generally acceptable. If the premium taken in is \$90 but the cost of healthcare services provided is \$100, the MLR is 111%, and the health plan lost money. For the subsequent year, the health plan will increase the plan sponsor's premium, or insist that the sponsor's benefit design include more stringent limitations (e.g., higher copayment) to help reduce inappropriate utilization or increase member cost-sharing. If the plan sponsor refuses, the health plan may not offer the plan sponsor a contract for the subsequent year. Through this mechanism, plan sponsors are encouraged to develop an effective benefit design, and copayment structure to encourage member responsibility in accessing healthcare services.

PHYSICIAN CONTRACTING AND REIMBURSEMENT MECHANISMS

Physician reimbursement depends upon the organizational structure of the managed care organization. Physicians employed by a staff model HMO are usually salaried, and often receive a bonus or incentive linked to plan performance. Physicians not salaried are often reimbursed through either capitation, or a discounted fee-for-service (FFS) contract. They may also qualify for a bonus linked to plan or individual performance (termed *pay for performance*, or abbreviated *P4P*). Physician capitation or discounted FFS reimbursement are the two reimbursement mechanisms most commonly used by MCOs, which are predominantly not staff or group model plans.

Capitation Reimbursement Under capitation arrangements, a physician (or medical group) receives a fixed monthly fee for providing covered services based upon the number of enrolled members that are assigned to the physician or medical group for a given month. The physician or medical group receives the same monthly fee per capita (per assigned member) regardless of how many times the members may see the physician or how many covered services the physician provides for members. Through capitation, the HMO transfers a portion of the financial risk to the physician. Theoretically, this will serve as an incentive to the physician to cost-effectively provide only needed care. While covered services will vary by contract, they often include all outpatient visits, preventive care, common laboratory, and other office-based services. Prescriptions may or may not be included. If the capitation includes pharmacy costs, the medical group will often develop its own drug formulary to encourage the use of the most cost-effective drugs. Physicians often share the financial risk for patients who are hospitalized, as an incentive to provide appropriate outpatient care and to prevent unnecessary admissions.

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Discounted FFS Reimbursement Under discounted FFS reimbursement mechanisms, physicians receive a payment whenever they provide covered services to a health plan patient. However, their reimbursement is discounted from usual and customary (U & C) reimbursement rates, and may be based upon the Resource Based Relative Value Scale (RBRVS) reimbursement rates developed by the California Medical Society. This provides a mechanism to reduce costs per service, and the reimbursement is often adjusted geographically as well as by demographic underwriting of the covered population. Also, physicians generally receive only a portion of the reimbursement at the time services are rendered (often 80%). The remaining 20% is withheld and maintained in a reserve to be paid out at the end of the year if certain plan and physician performance objectives are met. At the end of the year, the utilization of services and financial performance of physicians within a specialty group are reviewed and compared. High-risk outlier members that may unfairly skew the financial performance are eliminated. Physicians that do not perform efficiently (i.e., are most costly) forfeit their 20% reserve payment. Physicians that consistently are poor performers may be terminated from participating with the MCO. Physicians who are “average” performers receive their 20% reserve payment. Physicians who are the most efficient and least costly will receive a bonus, that is essentially the 20% withhold from the least efficient physicians. Through this mechanism, physicians within each specialty group compete among themselves, and physicians receive periodic “report cards” to help them monitor their performance and reduce inefficient practice variation.

Primary Care Physicians as Gatekeepers The “gatekeeper” concept, less common today, required members to obtain permission from their primary care physician (PCP) in order to consult a physician specialist. The dual purpose for gatekeeping was to allow the PCP to coordinate care and to minimize the use of more expensive specialists. Most MCOs found this to be inefficient and realized that specialists may be more cost-effective for many medical conditions. Most MCOs have eliminated the gatekeeper concept and allow members to “self-refer” to specialists, although there may be a higher copayment charged for specialist services.

Pay For Performance A logical extension of financial risk-sharing with physicians is to pay physicians a financial incentive when they achieve pre-defined clinical and or financial performance benchmarks that are structured to encourage the achievement of preferred clinical outcomes at the lowest net cost (cost-efficiency). Examples of managed care pay for performance programs include:

1. CMS P4P programs for cost-efficient care in Medicare.⁵
2. Employers and MCOs that embrace the Bridges to Excellence (Diabetes Care Link, Cardiac Care Link, and Spine Link) programs.⁶
3. MCOs pay incentives to physicians for improving HEDIS⁷ measure scores.
4. State Medicaid physician Pay for Performance programs.⁸

Ancillary Service “Carve Outs” Managed care is an extremely competitive business and is evolving to meet the expanding expectations of payers and members. Many MCOs offer a variety of optional “ancillary” benefits (beyond traditional hospital, physician, and pharmacy benefits), including dental, chiropractic, podiatry, vision, wellness, massage therapy, expanded durable medical equipment, mental health, acupuncture, and other alternative healthcare options. MCOs can customize a benefit design and premium and member cost sharing schedules to meet specific plan sponsor needs.

The term *carve-out* means that the plan sponsor removes (or carves out) a specific benefit from the internal health plan delivery system and offers the benefit through an external company that specializes in providing a particular ancillary benefit in a cost-efficient manner. Carve-out benefits often include benefit maximums (e.g., a maximum number of covered visits), and may include a higher copayment or coinsurance.

PURSUIT OF QUALITY

Managed care has created unprecedented competition among U.S. healthcare delivery systems. As a result of comprehensive claims databases, health plans could measure their costs as well as their clinical and economic outcomes, and identify the most cost-effective physicians, hospitals, and drugs. If these outcomes can be measured, they can be managed to minimize variation, and optimize use of resources. MCOs have identified the top medical conditions by cost, prevalence, incidence, and other parameters, and have implemented disease and care management programs to deal with these top diseases. The Disease Management Association of America⁹ provides educational resources and is a clearinghouse for disease management activities focused on high cost and high prevalence medical conditions, including obesity, hypertension, dyslipidemia and coronary heart disease, asthma, congestive heart failure, and several others.

National organizations, such as National Committee for Quality Assurance¹⁰, The Leapfrog Group¹¹, The Joint Commission (JCAHO)¹², URAC¹³, and various local organizations began measuring, accrediting, and publicly publishing health plan, physician, and hospital performance report cards to prospective purchasers as an incentive for plans to provide the most cost-effective healthcare. As a result of the market competition, plans must provide the benefits, cost, and outcomes demanded by plan sponsors in order to remain in business.

Health care, and especially commercial managed care, is a highly competitive, market driven business. Plan sponsors and members have access to an increasing amount of information to select the health plan that best satisfies specific cost management and benefit design demands. Managed care organizations are constantly evolving to meet and anticipate market demands. The market is also consolidating, with health plans acquiring others, PBMs merging, chain pharmacies buying PBMs through various horizontal and vertical integrations.

The plan sponsors and consumers should benefit from the market competition; however, with costs continuing to increase, plan sponsors and health plans are requiring members to

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pay higher and higher copayments and coinsurance percentages, and are subjecting members to higher deductible amounts and lower benefit caps. The future consumer of health care must be better informed, must practice self care for disease prevention, and must make wise choices when accessing more restrictive healthcare benefits.

FUTURE TRENDS AND CONSUMER-DRIVEN HEALTH CARE

Despite the pervasiveness of managed care, healthcare costs continue to escalate. However, the U.S. market has been dynamic, and significant changes have occurred over the past two decades, most of which have contributed to an increase in utilization of healthcare resources.

- The population grew by 20% to 300 million.¹⁵
- A greater percent of the U.S. population (85%) has healthcare insurance and pharmacy benefit coverage, including expensive subgroups (e.g., Medicaid, Medicare).
- The average life expectancy grew by almost 5 years to 77 years, increasing the percent of the population over 65 years, the highest utilizers of healthcare services.¹⁶
- The cardiovascular, cerebrovascular, cancer, homicide death rates declined, while the death rate from diabetes has increased.
- New drugs, including biotechnology agents, have improved outcomes for many life-threatening illnesses (see previous bullet), but the pharmacy benefit cost of managed care organizations has quadrupled.

Despite the improvements in quantity and quality of care, the U.S. population and plan sponsors are unable to maintain the same level of medical and pharmacy benefit coverage without greater cost-sharing with members. In response to plan sponsor requests, MCOs and PBMs are making significant changes in benefit design and healthcare delivery:

- Many new drugs are high cost, often injectable, bioengineered drug products. Managed care is depending upon specialty pharmacies (see Chapter 22) to optimize cost and utilization.
- Benefit designs include more formulary limitations and edits to better manage utilization of high costs drugs. The use of generic drugs before branded agents is often required, or heavily incentivized.
- Benefit coverage maximums are often capped at lower amounts, thus limiting the total dollar amount of benefits covered.
- Up-front member deductibles are more common and higher, and the member must pay \$2,500 out-of-pocket before health insurance covers any benefits.
- Member copayments and coinsurance levels are increasing. Twenty years ago, the average brand copayment represented 25% of the total prescription cost. Today it is often 40% or more.

In summary, there will be increased financial authority and responsibility given to the member through deductibles, copayments, and coinsurance amounts. Rather than have “first dollar” coverage with no deductible, the member will have to “spend down” his or her deductible with out-of-pocket dollars before covered benefits are accessible. This benefit change is termed *consumer-driven healthcare (CDH)*, and indicates the member will be given the authority and responsibility to make healthcare decisions and spend his or her healthcare resources with benefit design limitations.

CDH is a general concept that takes on many different forms among health plans and insurers. One of the popular CHF insurance products is called a *Health Savings Account (HSA)*, which is essentially a personal healthcare savings account that can follow a member for life, through many different insurers. HSAs typically have a relatively lower premium cost, but also has much higher front-end deductibles (often \$2,500 per individual or \$5,000 per family) that must be paid out-of-pocket before benefits are accessed. After the deductible is satisfied, covered benefits are accessed. HSAs often waive a deductible payment for certain preventive care services, such as an annual physician exam.

CDH-type plans present cost-sharing opportunities for MCOs, but must be accompanied with member education so that members spend their money wisely to make the best long-term healthcare decisions. An uneducated member may refuse to spend his or her own money for necessary preventive or wellness care, and may not avoid a preventable illness. This may result in an avoidable and expensive hospitalization that will be a covered benefit, thus shifting the costs back to the insurance company. As a result of these potentially perverse and misaligned incentives, MCOs are spending enormous resources on health and wellness education, health risk assessment and screening, and often paying members to access such services.

CONCLUSION

Managed care is the current primary economic and social choice in the United States for delivering quality health care in a cost-efficient manner. Managed care has specific policies and procedures all stakeholders must follow for the system to function properly. A basic tenet of managed care is to involve all stakeholders in the financial risk of the healthcare delivery process. Managed care is no longer an alternative form of healthcare delivery. It is now considered the main financing and delivery mechanism for healthcare within the United States. CDH changes in health care coverage promise to contain rising costs for plan sponsors, but can only do so if members are educated and become a partner in achieving clinical, economic, and quality of life outcomes.

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