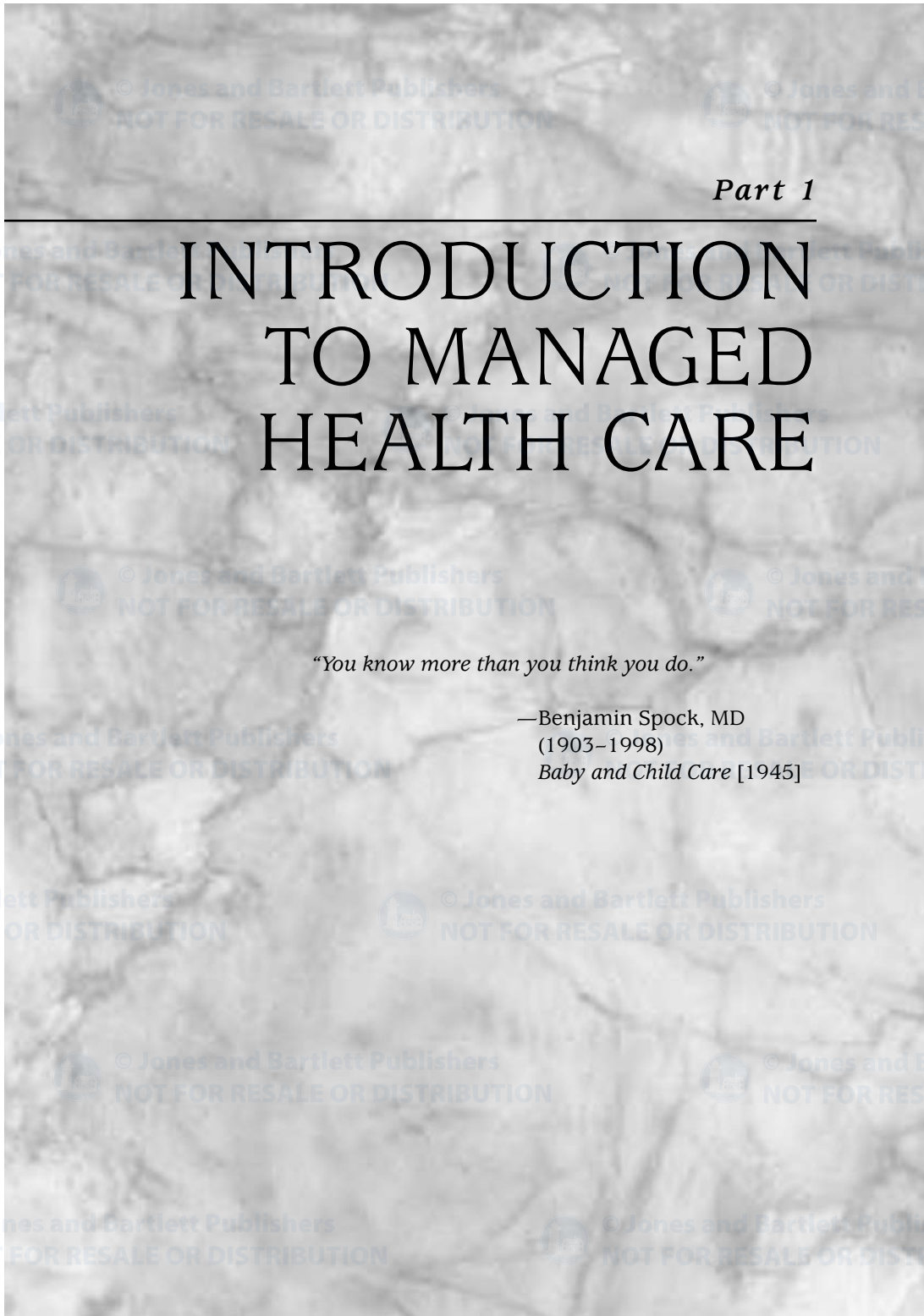


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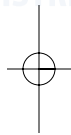


Part 1

INTRODUCTION TO MANAGED HEALTH CARE

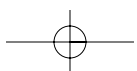
"You know more than you think you do."

—Benjamin Spock, MD
(1903–1998)
Baby and Child Care [1945]



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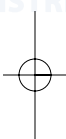
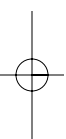
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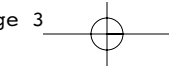
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1

THE ORIGINS OF MANAGED HEALTH CARE

Peter D. Fox and Peter R. Kongstvedt

Study Objectives

- Understand the evolution of managed care, including the forces that have driven this evolution.
- Understand current trends in managed care, including how market dynamics continue to change over time.
- Understand the public policy and market performance issues facing managed care.

Discussion Topics

1. Discuss why HMOs were formed in the first place.
2. Discuss what some of the managed care steps are that employers can take to constrain health care costs and promote wellness besides contracting with HMOs.
3. Discuss how important to employers it generally is that managed care plans demonstrate that they offer quality care.
4. Discuss the salient forces leading to the rise and fall of various types of managed care plans. Speculate on how current and future forces might lead to further changes.
5. Discuss how the relationship between the government and the managed care industry has changed over the years.

**MANAGED CARE:
THE EARLY YEARS (PRE-1970)**

This chapter addresses the development of health maintenance organizations (HMOs) and other managed care organizations (MCOs) rather than focusing on the operational issues found in the other chapters of this book. The historical roots are presented, and some of the major dynamics involved in the evolution of the managed health care industry are discussed.

The Western Clinic in Tacoma, Washington is sometimes cited as the first example of an HMO, or prepaid group practice, as it was known until the early 1970s. Starting in 1910, the Western Clinic offered, exclusively through its own providers, a broad range of medical services in return for a premium payment of \$0.50 per member per month.¹ The program was available to lumber mill owners and their employees and served to assure the clinic a flow of patients and revenues. A similar program was developed by a Dr. Bridge, who started a clinic in Tacoma that later expanded to 20 sites in Oregon and Washington.

In 1929, Michael Shadid, MD, established a rural farmers' cooperative health plan in Elk City, Oklahoma, by forming a lay organization of leading farmers in the community. Participating farmers purchased shares for \$50 each to raise capital for a new hospital in return for receiving medical care at a discount.² For his trouble, Dr. Shadid lost his membership in the county medical society and was threatened with having his license to practice suspended. Some 20 years later, however, he was vindicated through the out-of-court settlement in his favor of an antitrust suit against the county and state medical societies. In 1934, the Farmers Union assumed control of both the hospital and the health plan.

Health insurance itself is of relatively recent origin.³ In 1929, Baylor Hospital in Texas agreed to provide some 1,500 teachers prepaid care at its hospital, an arrangement that represented the origins of Blue Cross. The program was subsequently expanded to in-

clude the participation of other employers and hospitals, initially as single hospital plans. Starting in 1939, state medical societies in California and elsewhere created, generally statewide, Blue Shield plans, which reimbursed for physician services. At the time, commercial health insurance was not a factor.

The formation of the various Blue Cross and Blue Shield plans in the midst of the Great Depression, as well as that of many HMOs, reflected not consumers' demanding coverage or nonphysician entrepreneurs seeking to establish a business but rather providers' wanting to protect and enhance patient revenues. Many of these developments were threatening to organized medicine. In 1932, the American Medical Association (AMA) adopted a strong stance against prepaid group practices, favoring, instead, indemnity type insurance. The AMA's position was in response to both the small number of prepaid group practices in existence at the time and the findings in 1932 of the Committee on the Cost of Medical Care—a highly visible private group of leaders from medicine, dentistry, public health, consumers, and so forth—that recommended the expansion of group practice as an efficient delivery system. The AMA's stance at the national level set the tone for continued state and local medical society opposition to prepaid group practice.

The period immediately around World War II saw the formation of several HMOs, some of which remain prominent today. These HMOs represent a diversity of origins with the initial impetus coming, variously, from employers, providers seeking patient revenues, consumers seeking access to improved and affordable health care, and even a housing lending agency seeking to reduce the number of foreclosures. They encountered varying degrees of opposition from local medical societies. The following are examples of early HMOs:

- The Kaiser Foundation Health Plan was started in 1937 by Dr. Sidney Garfield at the behest of the Kaiser construction company, which sought to finance med-

ical care, initially for workers and families who were building an aqueduct in the southern California desert to transport water from the Colorado River to Los Angeles and, subsequently, for workers who were constructing the Grand Coulee Dam in Washington State. A similar program was established in 1942 at Kaiser ship-building plants in the San Francisco Bay area.

- In 1937, the Group Health Association (GHA) was started in Washington, DC at the behest of the Home Owner's Loan Corporation to reduce the number of mortgage defaults that resulted from large medical expenses. It was created as a nonprofit consumer cooperative, with the board elected periodically by the enrollees. The District of Columbia Medical Society opposed the formation of GHA. It sought to restrict hospital admitting privileges for GHA physicians and threatened expulsion from the medical society. A bitter antitrust battle ensued that culminated in the U.S. Supreme Court's ruling in favor of GHA. In 1994, faced with insolvency despite an enrollment of some 128,000, GHA was acquired by Humana Health Plans, a for-profit, publicly traded corporation. Since that time, it has been divested by Humana and the membership incorporated into Kaiser Foundation Health Plan of the Mid-Atlantic.
- In 1944, at the behest of New York City, which was seeking coverage for its employees, the Health Insurance Plan (HIP) of Greater New York was formed.
- In 1947, consumers in Seattle organized 400 families who contributed \$100 each to form the Group Health Cooperative of Puget Sound. Predictably, opposition was encountered from the Kings County Medical Society.

Only in later years did nonprovider entrepreneurs form for-profit HMOs in significant numbers.

The early independent practice association (IPA) type of HMO, which contract with physi-

cians in independent fee-for-service practice, was a competitive reaction to group practice-based HMOs. The basic structure was created in 1954 when the San Joaquin County Medical Society in California formed the San Joaquin Medical Foundation in response to competition from Kaiser. The foundation established a relative value fee schedule for paying physicians, heard grievances against physicians, and monitored quality of care. It became licensed by the state to accept capitation payment, making it the first IPA model HMO.

The Adolescent Years: 1970–1985

Through the 1960s and into the early 1970s, HMOs played only a modest role in the financing and delivery of health care, although they were a significant presence in a few communities such as the Seattle area and parts of California. In 1970, the total number of HMOs was in the 30s, the exact number depending on the definition used. From then until the early to mid-1990s, HMOs expanded at an ever-increasing rate. However, beginning in the early to mid-1990s, HMOs consolidated through mergers and acquisitions, resulting in a decline in the number of such plans beginning in the late 1990s, as discussed later in this chapter.

The major boost to the HMO movement during the early period of growth was the enactment in 1973 of the federal HMO Act. That act, as described later, both authorized start-up funding and, more important, ensured access to the employer-based insurance market. It evolved from discussions that Paul Ellwood, MD had in 1970 with the political leadership of the U.S. Department of Health, Education, and Welfare (which later became the Department of Health and Human Services).⁴ Ellwood had been personally close to Philip Lee, MD, Assistant Secretary for Health during the presidency of Lyndon Johnson, and participated in designing the Health Planning Act of 1966.

Ellwood, sometimes referred to as the father of the modern HMO movement, was

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asked in the early Nixon years to devise ways of constraining the rise in the Medicare budget. Out of those discussions evolved both a proposal to capitate HMOs for Medicare beneficiaries (which was not enacted until 1982) and the laying of the groundwork for what became the HMO Act of 1973. The desire to foster HMOs reflected the perspective that the fee-for-service system, by paying physicians based on their volume of services, incorporated the wrong incentives. Also, the term *health maintenance organization* was coined as a substitute for *prepaid group practice*, principally because it had greater public appeal.

The main features of the HMO Act were the following:

- Grants and loans were available for the planning and start-up phases of new HMOs as well as for service area expansions for existing HMOs.
- State laws that restricted the development of HMOs were overridden for HMOs that were federally qualified, as described later.
- Most important of all were the “dual choice” provisions, which required employers with 25 or more employees that offered indemnity coverage also to offer two federally qualified HMOs, one of each type: (1) the closed panel or group or staff model and (2) the open panel or IPA/network model, if the plans made a formal request* (the different model types are discussed in Chapter 2). Some HMOs were reluctant to exercise the mandate, fearing that doing so would antagonize employers, who would in turn discourage employees from enrolling. However, the dual choice mandates were used by other HMOs to get in the door of employer groups to at least become established.

*For workers under collective bargaining agreements, the union had to agree to the offering.

The statute established a process under which HMOs could elect to be federally qualified. Plans had to satisfy a series of requirements, such as meeting minimum benefit package standards set forth in the act, demonstrating that their provider networks were adequate, having a quality assurance system, meeting standards of financial stability, and having an enrollee grievance process. Some states emulated these requirements and adopted them for all HMOs that were licensed in the state regardless of federal qualification status.

Obtaining federal qualification had always been at the discretion of the individual HMO, unlike state licensure, which is mandatory. Plans that requested federal qualification did so for four principal reasons. First, it represented a “Good Housekeeping Seal of Approval” that was helpful in marketing. Second, the dual choice requirements ensured access to the employer market. Third, the override of state laws—important in some states but not others—applied only to federally qualified HMOs. Fourth, federal qualification was required for the receipt of federal grants and loans that were available during the early years of the act. Federal qualification is no longer in existence, but it was important when managed care was in its infancy and HMOs were struggling for inclusion in employment-based health benefit programs, which account for most private insurance in the United States.

The HMO Act also contained provisions that were seen by some as retarding the growth of HMOs. This stemmed from a compromise in Congress between members having differing objectives. One camp was principally interested in fostering competition in the health care marketplace by promoting plans that incorporated incentives for providers to constrain costs. The second camp, although perhaps sharing the first objective, principally saw the HMO Act as a precursor to health reform and sought a vehicle to expand access to coverage for individuals who were without insurance or who had lim-

ited benefits. Imposing requirements on HMOs but not on indemnity carriers, however, reduced the ability of HMOs to compete.

Of particular note were requirements with regard to the comprehensiveness of the benefit package* as well as open enrollment and community rating. The open enrollment provision required that plans accept individuals and groups without regard to their health status. The requirement for community rating of premiums (see Chapter 25 for a discussion of community rating) limited the ability of plans to relate premium levels to the health status of the individual enrollee or employer group. Both provisions represented laudable public policy goals; the problem was that they had the potential for making federally qualified HMOs noncompetitive because the same requirements did not apply to the traditional insurance plans against which they competed. This situation was largely corrected in the late 1970s with the enactment of amendments to the HMO Act that reduced some of the more onerous requirements. The federal dual choice provisions were "sunsetting," that is, expired, in 1995 and are no longer in effect. Further, many states require forms of community rating for the small group market from all carriers now, not just HMOs; a few states, however, continue to have differing rating requirements for HMOs than they do for indemnity plans.

Another reason that HMO development was retarded was the slowness of the federal gov-

ernment in issuing regulations implementing the act. Employers knew that they would have to contract with federally qualified plans. Even those who were supportive of the mandate, however, delayed until the government both determined which plans would be qualified and established the processes for the implementation of the dual choice provisions. The Carter administration, which assumed office in 1977, was supportive of HMOs. In particular, Hale Champion as undersecretary of the U.S. Department of Health and Human Services, made issuance of the regulations a priority, and rapid growth ensued.

Politically, several aspects of this history are interesting. First, although differences arose on specifics, the congressional support for legislation promoting HMO development came from both political parties. Also, there was not widespread state opposition to the override of restrictive state laws. In addition, most employers did not actively oppose the dual choice requirements, although many disliked the federal government in effect telling them to contract with HMOs. Perhaps most interesting of all was the generally positive interaction between the public sector and the private sector, with government fostering HMO development both through its regulatory processes and also as a purchaser under its employee benefits programs.

Other managed care developments also occurred during the 1970s and early 1980s. Of note was the evolution of preferred provider organizations (PPOs). PPOs are generally regarded as originating in Denver, where in the early 1970s Samuel Jenkins, a vice president of the benefits consulting firm of the Martin E. Segal Company, negotiated discounts with hospitals on behalf of the company's Taft-Hartley trust fund clients.⁵ Hospitals did so in return for the health plans having lower cost sharing for its users, thereby generating patient volume at the expense of its competitors.

Service plans (defined in Chapter 2), of which the Blue Cross and Blue Shield plans predominate, placed limits on maximum

*The ripple effects of the early HMO benefits requirements affect the health insurance and managed health care market even today. Prior to the comprehensive benefits that HMOs provided, indemnity health insurance and service plans (such as Blue Cross and Blue Shield plans) typically did not cover preventive care such as well child visits, routine health exams, or immunizations, and rarely provided coverage for outpatient drugs. HMOs were not required to offer drugs either but commonly did so to entice individuals to join. Soon the drug benefit became commonplace in all types of health plans.

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charges of physicians; those limits reflected a composite of actual charges using a methodology known as “usual and customary” fee calculation, that is, based on statistical profiles of what physicians actually charged for individual services. They also had limits on payments to hospitals, in some cases paying them based on their actual costs. As PPOs grew in the market, the service plans began to adopt new methods of calculating payment maximums. By the late 1980s, however, even the service plans had created PPOs in response to market pressures, with the primary difference being a greater level of discount paid to providers. (Reimbursement is discussed in detail in Chapters 6 and 7.) Finally, as noted in Chapter 2 and elsewhere in this book, there are no clear distinctions between managed health care plan types anymore, though various attributes are discussed further throughout this text.

Utilization review expanded outside the HMO setting between 1970 and 1985, although it has earlier origins:

- In 1959, Blue Cross of Western Pennsylvania, the Allegheny County Medical Society Foundation, and the Hospital Council of Western Pennsylvania performed retrospective analyses of hospital claims to identify utilization that was significantly above the average.⁶
- Around 1970, California’s Medicaid program initiated hospital precertification and concurrent review in conjunction with medical care foundations in that state, typically county-based associations of physicians who elected to participate, starting with the Sacramento Foundation for Medical Care.
- The 1972 Social Security Amendments authorized the federal Professional Standards Review Organization (PSRO) to review the appropriateness of care provided to Medicare and Medicaid beneficiaries. Although the effectiveness of the PSRO program has been debated, the PSRO program established an orga-

nizational infrastructure and data capacity upon which both the public and private sectors could rely. In time the PSRO was replaced by the Peer Review Organization (PRO), itself in turn replaced by the Quality Improvement Organization (QIO), which continues to provide oversight of clinical services on behalf of the federal and many state governments. Although the methods used by these organizations evolved along with their acronyms, their focus remained essentially the same.

- In the 1970s, a handful of large corporations initiated precertification and concurrent review for inpatient care, much to the dismay of the provider community.

Developments in indemnity insurance, mostly during the 1980s, included encouraging persons with conventional insurance to obtain second opinions before undergoing elective surgery and the widespread adoption of large case management—that is, the coordination of services for persons with expensive conditions, such as selected accident patients, cancer cases, and very low birth-weight infants. Utilization review, the encouragement of second opinions, and instituting large case management all entailed at times questioning physicians’ medical judgments, something that had been rare outside of the HMO setting. These activities, further discussed in Part III of this book, were crude by today’s standards of medical management but represented a radically new role of insurance companies in managing the cost of health care at the time.

Also during the 1980s, worksite wellness programs became more prevalent as employers, in varying degrees and varying ways, instituted such programs as the following:

- Screening (for hypertension and diabetes)
- Health risk appraisal
- Promotion of exercise (whether through having gyms, conveniently located showers, or running paths; providing subsi-

dies for health club memberships; or simply by providing information)

- Stress reduction
- Classes (smoking cessation, lifting of heavy weights, and the benefits of exercise)
- Nutritional efforts, including serving healthy food in the cafeteria
- Weight loss programs
- Mental health counseling

MANAGED CARE GROWS UP: 1985 TO 1995

The period between 1985 and 1995 saw a combination of innovation, maturation, and restructuring, each of which is discussed in the following sections.

Innovation

In many communities, hospitals and physicians collaborated to form integrated delivery systems (IDSs). These had two principal forms. The first entailed mergers or acquisitions that resulted in the creation of single legal entities, for example, of hospitals and group practices. The second was the formation of physician-hospital organizations (PHOs), principally as vehicles for contracting with MCOs. Typically, PHOs are separately incorporated, with the hospital and the physicians each having the right to designate half the members of the board. Most PHOs sought to enter into fee-for-service arrangements with HMOs and PPOs, although some accepted shared or full capitation risk. IDSs are discussed further in Chapter 2.

IDSs did not become important elements of the managed health care environment for a number of reasons, including provider participation requirements and reimbursement systems that did not support managed care goals. For example, most IDSs allowed all physicians with admitting privileges at the hospital in question to participate rather than selecting the more efficient ones. Also, the physicians were commonly required to use

the hospital for outpatient services (for laboratory tests) that might be obtained at lower cost elsewhere, hence hurting the ability of the PHO to be price competitive. Finally, some IDSs suffered from organizational fragmentation, reimbursement systems to individual doctors who were misaligned with the goals of the PHO, inadequate information systems, management that was inexperienced, and a lack of capital. In the end, most PHOs in particular were unable to sustain the financial risk for medical expenses.

A second innovation was the growth of carve-outs, which are organizations that have specialized provider networks and are paid on a capitation or other basis for a specific service, such as mental health (see Chapter 13), specialty disease management (see Chapter 10), chiropractic, and dental. The carve-out companies market their services principally to HMOs and large self-insured employers. In recent years, some of the large health plans that contracted for such specialty services have reintegrated them into the main company (so-called carve-in or insourcing arrangements). One reason for the reintegration was the view that carved-out services made it difficult to coordinate services, for example, between physical and mental health. Similar in concept are groups of specialists, such as ophthalmologists or radiologists, who accept capitation risk for their services (sometimes referred to as sub-capitation) through contracts with health plans and employer groups. Capitation is not the only method of reimbursement to carve-outs or specialty groups; discounted fee-for-service payments may also be used (see Chapter 6).

A third set of innovations are those made possible by advances in computer technology. Vastly improved computer programs, marketed by private firms or developed by managed care plans for internal use, that generate statistical profiles of the use of services rendered by physicians have become available. These profiles serve to assess efficiency and quality and may also serve to adjust payment levels to providers who are paid

under capitation or risk-sharing arrangements to reflect patient severity. Chapters 16 and 17 discuss further the uses of medical informatics.

Another example of the impact of computer technology is a virtual revolution in the processing of medical and drug claims, which is now much more commonly performed electronically rather than by paper submission and manual entry.* The result has been lower administrative costs and superior information, with the most prevalent and technologically advanced systems being the processing of prescription drug claims, enabling the pharmacist at the time a prescription is dispensed to receive information about eligibility of the member for coverage, amount of copay or co-insurance required on a drug-by-drug basis (real-time access to a health plan's formulary; see Chapter 12), and potential adverse effects. Management information systems can be expected to improve dramatically over the next few years as providers, almost universally, submit claims electronically. This impact from information technology is now being furthered by the requirements and mandated standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for administrative simplification, accelerating the movement toward inexpensive electronic interchange for the basic health insurance transactions, including the following:

- Claims
- Claims status
- Authorizations
- Eligibility checking
- Payment

*GF Anderson *et al* argue that “the United States lags as much as a dozen years beyond other industrialized countries” in the implementation of computer-based health information systems. See Anderson GF *et al*. Health care spending and use of information technology in OECD countries. *Health Affairs*. May/June 2006;XXV(3):819–829.

Maturation

Maturation can be seen from several vantage points. The first is the extent of HMO and PPO growth, with HMO enrollment increasing from 15.1 million in 1984 to 63 million in 1996; HMO enrollment reached 78.9 million in 2000, and then declined to 66.1 million in 2004.⁷ This market dynamic is discussed further in following sections. However, insurance carriers are selling hybrid products that combine elements of HMOs and PPOs, making statistical compilations difficult. For example, there are health plans that have two networks, a narrow network and a broader one, with high cost sharing when the broader one is used, and yet even higher when a non-network provider is used. Such a plan functions virtually like an HMO with a POS plan and may be licensed as such, but could also be classified and/or licensed as a PPO.

Medicare and Medicaid (see Chapters 26 and 27) have also increasingly relied on managed care. Whereas Medicaid managed care has enjoyed relatively steady growth, Medicare managed care is another story. After rising from 1.3 to 6.3 million between 1990 and 1999, Medicare managed care enrollment reversed itself and declined to 4.6 million in 2003.⁸ This decline has widely been attributed to changes in federal law enacted in 1997 governing reimbursement to Medicare managed care plans, resulting in financial losses and withdrawal of such care plans from many markets. However, analysis by Robert Berenson concludes that the law's provision that guaranteed annual increases, at a minimum of 2%, resulted in plans getting paid more than they would have received under the previous reimbursement formula.⁹ Other contributing factors besides reimbursement changes may have been health plans' lacking the care management systems necessary to care for a senior and disabled population and in some cases the plans having reduced premiums below, or increased benefits above, levels that were sustainable in the long term to acquire market share early.

The Medicare Modernization Act, discussed in Chapter 26, contains many provisions that are likely to lead to a return of growth for Medicare managed care in both HMOs and PPOs. Most notable are the provisions that result in plans' being paid at rates that are, on average, above Medicare fee-for-service costs.¹⁰ How Medicare managed health care evolves is not easily predicted, however, in light of the history over the past 20 years, particularly given the propensity of the federal government to alter reimbursement periodically.

Another phenomenon is the maturation of external quality oversight activities. Starting in 1991, the National Committee for Quality Assurance (NCQA; see Chapter 23) began to accredit HMOs. The NCQA was launched by the HMOs' trade association in 1979 but became independent in 1991, with the majority of board seats being held by employer, union, and consumer representatives. Many employers are requiring or strongly encouraging NCQA accreditation of the HMOs with which they contract, and accreditation came to replace federal qualification as the seal of approval. NCQA, which initially focused only on HMOs, has evolved with the market, for example, to encompass mental health carve-outs, PPOs, physician credentialing verification organizations, and others. In addition to NCQA, other bodies that accredit managed care plans have also developed, as described in Chapter 23.

Performance measurement systems (report cards) continue to evolve, the most prominent being the Health Plan Employer Data and Information Set (HEDIS), which was developed by the NCQA at the behest of several large employers and health plans. The HEDIS data set has evolved and grown on a regular basis; the HEDIS data set that is current at the time of publication may be found in Chapter 23. Other forms of report cards have appeared since then and continue to develop as the market demands increasing levels of sophistication.

Another form of maturation is the focus of cost management efforts, which used to be

almost exclusively inpatient hospital utilization. Practice patterns have changed dramatically in the last 25 years, however, and inpatient utilization has declined significantly. As illustration, hospital care as a percentage of national personal health care expenditures declined from 46.9% to 36.6%, whereas physician and other clinical services increased from 21.8% to 25.6%, and prescription drugs rose from 5.6% to 12.1%.¹¹ Although hospital utilization still receives considerable scrutiny, greater attention is being paid to ambulatory services such as prescription drugs, diagnostics, and care by specialists. Perhaps even more important is that the high concentration of costs in a small number of patients with chronic conditions has resulted in significantly more attention being paid to disease management, as discussed in Chapter 10.

Restructuring

Perhaps the most dramatic development is the restructuring that began in the late 1980s, reflecting the interplay between managed care, the health care delivery system, and the overall health care marketplace. The definitional distinctions have blurred as MCOs underwent a process of hybridization, making meaningful statistics difficult to collect. Staff and group model HMOs, declining in number and faced with limited capital and a need to expand geographically, formed IPA components, and in some cases (*eg.* Health-America of Pennsylvania's Pittsburgh plan, Harvard Pilgrim [née Harvard Community] Health Plan) even divested the medical group or staff model component. HMOs expanded their offerings to include PPO and point-of-service (POS) products, and some PPOs obtained HMO licenses. HMOs also found themselves contracting with employers on a self-funded rather than a capitated basis whereby the risk for medical costs remains with the employer, and a variety of hybrid arrangements has also emerged. The major commercial health insurance companies also dramatically increased their involvement in

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managed care by both acquiring local health plans and starting up HMOs and PPOs. In short, the managed care environment became even more complicated.

Another change is role of the primary care physician (PCP), who assumed responsibility for overseeing the allocation of resources. Most MCOs regard gaining the loyalty of PCPs as critical to their success. In a traditional HMO, the role of the PCP has been to manage a patient's medical care, including access to specialty care. This proved to be a mixed blessing for PCPs, who sometimes felt caught between pressures to reduce costs on the one hand and, on the other hand, the need to satisfy the desires of consumers who may question whether the physician has their best interests at heart in light of the financial incentives to limit resource consumption. The growing popularity of PPOs as compared to HMOs appears to have led to a shift away from PCP-based plans in recent years, for example, the requirement for authorization to access specialty services, known as the "gatekeeper" requirement. That being said, many plans (including PPOs) require lower copays if a member receives care from a PCP than if the member receives care from a specialist, thus retaining a primary care focus.

Finally, consolidation is notable among both health care plans and providers. Among physicians there continues a slow but discernable movement away from solo practice and toward group practice. As for hospitals, a substantial amount of consolidation on a regional or local level occurred, creating large local and regional systems. This consolidation occurred largely in the mid- to late-1990s and continues today, although at a much slower rate. National consolidation of hospitals has not been a significant factor in recent years, however. Hospital consolidation was commonly justified in terms of its potential for rationalizing clinical and support systems. A clearer impact, however, has been the enhanced ability to negotiate favorable payment terms, often to the chagrin of the health plans with which they contract¹² (see Chapter 7).

Health plan consolidation has also been robust and continues today. Smaller local health plans have been acquired or in some cases ceased operations because of a number of forces. Large employers with employees who are spread geographically have generally been moving toward national companies at the expense of local health plans. For smaller plans, the financial strain of having to continually upgrade computer systems and other technology can become excessive. Smaller plans may also find themselves unable to negotiate the same discounts as larger competitors, exacerbating the financial strain. Smaller plans in unique markets such as in rural areas or where physician loyalty is high (as may be found in one of the few successful provider-sponsored health plans; see Chapter 2) may continue to thrive, but that is the exception.

Even larger health plans have been targets for acquisition, primarily in the for-profit sector. Indeed, as of 2006 all of the Blue Cross Blue Shield plans that had converted to for-profit status have been amalgamated into a single company: Anthem (sometimes referred to as Anthem/WellPoint, reflecting the names of the two large predecessors). At the time of publication, four commercial for-profit companies accounted for the majority of covered lives: CIGNA, Aetna, United Health Care, and Anthem/WellPoint. Consolidation has not only occurred in the for-profit sector but also in the non-investor-owned (NIO)* sector, primarily in Blue Cross and Blue Shield plans. Market growth in the Blue Cross Blue Shield system has been considerable as a result of many factors, including its generally broad provider networks, the managed care backlash, and the Blue's improved ability to offer national accounts when compared to the

*NIO is a term preferred by a number of not-for-profit health plans because Blue Cross and Blue Shield plans in particular are taxed as though they are for-profit health insurance companies, not as though they are charitable organizations.

prior decade. In any given state, the Blue plan often has the highest market penetration of any health plan.

MANAGED CARE IN RECENT TIMES: 1995–2005

The economic boom of the mid- to late-1990s changed the dynamics in the managed health care industry. As a result of unemployment dropping below 4%, corporate profits becoming robust, and the economy growing, employers found it increasingly necessary to compete for employees. The anti-managed care rhetoric of political campaigns, combined with media “horror stories,” helped fuel negative public sentiment about managed care. Despite generally positive perceptions of their own health plans, most consumers have negative perceptions about managed care in general.

The Managed Care Backlash

Anti-managed care sentiment, commonly referred to as the “managed care backlash,” became a defining force in the industry. Political speeches, movies and television shows, news articles, and even cartoons increasingly began to portray managed care in an unflattering light.

In some respects, this is not surprising. Because managed care had significantly lower costs than traditional health plans did, it became a dominant form of health care coverage when many employers put their employees (and dependents) into managed care as their only type of coverage. When the number of individuals in managed care became substantial, the number of problems rose as well, including individuals who did not want to be in a managed care plan. Some of the problems were mostly irritants, such as mistakes in paperwork or claims processing in health plans with information technology (IT) systems that were unable to handle the load. Commonly, the consumer associated such problems with managed care even

though they were really part of health insurance in general. Other problems were highly emotional though not actually a threat to health, such as denial of coverage for care that was genuinely not medically necessary; for example, an unnecessary diagnostic test. Finally, a major source of contention with many consumers was the requirement that they obtain prior authorization from their primary care physician to access specialty care, although arguably this provision both reduces costs and increases quality by ensuring primary care physicians are fully apprised of the care that their patients receive.

A few problems, however, were real or—at least potential—threats to health, such as denial of coverage for truly necessary medical care or difficulties in accessing care resulting in subsequent ill effects on health. Although quite uncommon in practice (although not statistically studied), isolated problems of this nature could generate adverse publicity. The emotional overlay accompanying health care outstrips almost any other aspect of life. The loss of life or limb in a spouse or child causes grief in ways that a house fire or losing one’s employment does not.

The managed care industry was not simply an innocent victim of bad publicity. As health plans and managed care companies grew, their ability to actually manage the delivery system was severely tested and frequently found wanting. Where clinically oriented decisions on coverage were once done with active involvement of medical managers, the rapidly growing health plans became increasingly bureaucratic and distant from their members and providers. Rapid growth also led to greater inconsistencies in decision making regarding coverage for clinical services. The public’s perception that decisions regarding coverage of clinical care being made by “bean counters” or other faceless clerks may not have been fair or accurate in the opinion of managed care executives, but neither was it without merit. Decision-making authority was often delegated and applied using general policies and

not necessarily with a sense of compassion or flexibility.

When enough instances of serious problems occur, they make good fodder for news that uses the well-proven reporting technique of “identifiable victim” stories in which actual names and faces are associated with anecdotes of poor care or other very real problems. Whether problems portrayed in the news may or may not have been represented fairly from the viewpoint of the health plan was irrelevant. When added on top of disgruntlement caused by minor or upsetting (though not dangerous) irritants caused by health plan operations, the public is not liable to be sympathetic to managed care, particularly with the backdrop of few insurance companies being loved.

Perhaps the most serious charge leveled against the managed care industry was the accusation that health plans *deliberately* refused to pay for necessary care to generate profits and enrich executives and shareholders. The negative reaction was enhanced by media stories of multi million dollar compensation packages of senior executives. Putting aside the fact that financial incentives drive almost all aspects of health care to varying degrees, this was a particularly pernicious charge that health plans faced, specifically the increasing number of for-profit plans.

One result of the backlash was new consumer protections at the state and/or federal level, or at least the threat of such legislation. For example, many states have passed legislation—the so-called prudent lay person rule—guaranteeing payment for emergency services if the precipitating symptoms could reasonably have been interpreted as an emergency, for example, chest pain that subsequently turned out to be indigestion. States have also passed bills instituting state-supervised independent appeals processes in the event of a medical denial. Finally, several unsuccessful attempts were made at the federal level to pass a so-called Patient Bill of Rights, which would have mirrored a na-

tional level provisions that many states had adopted.

Last, a frequently cited reason for the managed care backlash is American’s desire for choice. People simply did not want to be told that they could not go to any provider and still receive full coverage for their care. This attitude caused many HMOs to expand their networks aggressively and fueled the shift from traditional HMOs to less restrictive forms of coverage. For example, whereas enrollment in HMOs decreased from 24% in 1998 to 15% in 2005, PPO enrollment increased from 35% to 61%. Also noteworthy is that traditional insurance has become of only minor importance, with the percentage of enrollment in traditional plans. That is, those without contracted networks or other forms of managed care, which stood at 73% of employer-sponsored plans in 1988, declining to only 3% in 2005.¹³

Another example of the movement toward less restrictive forms of coverage is that a number of HMOs abandoned the primary care physician model (the so-called gatekeeper model discussed in Chapter 2) to one of “open access,” allowing members to access any provider in the network (though usually with lower copays for primary care than for specialty care).¹⁴ During this time, the managed care industry kept pointing out the good things it was doing for members such as coverage for preventive services and drugs, the absence of lifetime coverage limits, coverage of highly expensive care, and so forth, but to no avail.

The managed care backlash has become mostly an echo. The volume of HMO jokes has declined, news stories about coverage restrictions or withheld care are now uncommon, and there is little or no state or federal attention paid to placing restrictions on managed care plans. The HMO’s legacy of richer benefits, combined with the general loosening of medical management and broad access to providers, collided with other forces by the end of the millennium, and health care costs once again shot up.

The Return of Health Cost Inflation

The rapid increases in health care costs experienced in the late 1980s and early 1990s had slowed considerably by the mid-1990s, but health cost inflation returned by the turn of the century. Managed care had been a significant contributor to holding down the rate of rise, but many of the fundamental reasons for increased health care costs remain today. It is worth noting that although the percentage of the gross domestic product (GDP) consumed by health costs throughout much of the 1990s remained steady at around 13.2%, this was only partially because of lower health cost inflation. The other reason was the robust growth of the GDP itself; in other words, health cost inflation slowed while the overall GDP grew at a higher rate than it had for many years.

The health economy is too complex to ascribe inflationary pressures to any single attribute, or even a small constellation of attributes. Where health cost inflation was once caused as much by unnecessary utilization as by anything else, other forces have always been present. The lessening of some of the controls traditionally associated with managed health care combined with a richer benefit package has certainly contributed to rising health costs, but numerous other factors have also been in play. Examples of other such factors are the following:

- Drug therapy advances and prescription drug prices
- Shifting demographics, including the aging of the population
- Expectations for a long and healthy life, regardless of costs
- Greater consumer demands upon the health care system
- The litigiousness of our society, leading physicians to practice defensive medicine
- High administrative costs related to the care that is delivered
- Inefficient or poor quality care rendered by some providers (professional and in-

stitutional) as evidenced by continuing large variations in practice behavior and insufficient adherence to evidence-based medical practice

- High incomes for some types of providers (regardless of efficiency or quality)
- The cost of complying with government mandates

These usual suspects are not the only ones pushing health cost inflation, however. Two relatively new categories are establishing themselves as major drivers of cost inflation: (1) rapidly developing (and usually expensive) medical technology, in some cases diffused widely with minimal evidence of effectiveness, and (2) genomics. Examples of new medical technology are the implantable cardiac defibrillator, drug-eluting vascular stents, new orthopedic implants, and miniaturization of devices, to name a few. In the arena of genomics, the appearance of so-called specialty pharmacy, injectable drugs that are proteins manufactured through DNA replication, has led to treatments that may not be used frequently but that are hugely expensive when they are used, commonly costing in excess of \$10,000 per patient per year or more. The discovery of various alleles (*ie*, genes) for cancer that help guide physicians as to the best therapy depending on the genetic profile (*eg*, for breast cancer) are all adding to cost inflation. On a more positive note, although stem cell research has yet to result in concrete therapies, such new approaches to treating disease could be discovered and result in both improved treatment and lower cost.

Managed Health Care in Mid-Decade

At the same time health benefits costs began rising, the economy began to soften, and increasingly U.S. companies have become confronted with competition from abroad from companies that do not face the insurance costs of their American counterparts. These two forces led not to a return to traditional

managed care but rather to an increase in cost sharing with consumers through higher payroll deductions for health benefits coverage and, more important, in the form of changes in the benefits. Levels of copayments and co-insurance have been rising and in many cases have become more complex. For example, physician office visit copays that were once most commonly \$5.00 are now \$20.00 or higher, and pharmacy benefits that were once simple copays now have widely differing levels of copayment tiering as well as significant deductibles. Ironically, cost sharing was the primary method of cost control available to indemnity insurance prior to the advent of managed health care.

The most recent significant development is the rise of the consumer-directed health plan (CDHP), including such variants as Health Savings Accounts (HSAs) and other types of high-deductible health plans. CDHPs are described in Chapter 2, and issues associated with consumerism are more fully discussed in Chapter 20. A hallmark of a CDHP, though, is the notion that consumer choice and consumer accountability have substantially increased in importance. Health plans are improving the ability of members to choose physicians, hospitals, benefits plans, and so forth easily, using technology such as the Internet. They are also providing members with better information regarding the quality and cost of the care they are seeking along with information to help them understand their health care options. Aspects of informing consumers through data or information transparency, decision support tools, financial budgeting tools, and the like are currently the focus of much effort in all health plans, not just CDHPs.

The other aspect of CDHPs in their various forms is a benefits design that depends on greater cost sharing with consumers, a dynamic also observed with almost all benefits designs whether considered CDHPs or “traditional” managed care products. Through the existence of a gap in coverage between the pre-tax savings and when the high-deductible health plan coverage comes into play, the

consumer is responsible for expenses. It is not yet clear whether CDHPs as they exist at the time of publication actually require more cost sharing by consumers than do other plan designs because of the rapid increases in cost sharing in all benefits designs. In fact, one study reports that CDHPs actually reduce cost sharing for many groups, in particular the small group of members responsible for half of all medical spending.¹⁵

Managed care has not ceded the field to the imposition of higher cost sharing combined with improved information to assist in decision making. For example, new pay-for-performance programs are being tested and implemented to align financial incentives for providers with quality goals, as discussed fully in Chapter 8. Practice behavior by physicians has evolved, and as care management becomes more sophisticated, managed care companies have placed more emphasis on chronic and/or highly expensive medical conditions, with less focus on routine care, as discussed in detail in Part III of this book.

CONCLUSION

The health care sector in the United States is highly dynamic. The roots of managed health care, and health insurance in general, are many. The continued growth and evolution of managed health care is affected by the health sector economy, marketplace needs, legal and regulatory requirements, changes in health care delivery, consumer demands, politics, and a myriad of other forces, many of which interact with each other. What started out with simple roots has become complex and robust and will only become more so.

ADDITIONAL RESOURCES

Following is a list of several good sources on managed care trends. (Note: All Web addresses are current as of August 2006, but are subject to change.)

1. The Center for Medicare and Medicaid Services (CMS), especially the Office of the Actuary; navigate to <http://www.cms>

- .org, or more specifically to [http://www.cms.hhs.gov/NationalHealthExpendData/\(free\)](http://www.cms.hhs.gov/NationalHealthExpendData/(free)).
- The Henry J. Kaiser Family Foundation (<http://www.kff.org>), particularly the series on the health care marketplace trends (free).
 - The Sanofi-Aventis Managed Care Digest Series, updated annually and accessible at <http://www.managedcaredigest.com> (free with registration).
 - HealthLeaders-InterStudy, accessible at <http://home.healthleaders-interstudy.com> (requires purchase).

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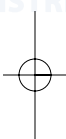
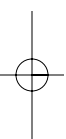
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