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The Rise of Managed Care: A Study of Its Current Trends and Future Effects

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Honors 498

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Executive Summary

For the greater part of last century, health care was run and financed by a system known as the fee-for-service system. Just as the name implies, physicians would perform a service, then charge the patient a particular fee. The patient would then pay for the service out-of-pocket, or if the patient had health insurance, he or she would send the bill to their insurer for reimbursement. Physicians and patients were both very pleased with the way this system was run. Doctors had a great deal of earning power and professional autonomy, while patients were free to choose any doctor they wished while requesting any and all tests and procedures. However, the fee-for-service system's general disregard of cost-efficiency ultimately led to its demise.

The system of health care that replaced the fee-for-service system was known as managed care. Managed care differed from fee-for-service medicine in that managed care was pre-paid, more coordinated, and paid much more attention to the economics of medicine. Managed care can be traced back as early as the beginning of the 20th century, but it really first made an impact on health care with the HMO Act of 1973. Managed care organizations attempted to be very cost-efficient and coordinated using a variety of techniques. Among these tools was the establishment of provider networks, as well as the use of utilization reviews, gatekeepers, and preventative medicine.

Managed care was able to cut health care costs, but this came at the price of reduced choice for patients. As a result of consumer demands, many managed care organization began to offer different managed care plans. These options, such as PPO

and POS plans, offered patients more choice of provider but generally came at a slightly higher price. However, many patients seemed willing to pay this as PPOs passed the more restrictive HMOs in number of enrollees.

Not only are there many different types of managed care organizations, but managed care exists in many different “stages” across the nation. In other words, managed care has had a much greater effect on health care in some regions of the country than in others. Regardless of how great the impact is, managed care has drastically changed how health care affects physicians, patients, and even the Medicare population.

Physicians generally have a negative view of managed care. Whereas they once had one of the most financially lucrative and most autonomous professions around, managed care both reduced doctors’ average salary and second-guessed many of their decisions. Many physicians believe this hurt the quality of care that patients received. Moreover, managed care completely altered the practices of both generalist and specialist physicians. Generalists were no longer finding themselves practicing family medicine, but were playing the role of gatekeeper for managed care organizations. Although their role has not changed as much, specialists have seen major decreases in their earnings because managed care has put the squeeze on many of their procedures. Both types of physicians are now leaving their solo practices in order to join group practices, which help physicians reduce overhead by sharing resources.

The practice of capitation perhaps had more impact on physicians than any other aspect of managed care. Capitation is the process by which doctors receive a flat fee each month for each of the HMO’s enrollees that they provide care for. The doctors receive this fee whether or not the patient is treated. The idea behind capitation is that

doctors will stop over-utilizing care if their personal income is at stake. However, critics of capitation claim that many doctors withhold care in order to maintain their personal earnings. This is just one of several ways that managed care has put a strain on the doctor-patient relationship.

Just like physicians, many patients also did not respond well to the rise of managed care. They viewed provider networks as unnecessary restrictions, and were often frustrated by denials of their proposed treatments. In fact, there was such a consumer backlash against managed care that many state and federal legislatures made patients' rights a top priority. Many states passed laws banning HMO practices that potentially harmed the quality of care for patients. Moreover, many laws were also passed to make managed care more physician-friendly.

In addition to patients' rights, there are many other ethical issues that have arisen because of managed care. The practice of for-profit medicine is a very hot topic, as many believe that this damages the quality of health care. Also very controversial is the practice of selective marketing, where managed care organizations seek to recruit healthy, and thus less costly, patients.

Managed care also had a large impact on the Medicare and Medicaid population. Medicare, a government program designed to provide health care to the elderly, seemed to be the new "promised land" for many HMOs in the mid-1990s, as there were many inefficiencies to be worked out of the system. However, the Balanced Budget Act of 1997 slashed Medicare reimbursements, and put higher standards on HMOs who wished to remain in the Medicare market. However, Medicaid, a government program that provides health care for the impoverished and permanently disabled, continues to enroll

its patients in managed care. Medicaid is different from Medicare in that each state decides how to administer their Medicaid program. In 1994, Tennessee decided to enroll all of its Medicaid-eligible population in managed care, a program known as TennCare. TennCare provides a useful case study on the pros and cons of both managed Medicaid and attempts at universal health care coverage.

Where managed care is headed in the future is a subject of much debate. Some experts believe that the HMO industry is showing many signs of a dying industry. If managed care fails, then a government-run health care system is a distinct possibility. Although some people support the idea of a government system, many oppose it. They believe that a government-run health care system would be too bureaucratic, and that the quality of care would be reduced. In order for managed care to become the nation's permanent health care system, the industry must now shift its focus from cost control to quality control.

I propose six strategies for the managed care industry to improve the quality of health care without sacrificing its cost-efficiency. The six strategies are: 1) the shift from for-profit to non-profit care, 2) preventative medicine, 3) consumers choosing health plans rather than employers, 4) long-term contract agreements between plans and purchasers, 5) a more cooperative relationship between providers and plans, and 6) the attainment of universal health care coverage. The funding for universal coverage could come from a variety of sources, such as the government or even employers. There is much debate about what would be the best way to finance universal health care coverage.

Although there may not be any obvious short-term incentives for some of these strategies, providers, plans, and purchasers need to realize that these strategies are

focused on the long-term success of managed care. If every party involved in health care could focus on these tactics, managed care would be solidified as the health care system of the future, while making everyone almost completely forget about how medicine was run before the rise of managed care.

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Foreword

Health care is the largest industry in the United States, consuming every 7th dollar of the gross domestic product (Bennahum 1999). In 1996 alone, the nation spent over one trillion dollars on health care expenditures (Baldor 1998). The United States' health care industry has gone through more changes in the past ten years than perhaps any other business in modern times. First of all, health care spending has grown exponentially over the past half-century. Per capita health care spending stood at \$141 in 1960, but by 1997 this figure had risen to \$3,925. Furthermore, per capita medical expenditures are expected to rise to over \$7,000 by 2008 (Deloitte & Touche and VHA 2000). Several factors contributed to this incredible growth. The population in the United States is increasingly getting older, and it is the elderly that require the most medical care. Also, medical technology has made tremendous strides during this time, and with increased technology comes an increased price tag. These rising medical costs first became an issue during the Nixon administration, and eventually reached a boiling point in the late 1980s. By this time, health insurance premiums were increasing 15 to 20% per year (Berenson and Zelman 1998, Brink and Shute 1997, and others).

Up until this point, health insurance and physician reimbursement were set up on a "fee-for-service" basis. Although many doctors and patients tell stories about how wonderful this "old system" was, it will be shown that in fact this system had many flaws. The method of health care financing that replaced the fee-for-service system was known as managed care. Among the many differences between the two systems, one of the most important differences between managed care and fee-for-service was the fact

that managed care was on a prepaid basis, whereas fee-for-service was not. Using stricter controls and guidelines, as well as other cost-control methods that will be discussed later, managed care was able to bring spiraling insurance premium costs under control. By 1996, health care premiums were only rising about 3% per year (Brink and Shute 1997). Managed care was also able to become the dominant form of health care financing in the nation. Americans enrolled in managed care organizations rose from 33 million in 1988, to 56 million in 1995, to over 80 million by 1998 (Berenson and Zelman 1998).

However, managed care suffered a major backlash at the hands of doctors and patients. Doctors were displeased with their professional autonomy being reduced, and patients did not like that they had fewer choices of doctors and hospitals. At present, managed care organizations are trying to gear their products to be more consumer-friendly. However, this comes at an extra price.

There are still many things wrong with the way health care is financed today. Almost all sources indicate that the number of Americans without health insurance is somewhere around 40 million people, or roughly 15% of the population (Baldor 1998, Deloitte & Touche and VHA 2000, and others). There are still many inconsistencies in the standards and guidelines of quality medical care. Perhaps worst of all, managed care sometimes can lead to denial of care that turns out to be necessary for the patient's survival. Although these cases are the exception to the rule, they have a profound impact on the industry because of the extensive media coverage they receive, coverage that usually attacks the managed care organization.

In the following pages, both the breakdown of the fee-for-service system and the rise of managed care will be discussed. This study will also look at how managed care

has affected doctors, patients, Medicare recipients, and Medicaid recipients. Finally, data will be examined to try and determine where managed care is headed in the future, and what strategies need to be undertaken to make sure this system works. The most important strategy managed care organizations can focus on right now is quality control. Managed care may have made a mistake by trying to cut health care costs without first trying to improve the quality of care. I recommend six strategies that would allow the managed care industry to improve the quality of care while still being cost-efficient. These six strategies are: 1) the shift from for-profit to non-profit care, 2) preventative medicine, 3) consumers choosing health plans rather than employers, 4) long-term contract agreements between plans and purchasers, 5) a more cooperative relationship between providers and plans, and 6) the attainment of universal health care coverage. By paying attention to these strategies, the managed care industry should solidify its position as America's health care system for the 21st century and beyond.

Chapter 1

The Breakdown of the Old Health Insurance System

For the greater part of the past century, medical services were paid for on what was known as a fee-for-service basis. Just as the name implies, doctors would perform a test or procedure, the patient would be charged a “customary” fee, and either the patient or the patient’s insurance company would float the bill. This system seemed all too simple: doctors performed whatever tests they could in order to diagnose a patient’s symptoms, and the patient would pay a co-payment, usually around 20%. The doctor was in a true sense the patient’s advocate, he could do everything in his power to try and remedy the patient’s ills without having to worry too much about controlling costs.

However, the fee-for-service system, sometimes referred to as indemnity coverage, was not without its share of problems. For one thing, there were no universal guidelines to medical care. This led to much regional variation in both medical practice and health care spending. For example, one study showed that in one Maine county 70% of women over the age of 70 were given hysterectomies, while in another Maine county less than an hour away this number was only around 20%. In a similar study, 8% of children in one Vermont county were given tonsillectomies, while in a neighboring county a whopping 70% of children underwent this procedure (Berenson and Zelman 1998). Even in the early 1980s when Medicare introduced diagnosis-related groups (DRGs) as a set of standards for its reimbursements, universal guidelines still had very little impact on medicine as a whole.

Yet another mistake the fee-for-service system made was not utilizing preventative care. The general attitude in the old system was to attack and try to cure a patient's symptoms, rather than trying to prevent these symptoms from ever occurring. This not only led to higher costs, since breast cancer surgery is much more expensive than a mammogram, but it generally led to more patients getting serious diseases.

Perhaps the biggest problem with the fee-for-service method of health care financing, and the one that ultimately led to its demise, was its failure to control costs. From 1965 to 1983, health care inflation averaged 12.5% a year, an average of 5% above the overall inflation rate (Berenson and Zelman 1998). Between 1980 and 1990 health care spending as a percentage of gross domestic product (GDP) rose from 8.9 to 12.2% (Deloitte & Touche and VHA 2000). Clearly, the fee-for-service system was responsible for these spiraling expenses. The primary reason for this was that under this system, physicians were rewarded for doing more. The more tests and procedures they performed, the more fees they could charge, and the greater their income was. The result was that a great deal of procedures being performed by physicians were probably completely unnecessary. Even as far back as the 1970s, studies were indicating that up to 25% of invasive procedures were inappropriate or not required (Berenson and Zelman 1998). In essence, insurance companies were handing a blank check to physicians, and reimbursing them for whatever they charged without ever asking any questions. Moreover, the insurance companies didn't have much incentive to control costs. They could pass on most cost increases in the form of higher premiums.

Yet another factor that contributed to these spiraling health care costs was the lack of competition in the health care market. Most health plans offered similar benefits, paid

roughly 80% of medical bills, and allowed patients to visit any health care provider they wished (Berenson and Zelman 1998). Since there was really no product differentiation among health insurers, there was not much competition. And without major competition, insurance companies had even less incentive to control costs.

Despite the high costs, consumers were in love with the fee-for-service system. Since patients' out-of-pocket expenses were usually in the form of deductibles or reasonable co-payments, patients could demand every procedure in the world with little or no apparent additional cost to their personal finances. Even more important, patients were free to choose any doctor that they liked. If they weren't satisfied with a doctor's performance, they could simply leave his practice and join another one, and the insurance companies would pay the bill just the same. This form of quality control was one of the fee-for-service system's strong points. Any physician with a poor performance would simply lose patients because of it.

It seems that almost everyone was in love with the fee-for-service system. Patients enjoyed the choices, and doctors had one of the most well respected and financially lucrative professions in the nation. Even insurance companies were not too worried about the rising medical costs. Then who was it that finally decided that the fee-for-service system's cost unconsciousness was unacceptable?

The people who finally decided fee-for-service was not worth the price were employers. The majority of people who have health insurance get it as a benefit from their employer. By the late 1980s, the relationship between stagnant wages and rising premiums grew more serious, and employers began to become concerned with health care costs. In fact, by 1988 General Motors found that it was spending twice as much on

health benefits as it was on steel (Brink and Shute 1997). Not only were these high health care costs jeopardizing some companies' profitability, but they were affecting employer-employee relations. By trying to pass on some of the higher costs to their employees, employers were damaging their employees' morale. It was at this point that many employers began to decide that HMOs would be a good cost-cutting alternative for their health benefits. HMOs, or health maintenance organizations, were not very prominent in American health care at the time, but would soon introduce the nation to the cost-savings resulting from managed care.

Chapter 2

The Rise of Managed Care

Before going any further, it would be helpful to discuss exactly what the term “managed care” means. One generally accepted definition is that managed care is any prepaid health care service within a network or group of certain providers (Baldor 1998). Although many people think that managed care is a relatively new phenomenon, its roots actually date back almost a hundred years.

The earliest known form of managed care is found in Tacoma, Washington in the year 1910. In this small industrial town, two doctors contracted with a lumber company to provide medical care for their employees (Deloitte & Touche and VHA 2000). The arrangement that was made required the lumber company to pay the doctors \$50 per employee, per month of coverage. In exchange, the doctors provided any and all medical services to the employees, regardless of the cost (Bennahum 1999). It was not until the 1940s, however, that the predecessor to many of today’s managed care organizations, the Kaiser health plan, came into existence.

Henry J. Kaiser was a very successful businessman in California in the 1930s and 40s. He owned businesses of all types, and had over 100,000 employees (Bennahum 1999). In the late 1930s, Henry Kaiser became aware of a physician by the name of Dr. Sidney Garfield that was supplying on-the-job, prepaid medical care for a large manufacturing company in Southern California. Mr. Kaiser then made an arrangement with Dr. Garfield where he paid the doctor in advance for all on-the-job medical care. In an even more innovative move, Mr. Kaiser allowed employees to deduct a certain portion

of their wages in exchange for off-the-job care for the employee's family. By 1942, Henry Kaiser had over 90,000 of his employees covered under this arrangement (Bennahum 1999). In 1945, Mr. Kaiser opened this system to public enrollment, and it became known as the Kaiser Permanente Health Plan (Deloitte & Touche and VHA 2000). It was this health plan that managed care organizations would try to emulate during the early stages of the managed care movement.

Gradually, a few more managed care organizations began to pop up. By the 1950s and 60s, at least most people were familiar with managed care and what it was about. However, it was not until during the Nixon administration that managed care took center stage in the health care financing scene. Nixon's administration decided that health care costs were on the verge of getting out of hand. A physician named Dr. Paul Ellwood approached the administration with an idea for health care financing reform. Dr. Ellwood believed that the fee-for-service system of medicine created what he called "perverse incentives" for physicians: rewarding providers for treating illness, and withdrawing those rewards when a patient's health was restored (Bennahum 1999). Dr. Ellwood proposed that health care organizations should focus on prevention, and that this would avoid a great deal of high-tech, and high-cost, medical care. He referred to these organizations as HMOs, or health maintenance organizations. Dr. Ellwood pointed to the Kaiser Permanente Health Plan as a model for HMOs. Dr. Ellwood's proposal really appealed to President Nixon. This was because it did not call for a great deal of government intervention, nor did it call for large sums of taxpayers' dollars. Moreover, it involved initiative in the private sector. Dr. Ellwood's idea of the HMO, which was later carried on by his son Paul, led Richard Nixon to pass the HMO Act of 1973.

The HMO Act was passed with the intent to make managed care a more mainstream part of American health care financing. It had two main provisions. First, it provided start-up grants and loans to HMOs. Secondly, it required large employers (more than 25 employees) to offer their employees at least one HMO option in their health care benefits, as long as there was an HMO in their vicinity (Berenson and Zelman 1998). The legislation had profound effects in helping establish new HMOs. In 1970, before the legislation passed, there were only 33 HMOs in the United States. By 1975, only two years after the HMO Act went into effect, the number of HMOs nationwide had exploded to 166 (Bennahum 1999).

As stated earlier, when health care premiums began spiraling out of control in the late 1980s, employers decided to turn to HMOs for a cost-cutting solution to medical benefits. This trend progressed so rapidly among employers during the early 1990s that managed care became the dominant form of health care financing in the nation. By 1993, managed care enrollment exceeded 50% of those with job-based coverage (Deloitte & Touche and VHA 2000). By 1997, 80% of Americans insured through their employer were enrolled in managed care organizations (Berenson and Zelman 1998). Today, managed care has become the dominant form of health care financing in the nation. By 1999, 78.8 million Americans were enrolled in an HMO, with millions more enrolled in other types of managed care organizations (Coile 2000).

What were the goals of managed care organizations that made them so appealing to employers? The model of the ideal managed care organization was actually quite clear-cut, simple, and practical. Managed care sought to critically evaluate patient care for cost and efficiency, so that no one would receive excessive or unnecessary care. Physicians

and hospitals would be encouraged to be as efficient as possible with their time and resources. These factors would lead to lower insurance costs, and the savings could even be used to help finance care for the uninsured (Bennahum 1999).

Managed care organizations use many different tools and techniques to help “trim the fat” off of health care costs. Among these tools are the practice of selective contracting and the establishment of provider networks, utilization reviews and pre-authorizations, the use of primary care physicians as health care “gatekeepers,” and preventative medicine. Each of these practices has had a unique impact on the practice of medicine; while some have improved both cost and quality, others have had a more negative overall effect.

Selection of and subsequent use of a network of physicians is the feature that probably most distinguishes managed care from the fee-for-service system. In the old system, a patient could go see any physician that he or she pleased, without having to worry about whether or not their insurance company would reimburse the visit. However, managed care organizations enter into contracts with individual doctors, and sometimes groups of doctors, to establish a “network” of doctors that their patients are allowed to see. HMOs usually do not reimburse any visit to a physician outside the network unless it has been previously approved by the health plan.

Establishing networks has allowed managed care organizations to reduce costs. When setting up contracts with doctors, many HMOs simply contracted with physicians from whom they could obtain the deepest discounts. Although this may not have led to the highest possible quality of care, it quickly helped reduce the health care premiums that were rising out of control. As managed care became more prevalent, more doctors

became willing to accept discounted contracts from HMOs, simply because more and more patients were enrolled in HMOs. HMOs could then use the threat of *not* contracting with a physician to obtain a discount from him.

Selective contracting can have its advantages. One major benefit would be that it could increase communication among physicians in the network, leading to fewer errors in patient care. Yet another plus would be that many of the more successful HMOs could use selective contracting as an instrument to build a top-notch panel of physicians. On the contrary, this has rarely happened. Most HMOs have been more likely to use selective contracting as a weapon for getting concessions from financially insecure doctors. Establishing a network of doctors whose only common ground is willingness to accept deep discounts could lead to less coordination than in the old system (Berenson and Zelman 1998).

Another technique used by managed care organizations that has garnered more criticism than praise is the use of utilization reviews. A utilization review is an analysis by an outside committee, usually employed by the managed care organization, to make sure that the medical care a patient is receiving is “medically necessary.” Generally, there are three types of utilization reviews: prospective, concurrent, and retrospective (Baldor 1998). Prospective reviews, also referred to as pre-authorizations, are the most common. In a prospective review, the HMO’s committee reviews a proposed treatment, and then decides not only if the treatment is warranted, but also whether or not the patient could get equal benefit from a less costly treatment or procedure. In a concurrent review, a physician may receive memos or phone calls asking if a patient is ready to go home from the hospital yet. In a retrospective review, usually the most frustrating type of

utilization review for a physician, the HMO's committee does a random audit of care *after* a treatment, and then decides whether or not the treatment was required and if they will reimburse the physician for it.

There are a couple of major problems with utilization reviews. First of all, there is a possibility that an HMO will deny a treatment that *is* necessary, perhaps because they are not aware of a patient's special circumstances. Even though this does not happen as often as many people believe, when it does happen it can lead to court battles between the HMO and the patient, and to noisy front-page stories in local papers. Moreover, too much pre-authorization can lead to a nightmare in administrative costs. This is leading some health plans to drop the practice of utilization reviews altogether. Aetna, the nation's largest insurer, said that it would no longer require pre-approvals for many surgical procedures and certain hospital stays. Aetna's motivation is to eliminate some of the ill will between the health plan and both doctors and patients (Bernstein 2000). Another large managed care organization, United Health Group, said that they were getting rid of most pre-authorization procedures because studies showed that it was costing more to process requests than the pre-authorizations were saving (Appleby 2000).

One tool of managed care that has received a lot of mixed reviews is the use of primary care physicians as health care "gatekeepers." A gatekeeper is a primary-care doctor that an HMO employs to coordinate a patient's care. Each patient enrolled in an HMO is required to choose a gatekeeper from the HMO's primary care network. This gatekeeper will then be responsible for overseeing all of the patient's care. These doctors are supposed to emphasize prevention, and make sure that patient's see specialists only

when absolutely necessary. In fact, most HMOs will not reimburse a patient for a visit to a specialist unless the patient's gatekeeper has approved it.

Ideally, gatekeepers can improve health care quality while also reducing costs. Gatekeepers can increase the quality of a patient's care by avoiding inconsistencies, duplication of efforts, and unnecessary procedures (Bennahum 1999). At the same time, reducing unnecessary or marginally effective care also helps the HMO's bottom line. And since specialist visits come at a much higher price than do generalist visits, the gatekeeper also helps the HMO reduce costs by reducing visits to specialists.

However, some physicians feel that the practice of gatekeeping is not so beneficial. For starters, they feel that it has led to a tremendous work overload on primary-care physicians, drastically reducing the amount of time the physician gets to spend with each patient. Furthermore, some specialists feel that primary care physicians are not adequately trained to play the role of gatekeeper. How physicians feel the gatekeeper role has affected their practices will be discussed in more detail later.

Despite all of the mixed feelings regarding these other tools of managed care, all parties involved in health care delivery view preventative medicine as a beneficial practice. Many HMOs across the country are now offering more mammograms, childhood immunizations, screenings for diabetes, and other preventative tests and screenings. One of the major changes resulting from this type of health care is that hospital inpatient days have been drastically reduced. In 1983, the average number of hospital inpatients per day, nationwide, was somewhere around one million. By 1996, after the rise of managed care, this number had been reduced to 685,000 (Coile 2000). Managed care organizations are always trying to avoid inpatient care, because this is

generally the most expensive type of medicine. As for the inpatient care that could not be avoided by preventative medicine, HMOs have tried to move as much as possible to an outpatient setting. For clarification, inpatient care is any care in which the patient stays in the hospital overnight, while in outpatient care the patient returns home during the same day as the procedure. Because HMOs realized that outpatient care, also sometimes referred to as ambulatory care, was much less expensive than inpatient care, by the early 1990s outpatient surgeries exceeded inpatient surgeries (Coile 2000).

Not only does preventative medicine lead to reduced costs by decreasing hospital inpatient care, but this type of medicine also has a benefit for the patient. Catching something early, such as a cancerous breast tumor, is much less traumatic than being hospitalized for breast cancer. Since this method of reducing costs is also an advantage for patients, no one has really had any valid complaints against preventative medicine.

All of these techniques used by managed care organizations showed evidence of bringing spiraling health care costs under control. Between 1995 and 1997, health insurance premium increases actually fell below the inflation rate for the first time in over 20 years (Berenson and Zelman 1998). Even though all of these techniques employed by managed care were successful in reducing health care expenditures, many did not go over well with consumers. Many consumers were unhappy with the restricted choices of physicians and hospitals. Many patients also had complaints that denials of treatment were coming too often. To respond to consumer demands, managed care organization began to offer many other options beside the traditional HMO. These new options are an integral part of how managed care is shaped today.

Chapter 3

The Many Forms of Today's Managed Care

During the early stages of managed care, HMOs existed in forms that are known today as staff-model and group-model. In a staff-model HMO, the health plan contracts with individual doctors who become employees of the HMO. These physicians work exclusively with the HMO with whom they contract, and therefore are not allowed to see patients that are not enrolled in that particular HMO. The group-model HMO is very similar to the staff-model, the only difference being that the HMO contracts with an existing group of physicians rather than with individual ones. In these early models of HMOs, the health plans had clinics for their contracted doctors to practice in. However, the large outlay of money to build clinics forced the HMOs to hire fewer physicians than they would have liked. This resulted in limited choice of provider for the patient, and thus these two types of HMO plans are more restrictive than any other type. Because of their restrictive choices, enrollment in staff-model and group-model HMOs has been on the decline for the past several years (Deloitte & Touche and VHA 2000).

The next type of plan offered by HMOs was brought about by the creation of IPAs, or independent practice associations. An IPA is a group of physicians that has been formed for the sole purpose of contracting with managed care organizations (Baldor 1998). This had two major impacts on the managed care industry. First, the IPAs allowed physicians to contract with HMOs, but still maintain their practices with patients outside the HMO. The advent of the IPA also allowed HMOs to greatly reduce their

initial cash outlay because now they did not have to build clinics; they could simply send their enrollees to one of the IPA physician's previously established offices. Since HMOs were saving a lot of money by contracting with IPAs, they were able to not only improve their profit margins, but also could afford to contract with even more physicians and offer consumers a broader choice of health care providers.

Still, many consumers found that they were displeased with the provider networks that had been established by HMOs, even the ones as broad as offered by the IPA-model. HMOs would generally not reimburse a patient for a visit to a doctor outside the plan's network, and this made many people realize that they wanted to be able to choose their doctor completely on their own. Because of this, the next type of managed care plan to emerge was the PPO, or the preferred provider organization. PPOs were drastically different than any type of HMO plan that had been previously offered. A PPO is typically made up of a group of physicians, sometimes including hospitals, who agree to provide care for a set price (Coile 2000). PPOs contract with health insurance companies so that the insurer may offer the PPO's services as one of its health plan options, but sometimes PPOs contract directly with employers (Coile 2000). PPOs generally offer a broader choice of providers than HMOs, and they generally use fewer utilization reviews than their HMO counterparts. Also, PPOs do not require their patients to use a gatekeeper to coordinate care. Of course, reducing all of these restrictions on care comes at a price, as PPO premiums are generally higher than HMO premiums. However, the PPO offers consumers perhaps what they missed most from the fee-for-service system, the freedom (although somewhat limited) to choose whatever doctor they pleased. Patients of a PPO are allowed to visit physicians that are *not* in the PPO's network, with

the only requirement being a co-payment that usually runs about 20-30% (Berenson and Zelman 1998).

Consumers really warmed to preferred provider organizations. Even though PPO plans are more expensive than HMOs, often times the difference in premiums is only around \$10 or less per month (Coile 2000). Not surprisingly, millions of people decided that this extra \$10 per month was well worth the freedom of provider choice. In fact, PPOs have now surpassed HMOs as the dominant type of managed care organizations. PPOs continue to grow, having now enrolled roughly 90 million people, or 34% of those with health insurance. Meanwhile, HMO growth has been stagnant, hovering around 80 million enrollees, or 30% of the market, for the last couple of years (Coile 2000).

Preferred provider organizations became so popular in the insurance market that many HMOs decided they needed to come up with a competitive product. As a result, many HMOs began to offer what they called POS, or point-of-service, health plan options. The POS plan, also sometimes referred to as an open-access HMO, is very similar to the PPO plan. Patients are allowed to visit physicians outside the network for a reasonable co-payment. The thing that differentiates POS plans from PPOs is the fact that POS plans use HMO techniques, such as gatekeepers and capitated payments (discussed in much greater detail later), within the network of providers (Berenson and Zelman 1998). The point-of-service option proved to be a profitable tool for HMOs, and a vast majority of HMOs scrambled to offer them. In fact, by 1997, over 75% of HMOs offered their customers a POS option (Berenson and Zelman 1998).

Today's managed care environment is not only shaped by the many different types of plans offered, but also by the fact that managed care exists in several progressive

“stages” in different parts of the nation. In other words, there are some regions of the country in which managed care is practically the only form of health care financing available, and yet there are other regions where managed care has almost no impact on health care financing whatsoever. In his book *New Century Healthcare: Strategies for Providers, Purchasers, and Plans*, author Russell Coile divides these different levels of managed care penetration into what he calls the “five stages of managed care” (2000).

In a Stage 1 market, which Coile satirically refers to as a market that “can’t spell HMO,” managed care hardly has any effect on the health care financing scene. Stage one markets are characterized by less than 5% of the population being enrolled in managed care organizations (Coile 2000). These areas usually have a thin population density, and have very few large employers. Stage one markets experience a great deal of physician resistance to HMOs, as reimbursements are still paid largely on a fee-for-service basis. Other than in very rural areas, it is difficult to find a stage one managed care market these days. Almost every metropolitan area experiences some form of managed care.

Stage 2 markets are those that have between roughly 5 and 15% of the population enrolled in managed care organizations (Coile 2000). A common scenario for these markets is to have one main HMO that offers managed care plans to the population. During this stage, physicians and hospitals encounter more hassles from HMOs over approval of care, and thus many see their incomes start to slide. During stage two many physicians begin to form provider organizations so that they will have a bit more clout when negotiating with health plans.

Once a region has moved into the third stage, the transition to a managed care marketplace is complete. Coile defines stage 3 markets as those with 15-25% of the

population enrolled in managed care plans (2000). Although many of them may not like it, most physicians have accepted managed care by this time. There are usually two or three HMOs competing for enrollees, just as there are two or three main provider networks beginning to emerge (Coile 2000). Stage 3 markets are perhaps the most chaotic, because many old patterns are disappearing and networking is very active (Coile 2000).

Stage 4, also referred to as managed competition, refers to a market in which between 25 and 40% of the population is enrolled in managed care (Coile 2000). This is the ugliest stage of managed care, as physicians are in head-to-head competition with managed care organizations to see who will control the market. It is usually stage four markets that lead to heated disputes that can often end up on the cover of *USA Today*. HMOs have several advantages over physicians, as they have much more capital, and they also own the enrollees. However, physicians try to use their patients' loyalty and cooperation with hospitals as leverage. Neither HMOs nor physicians are really to blame for these types of disputes. Rather, it is the large employers who are encouraging HMO price competition, which leads to cuts in physician reimbursements (Coile 2000).

Stage 5 markets, those with over 40% of the population enrolled in an HMO, are not very common and are mostly found on the west coast (Coile 2000). By this time, managed care is the rule rather than the exception. Even Medicare and Medicaid programs are committed to managed care strategies in a stage five market. By this point, physician's incomes are not quite hurting quite as much due to the fact that both doctors and insurers have worked to reduce some of the high administrative costs associated with the early stages of managed care penetration (Coile 2000). By the time a market reaches

stage 5, most parties involved are usually concerned with how they can make the system work better rather than how they can gain an advantage.

As can be seen, managed care takes many shapes and forms all across the nation. Sometimes it can be quite confusing for customers to distinguish among PPO, POS, HMO, IPA and any other managed care abbreviations that may be thrown their way. Moreover, since managed care has experienced different levels of penetration in different regions of the country, every physician and patient has a unique experience concerning how managed care has affected them.

Chapter 4

The Impact of Managed Care on Physicians and Their Practices

The group of people that has been the most opposed to managed care has been physicians. Actually, this really should not come as much of a surprise. By the 1980s, being a doctor was one of the most financially lucrative prospects in the country. Since patients did not “shop around” based on price, doctors did not have to compete with one another by lowering fees. What’s more, physicians had basically been trained to try *everything* that they had been trained to do, regardless of the benefit/cost ratio (Berenson and Zelman 1998). As medical technology became more expensive, this resulted in huge increases in the average physician’s income. Not only did physicians make very comfortable livings, but they had perhaps more professional autonomy than any other occupation. Rarely did people question a physician’s decision, creating a “doctor knows best” attitude among the entire population.

For all of these reasons, doctors were very pleased with the way the fee-for-service system was run. When HMOs first began popping up in the 1940s and 50s, most doctors looked down upon this type of medicine. The American Medical Association was quite possibly the strongest factor in preventing any success for early managed care organizations, sometimes going as far as denouncing managed care as “socialism” (Berenson and Zelman 1998).

Doctors successfully beat down the effort to reform health care financing for a long time because of their credibility as professionals, the patient’s idea that their doctor “knew best,” and also because of America’s fear of government intervention (Berenson

and Zelman 1998). Even as managed care has come to dominate the health care market today, most physicians still have a negative view of its impact on medicine.

No one should be shocked that physicians are opposed to managed care. First of all, the rise of managed care has decreased their incomes. Average physician income dropped from 1994 to 1995, marking the first drop since the inception of the American Medical Association (Easterbrook 1997). Physician income continued to decline, as between 1996 and 1997 the average physician's salary fell another 2% (Deloitte & Touche and VHA 2000). This income decrease particularly hit some specialists very hard, as reduced hospitalization due to managed care resulted in reduced revenues for the specialists.

Even though there should probably not be too much concern about doctors' incomes suffering, another concern is that many doctors feel that managed care is hurting the quality of medicine that the patients receive. In one recent study, 88% of Connecticut doctors surveyed said that the quality of care was worse under managed care than it was under the fee-for-service system (Ball 2000). Specifically, the doctors said that they were not being able to spend enough time with their patients, and that they did not have enough autonomy in their medical decisions.

Physician autonomy is obviously threatened by some managed care techniques such as utilization reviews. Many physicians feel that this is *the* most negative aspect of managed care. Some doctors claim that while taking histories and doing physical exams, they must now also think about what to include in the charts to justify their medical decision to insurers (Noonan 2000). The biggest problem with this situation is that the person or persons that are approving the doctors' decisions not only have little or no

medical training, but they also often have no contact with the patient. As one Chicago physician put it: “You can’t do anything anymore without first calling an 800-number where someone with a high school education asks you to spell out the diagnosis” (Easterbrook 1997). Since insurers are sometimes making medical decisions, many doctors have begun to wonder about the point of going through the many years of medical school.

There are other managed care tools besides pre-authorizations that doctors do not look favorably upon. Many physicians feel that prescription formularies, which HMOs use to decide which drugs will be covered, are too restrictive and often do not consider special circumstances. Moreover, doctors are often not pleased by HMOs setting up networks. Often, doctors find themselves in a group of doctors that they don’t know, or worse, in a group of doctors that they do know as poor-quality physicians (Berenson and Zelman 1998).

Doctors do have a few positive things to say about managed care. In one survey conducted by Kaiser, 45 % of doctors said that managed care increased the likelihood of preventative care. Moreover, 68 % of physicians polled said that managed care led to use of more practice guidelines and disease management protocols (Toner 1999).

However, it seems that doctors feel that managed care offers more negatives than positives. In the same survey mentioned above that offered a few of managed care’s advantages, 95 % of doctors said that managed care increased administrative paperwork, 72 % said it decreased the overall quality of care that patients received, and 83 % said that managed care decreased the amount of time spent with patients (Toner 1999). At

least through the eyes of most physicians, managed care has decreased the quality of medical care in the United States.

Whether or not the rise of managed care has been harmful to medicine as a whole, one thing that is certain is that managed care has drastically changed the practices of almost all physicians. Both generalists and specialists have seen incredible variations arise in their practices. The first phenomenon that has resulted from managed care is the movement of physicians away from solo practices and into group practices. This probably would have happened eventually without managed care, since medicine is becoming too technologically complex for a solo practitioner to provide high-quality care (Berenson and Zelman 1998). However, managed care's focus on cutting costs forced the move into group practices even sooner. When in a group practice, defined by the AMA as a practice of three or more physicians, doctors can share resources in order to reduce their overhead costs. They can make joint use of both expensive medical equipment and administrative personnel. These advantages have made the solo practice a thing of the past, as the number of group practices nationwide nearly doubled between 1995 and 1998, with nearly 60 % of all physicians belonging to a group practice (Deloitte & Touche and VHA 2000).

In addition to increasing the number of group practices, managed care has also completely redefined the role of the primary-care physician. Whereas most generalists in the past practiced as "family doctors," primary-care physicians are increasingly being moved out of this role into the role of HMO gatekeeper. As previously mentioned, the role of a gatekeeper is to coordinate a patient's care, emphasizing prevention and making sure that patients see specialists only when really necessary. The theory behind

gatekeeping is sound, as the gatekeeper makes sure that relevant history or clinical information is not overlooked, and that costly duplications of effort are avoided (Berenson and Zelman 1998).

Physicians have mixed feelings regarding how gatekeeping affects the quality of care. Although some primary-care physicians are discouraged by having less time to spend with patients, others welcome the change. Due to the widespread use of managed care, most hospitals are now heavily recruiting primary-care physicians. In fact, when asked what types of doctors they are recruiting, 76 % of hospitals mentioned primary-care physicians, while no other specialty was even mentioned 25 % of the time (Deloitte & Touche and VHA 2000). Moreover, many primary-care physicians feel that specialists have become so technology-oriented that they forget they are caring for real people and not just organ systems (Berenson and Zelman 1998). Thus, some generalists believe gatekeeping can lead to more personal care by requiring a patient to see a primary-care physician. However, there are some doctors who hold the opposite view. Many doctors, especially specialists, feel that primary-care doctors cannot possibly stay current enough with all of today's technology to make an accurate judgement on whether or not a patient should see a specialist (Berenson and Zelman 1998).

Whereas there are different opinions on the effect of managed care on primary-care physicians, no one disagrees about how hard specialists have been hit. One of managed care's cost-cutting techniques is to reduce hospitalization rates. Since most specialists work out of hospitals, fewer patient admissions and shorter lengths of stay have led to decreased business for the specialists. Furthermore, the onset of managed care found that many procedures performed by specialists were unnecessary. Some of the fields that

were hit especially hard were radiology, plastic surgery, psychiatry, and anesthesiology (Anders 1995). Anesthesiology provides a useful case study of how specialists' practices have changed due to managed care.

Throughout the 1980s and even into the early 1990s, during the times of rising health insurance premiums, anesthesiology flourished. The average salary jumped from \$131,900 in 1982 to \$228,500 in 1992 (Anders 1995). However, managed care put a squeeze on anesthesiology. Many of the procedures that required it were found to be unnecessary or inappropriate. Lower surgery volumes thus meant less business for anesthesiologists. Moreover, HMOs began to ask for large discounts from anesthesiologists, sometimes as high as 30 % (Anders 1995). Also, many hospitals began making use of nurse anesthetists, who typically earn less than half as much as their physician counterparts.

However, if it were not for the oversupply of specialist physicians, these factors would not have had as much impact. The number of doctors per thousand people has more than doubled over the past thirty years (Deloitte & Touche and VHA 2000). Moreover, by 1995, 70 % of doctors were specialists, while only 30 % were generalists (Baldor 1998). Since specialists were in such gross oversupply, they almost had to accept the discounted payments from HMOs, because if they did not certainly someone else in their field would. This happened to anesthesiology, where technology and high earning power made it an attractive specialty. Soon the job market became saturated, and in some large cities there were few if any anesthesiology positions available (Anders 1995). Thus, many specialists have seen their earning power deteriorate significantly. In some large cities with high HMO penetration such as Boston and San Diego, the oversupply of

specialists has led to the emergence of primary-care retraining programs. Even with all of the changes in physicians' practices mentioned thus far, no single aspect of managed care has affected the practices of all physicians as much as capitation. Capitation is the process employed by managed care organizations by which doctors get a flat fee each month for each of the HMO's enrollees that they provide care for. The doctors receive the "per member/per month" fee, usually adjusted for the patient's age and gender, regardless of whether or not the patient receives any treatment. If a referral or lab work is ordered, the cost is deducted from the doctor's fee. The main objective of the capitation system is to provide doctors with even more incentive to be cost-efficient.

It is obvious that capitation causes doctors to be more cost-efficient, for the arrangement places the physician's personal income at stake. This process can be beneficial, as it can reduce unnecessary procedures and encourage doctors to practice preventative medicine. Capitation also reduces the need to review overutilization. However, there are a couple of major problems that have arisen due to capitated arrangements.

In essence, capitation shifts risk from the insurance company to the physician. Because of this, a physician needs a reasonable capitated patient base, usually at least 300 patients, to safely handle this type of risk (Baldor 1998). Similarly, some doctors may accept capitation payments that are simply too low to cover all of the patient's needs. Critics of capitation say that both of these situations usually result in the physician skimping on care in order to avoid sacrificing his or her income. Doctors placed under too much risk may not order necessary tests or referrals. As one doctor put it, "physicians under capitation are forced to choose between their children's college fund

and their patient's well-being, with the HMO being the only sure winner" (Bennahum 1999). Moreover, some studies suggest that doctors spend less time with capitated patients than with patients not under capitation (Bennahum 1999). And even though managed care organizations do not need to be concerned about reviews of overutilization, there may be a need to review whether or not doctors are underutilizing care.

Another problem with capitated payments is that they are usually the same whether the patient is sick or healthy. This may cause some physicians to be particularly vulnerable to inadequate payments, especially those in geriatrics or underserved areas.

Capitation is not the only form of financial incentives physicians are faced with to be cost-efficient. Many managed care organizations offer physicians bonuses for obtaining a certain hospitalization rate or other cost-cutting objective. Some plans offer profit-sharing options to physicians. Still others use a technique known as withholding. Under this arrangement, a percentage of the physician's payment is withheld until certain financial goals are met (Bennahum 1999). No matter what type of financial incentive is offered to physicians, there is still the issue of whether or not these incentives cause physicians to withhold necessary care.

Despite all of these problems with capitation, it continued to increase as a tool used by managed care organizations throughout the 1990s. By 1998, 37.5 million HMO members obtained primary care under capitation arrangements (Coile 2000). Some specialists, especially in California where HMO penetration is very high, even began accepting capitated payments. The reason that doctors had to accept these undesirable arrangements was because, as previously mentioned, there was and still is a large

oversupply of physicians in the United States. If a physician refused a capitated contract, there was a good possibility that a nearby physician would accept it.

How can doctors accept capitation without sacrificing their incomes? Some insurance companies offer doctors the option of stop-loss insurance, also known as re-insurance. This type of insurance gives doctors coverage against the possibility of providing care that will exceed their capitated payment (Bennahum 1999). However, not very many doctors have made use of this opportunity. One thing that has happened is that there have been several federal and state regulations placed on the financial incentives offered to physicians by managed care organizations. Between 1995 and 1996 alone, four states passed laws restricting these financial incentives, and nine states passed laws requiring doctors to disclose their financial incentives to patients (Bennahum 1999).

Even though capitation was a significant part of the managed care movement, recent studies suggest that it is on the decline. With the exception of primary care, the percentage of patients covered by capitation decreased in every major field in 1999 (Deloitte & Touche and VHA 2000). Even in primary care, capitation's growth rate was very low compared to recent years past (Deloitte & Touche and VHA 2000). This really should not come as a surprise, as capitation agreements were generally not profitable to anyone other than health plans. A majority of both physicians and hospitals surveyed reported profit losses due to capitation contracts (Deloitte & Touche and VHA 2000). Both doctors and hospitals became increasingly unwilling to assume capitated risk because of the losses they were incurring. Both parties began organizing into larger groups so that they could have more negotiating clout against HMOs. In areas where

physicians quickly consolidated into large groups, capitation arrangements often declined almost immediately (Coile 2000).

Another suggestion made by some trying to explain capitation's decline is the fact that medical groups had neither the money nor the expertise to manage risk like an insurance company (Bernstein 2000). Insurance companies have hundreds of millions of revenue coming in each month to pay claims, as well as staffs of skilled actuaries to calculate how much might be needed to handle claims and how deep the company's reserves ought to be (Bernstein 2000). Medical groups and hospitals have neither of those things. Although handling risk gives doctors some advantages, such as control over allocation of premiums, it stands that physicians are simply not as well geared toward handling risk as an insurance company.

Perhaps the most important issue regarding capitation is whether or not it harmed the doctor-patient relationship. This question is met with a very mixed response. Obviously, legislation requiring physicians to disclose their financial incentives to patients can cause a strain on the doctor-patient dynamic. If a patient believes that a physician may cut corners on care in order to supplement his income, then common sense would say that a degree of trust inherent in doctor-patient relationships of the past might be taken away. However, some studies indicate the opposite. One survey found that patients under capitation were skeptical about the financial motives of the managed care organization, but still trusted their physician to act in their best interest (Bennahum 1999). As a matter of fact, the use of capitation as well as other managed care techniques often results in the physician acting as a "patient advocate," intervening with the plan on the patient's behalf. One survey found that over 60 % of physicians have acted on a

patient's behalf in order to get a needed prescription or procedure that was originally denied by the patient's health plan (Deloitte & Touche and VHA 2000). Along the same lines, another study found that about one-third of doctors and nurses had exaggerated a patient's condition in order to get what they deemed to be necessary care (Toner 1999).

However, there are also some signs that managed care has hindered the doctor-patient relationship. When an HMO denies a requested procedure, it is hard for the patient to get angry with the HMO since there is usually no one from the plan around. Sometimes the patient ends up blaming the physician for the denial instead. As one Rhode Island doctor put it: "patients get mad at you when a procedure isn't covered even though it's not your fault. We end up being the bad guys." (Noonan 2000).

It is very important that the doctor-patient relationship is not damaged, as no managed care organization can provide a substitute for a patient's trust in his or her physician (Berenson and Zelman 1998). Good communication between doctors and patients is imperative in order to improve the quality of health care. Only if this confidence is maintained will managed care progress without more regulation from outside sources.

Chapter 5

Patients' Rights and Other Ethical Issues Arising From Managed Care

The practice of medicine has always been fraught by many ethical dilemmas, everything from the issue of abortions to whether or not to treat severely impaired infants. However, the rise of managed care brought about many more ethical concerns. First and foremost on the list is the issue of patients' rights.

Although they were not as opposed to managed care as were physicians, patients certainly had several reasons to hold a negative view of HMOs and other managed care organizations. For one thing, patients are the least likely party to see the benefits of managed care. The lower costs seem only to benefit employers, who pay lower premiums, and health plans, who make more profits (Berenson and Zelman 1998). Moreover, patients often hold a negative view of many of the techniques that HMOs use in order to cut costs. Patients view a network as a loss of access to a favored physician. They also fear that plans choose doctors not based on competence but on who accepts the greatest discount (Berenson and Zelman 1998). To a certain extent, they are probably right. Patients also generally disapprove of utilization reviews, as they often lead to denial of a prescription or treatment that the patient believes is necessary. In fact, one survey said that as many as 90 % of patients experienced denials of treatment from their health plan in the last year (Deloitte & Touche and VHA 2000).

All of these issues led many to believe that patients were being treated unfairly by managed care organizations. And as previously mentioned in chapter 4, some research even pointed to the idea that managed care was decreasing the quality of care for patients.

One survey found that HMO members were more likely to face “barriers” to receiving care than patients in other types of health plans. For example, 23 % of HMO members reported having to wait too long for approval of treatment, compared to 14 % of patients enrolled in less restrictive PPOs, and only 9 % of patients in traditional indemnity plans (Deloitte & Touche and VHA 2000). By the same token, research indicated that patients basically did not trust their HMOs. One study found that over two-thirds of patients believed that their plan would be more concerned with saving money rather than providing quality care (Deloitte & Touche and VHA 2000).

This “consumer backlash” against managed care directly resulted in more government regulation of HMOs. Most of the legislation was to protect patients’ interests while receiving medical care. During the latter part of the Clinton administration, there was much discussion of passing a “patients’ bill of rights” in Congress. Some of the key issues regarding patients’ rights were: the ability of a patient to have an outside review of denied treatment; the ability to see any specialist in their plan and/or go outside the plan if the health plan lacks expertise in a needed area; that plans should reimburse any and all emergency care such that “emergency” would be defined by a prudent layperson (Baldor 1998, Bennahum 1999, and Coile 2000).

Although these and other patients’ rights concerns have been under much discussion on Capitol Hill, Congress has yet to pass a patients’ bill of rights to date. However, many state legislatures have decided to take actions of their own in regulating managed care organizations. In 1997 alone, state legislatures passed a record 182 laws against managed care organizations (Brink and Shute 1997). Many of the laws passed by state legislatures addressed the same issues being discussed in Congress, as several states

passed their own versions of a patients' bill of rights. Furthermore, many of these state laws addressed other patients' rights issues. Some laws banned "drive-through deliveries," requiring a 48-hour stay for new mothers rather than the 24-hour stays that many HMOs were imposing (Baldor 1998). Other laws required HMOs to disclose not only their financial incentives to patients, but their preauthorization requirements, specialist panels, and typical waiting times as well (Bennahum 1999). Connecticut was the first state to allow outside review of a health plan's denial, while Texas, Georgia, and California all passed laws allowing patients to sue their HMOs (Brink and Shute 1997). In fact, the first HMO malpractice lawsuit filed by a consumer was in Texas in 1998 (Deloitte & Touche and VHA 2000).

Many consumers were very relieved by all of the legislation regulating managed care organizations, particularly by the ability to sue their HMOs. However, these lawsuits proved to be fairly ineffective. In nearly all lawsuits against managed care organizations in the last decade, HMOs have hidden behind the Employee Retirement Income Security Act (ERISA) of 1974 (Japsen 2000). ERISA was originally enacted to protect employee pension plans from state regulation, but actually protects all employee benefits, including health plans (Bennahum 1999). This basically translated into HMOs being immune from lawsuits in state courts. Nonetheless, a Chicago-based HMO recently lost a lawsuit brought by a patient who wanted the HMO to pay for the recommendations of an outside physician (Japsen 2000). This was a landmark victory for those wanting to take legal action against the HMO industry, as it seemed to show that HMOs could not use ERISA as immunity from all lawsuits.

Although all of the previously mentioned pieces of legislation have been passed by individual states, there has been one major federal law passed recently trying to protect patients' rights: the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA has a couple of major provisions that are aimed at protecting patients' rights. First, HIPAA limits, and in some cases bans, the use of "pre-existing condition" exclusions, which some HMOs had been using to avoid having to absorb the high costs of treating the extremely ill. Secondly, if a person should lose his or her job, HIPAA allows that person to continue their health coverage until they find a new job (Baldor 1998). Finally, HIPAA tries to help small businesses afford to offer health benefits by establishing medical savings accounts. Although there are a few loopholes in HIPAA that allow HMOs too much leeway, this legislation was still a step in the right direction.

In addition to passing laws that protect patients' rights, many states have also enacted legislation that protects physicians from abusive HMO practices. Many states have placed a ban on "gag clauses" in physician contracts. Gag clauses reprimand physicians who badmouth the HMO, and they also penalize doctors who advocate care not covered by the plan (Baldor 1998 and Bennahum 1999). In another move protecting doctors from HMOs, twenty-six states have passed "prompt payment" regulations that require health plans to pay claims within a specified period (Coile 2000). Yet other states have passed "any willing provider" laws, which require managed care organizations to contract with any physician that is willing to provide care to its enrollees.

Despite all of the attention that it has received, the issue of patients' rights is not the only ethical concern raised by managed care. One of today's extremely hot topics is the rise of for-profit health care. Managed care health plans fall into either of two

categories: non-profit and for-profit. In non-profit HMOs, such as Kaiser Permanente, all profits are used to give more health care or improve existing care. For example, some non-profit HMOs use their extra earnings to enhance existing prevention programs or to establish prenatal care programs (Bennahum 1999). Such is not the case in for-profit HMOs, such as Aetna and Cigna. For-profit HMOs, also euphemized as “investor-owned” HMOs, spend almost all of their profits on advertising, management expenses, and shareholder dividends (Bennahum 1999). Thus arises the main argument against for-profit managed care: that these insurers will ultimately skimp on care in order to maintain their profit margins.

Does the practice of for-profit medicine actually harm the quality of health care? Although there has not been a great deal of research on this subject until recently, most studies suggest that for-profit care actually does decrease the quality of care. One major study found that on every one of fourteen quality-of-care indicators, for-profit health plans scored worse than their non-profit counterparts (Stolberg 1999). For example, this research found that non-profit HMOs had 72.3 % of their two-year old enrollees fully immunized, as compared to 63.9 % of those in for-profit plans. Similarly, 70.6 % of non-profit plan enrollees were given potentially life-saving beta-blockers after heart attacks, compared with only 59.2 % of those enrolled in for-profit HMOs (Stolberg 1999). All of these indicators should not be very surprising when one considers that in 1998 non-profit plans spent 91 % of their revenues on patients, while for-profit managed care organization spent only 79 % of their revenues on health care (Bennahum 1999). No one denies that sound business and management practices may well serve to eliminate waste

and inefficiencies from the practice of medicine. However, medicine is not just another business, as people's health and even their lives are at stake.

Even though for-profit medicine appears to hinder health care quality, it has become the dominant form of managed care in the United States. By 1997, 82.8 % of all managed care organizations were for-profit, and 62 % of all HMO patients were enrolled in these organizations (Brink and Shute 1997 and Stolberg 1999). The primary reason that there been this growth is because for-profit HMOs have a great deal more capital than their non-profit counterparts. Non-profit managed care organizations do not have the opportunity to sell shares of their stock and thus raise capital the way that for-profit HMOs do (Bennahum 1999).

Although for-profit managed care has become dominant, many experts are convinced that these investor-owned organizations will not succeed. First of all, economists are convinced that the American public simply will not support a health care model in which over 20 % of premiums are skimmed off the top for shareholder dividends and high administrative costs (Coile 2000). Others believe that for-profit managed care organizations may struggle to survive because of increased government regulation, and because of the possibility that significant annual profits may be difficult to maintain once existing waste and inefficiencies in the health care system have been eliminated (Bennahum 1999). Regardless of whether or not for-profit health care thrives, the idea that an HMO would skimp on care in order to maintain profits is a startling proposition.

One other ethical issue that has come into light due to the rise of managed care is the practice of selective marketing, also known as "cherry-picking." Selective marketing

is the process by which managed care organizations recruit healthier, and thus less costly, patients (Bennahum 1999). This can be done by several methods. First, many HMOs use “pre-existing condition” exclusions, saying that they will not enroll a patient who already has a serious illness. Another such technique is for managed care organizations to contract only with employers, because people in the workforce are generally young and healthy compared to those who are disabled or retired. Yet another technique used to attract healthy customers has been seen by HMOs holding “signups” at social functions that generally exclude the frail or bedridden (Bennahum 1999).

Obviously, managed care organizations try to attract healthy customers because they are less costly to treat. However, this is clearly an ethical violation. It is the sick people that truly need the most medical attention, yet they often have trouble getting coverage. Physicians have conceivably the biggest ethical dilemma in this case, because they are torn between trying to treat those who need health care the most and trying to do what is best for the organization who contracts them.

Chapter 6

Medicare and Medicaid

In the mid-1960s, both the Medicare and Medicaid programs were passed into law in order to help those who had trouble obtaining health insurance. Medicare was introduced in order to provide health care to the elderly, while Medicaid was passed in order to help the poor and permanently disabled obtain medical care. Medicare consists of two parts: part A, which covers inpatient care, and part B, which covers outpatient care and physician visits. Both parts have a deductible, and part B requires a 20 % co-payment after the deductible is met (Baldor 1998). Medicare does not currently offer a prescription benefit. However, many companies offer supplemental insurance to Medicare patients, often known as “Medigap insurance.” This supplemental insurance covers the deductibles and co-payments of Medicare, and usually includes prescription coverage.

Medicaid, which provides health care to the poor and permanently disabled, is run a bit differently than Medicare. Unlike Medicare, each state determines how to run its Medicaid program, and the federal government then reimburses the state between 50 and 83 % of the cost, depending on the state’s per capita income (Baldor 1998). For instance, Oregon decided to create a priority list of diagnoses, and rations its Medicaid funds according to that list (Baldor 1998). Tennessee employed a program called TennCare in order to cover its Medicaid eligible population, with around 95 % of these people now insured (Deloitte & Touche and VHA 2000). The TennCare program, discussed in more

detail shortly, provides a good case study of the pros and cons of enrolling Medicaid patients in managed care organizations.

Although both of these programs were enacted with the best of intentions, they were far from perfect. To achieve political passage and initial acceptance, both programs were ratified without effective mechanisms for controlling costs. Specifically, the Medicare statute had a clause that prohibited the federal government from “exercising any supervision or control over the practice of medicine” (Berenson and Zelman 1998). Furthermore, the fee-for-service system really hurt Medicare and Medicaid, again because of the lack of guidelines. For decades, physicians were charging exorbitant amounts to the federal programs, knowing that they would be reimbursed.

Because of these reasons, the two programs, and in particular Medicare, became extremely inflationary. For example, medical inflation averaged 3 % per year before Medicare was enacted. During the first five years after the law was passed, that figure averaged 7.9 % per year (Berenson and Zelman 1998). By the early 1980s, Medicare’s costs were five to six times greater than original estimates, while doctors and hospitals were racking up profits (Berenson and Zelman 1998). The situation became so bad that in 1983 the Reagan administration mandated that hospitals under Medicare be reimbursed using diagnosis-related groups (DRGs) rather than a fee-for-service system (Deloitte & Touche and VHA 2000). DRGs, previously mentioned in chapter 1, were basically standardized reimbursements hospitals were to receive based on a national average cost for a particular diagnosis (Baldor 1998). This new reimbursement system completely altered hospitals’ incentives when dealing with Medicare patients. Up until then, longer hospital stays and more procedures meant more revenue. However, the introduction of

DRGs meant that these same factors now led to higher costs and fewer profits (Berenson and Zelman 1998). The establishment of diagnosis-related groups was significant because it was the first major form of guidelines set on health care payments, and a preview of what was to come with the rise of managed care.

In spite of the introduction of DRGs to help alleviate its high inflation, Medicare was hardly cost-efficient. In fact, there were so many wasted resources in Medicare that many HMOs, particularly for-profit HMOs, decided that Medicare would be their new “promised land” (Eckholm 1995). By applying managed care techniques such as curbing excess procedures and pursuing prevention, HMOs figured they could turn Medicare’s wastefulness into significant profits. Thus, there was a large movement of managed care organizations trying to sign up Medicare patients, with the peak of the movement coming in the mid-1990s. In fact, Medicare HMO enrollment doubled between 1993 and 1997 (Berenson and Zelman 1998). HMOs appealed to seniors by offering a deal that seemed to be too good to be true. Medicare enrollees could sign up, pay nothing, and get all of their previous Medicare benefits plus prescription coverage and no co-payments (Eckholm 1995). What’s more, this meant that people could drop their Medigap insurance, which typically ran anywhere from \$60 to \$100 per month (Eckholm 1995). The only catch was that those who joined were required to have a gatekeeper and stay within their HMO’s network of providers.

Many seniors obviously decided that using these HMO techniques would be worth all the extra benefits, as Medicare HMO enrollment reached its peak growth rate in 1996 at around 36 % (Deloitte & Touche and VHA 2000). Meanwhile, Congress was busy looking at the possibility of the Medicare program crashing in the near future.

Depending on the source, Medicare's hospital trust fund is expected to go into the red anywhere from 2015 to 2020 (Appleby 2000 and Deloitte & Touche and VHA 2000). What's more, some research actually suggested that the government was actually losing money when Medicare patients joined HMOs (Eckholm 1995). This was because the seniors who were joining HMOs were found to be generally healthier than those who were shying away from HMOs. However, the government continued to pay the same amount per Medicare patient (Eckholm 1995). As a result, Congress passed the Balanced Budget Act of 1997. This legislation drastically changed the roles of HMOs in the Medicare market.

The Balanced Budget Act (BBA) basically put higher standards on HMOs who wished to be in the Medicare market. The BBA forbade Medicare HMOs from using pre-existing condition clauses, required these HMOs to reimburse any and all emergency services as defined by a prudent layperson, and required each Medicare HMO to have an internal quality assurance program. The legislation also had clauses requiring prompt payments to physicians, increased capitated payments to physicians, as well as many other articles that made it tougher for Medicare HMOs to turn profits. In fact, some have estimated that the BBA would reduce payments to Medicare HMOs nationwide by over \$22 billion dollars through 2003 (Coile 2000). As a result, many HMOs have simply begun to leave the Medicare market. In the first year after the Balanced Budget Act was passed, 43 HMOs dropped their Medicare operations (Coile 2000). Since most of the HMOs who originally entered the market were for-profit organizations, they decided it was not worth the effort if the Medicare market could no longer be milked for all those excess earnings. During the mid-1990s, the total number of Medicare patients enrolled in

HMOs nationwide had reached as high as 16 %, but in 2000 Medicare HMO enrollment was the lowest in five years (Deloitte& Touche and VHA 2000 and Coile 2000).

Unlike Medicare, Medicaid recipients have continued to be enrolled in managed care at an increasing rate. Of the roughly 36 million people eligible for Medicaid, about one-third of them were enrolled in a managed care organization in 1998 (Deloitte & Touche and VHA 2000). By 1999, this figure had risen to almost 40 % of Medicaid patients (Coile 2000). The main reason that Medicaid HMOs continue to grow is because Medicaid is run differently by each state, as opposed to Medicare, which is universally run by the federal government. Since Medicaid is run by each state, there are really no barriers such as the BBA. In fact, Medicaid programs in some states have enrolled greater than two-thirds of their Medicaid patients in managed care (Deloitte & Touche and VHA 2000). Tennessee, with its TennCare program, has enrolled over 90 % of its Medicaid patients into managed care (Coile 2000). This program provides a good example of both the rewards and the difficulties associated with shifting to a managed Medicaid program.

In 1994, Tennessee converted all of its Medicaid benefits to managed care with the goal of using the savings to cover those who were uninsured as well as those who were not eligible for traditional insurance. This program was known as TennCare. People who are eligible for Medicaid automatically qualify. Those who were previously uninsured may join TennCare by paying income-adjusted premiums, as well as deductibles. Those who are not eligible for other insurance, known as “uninsurables,” qualify for TennCare merely by presenting a letter from a health plan denying them coverage. The program boomed. By 1998, 24 % of the state’s total population had

health insurance through TennCare, with over 90 % of Medicaid patients being covered (Kilborn 1999). The program grew so much that Tennessee decided to close TennCare to the uninsured once enrollment reached 1.3 million (Kilborn 1999).

However, Tennessee kept enrolling “uninsurables,” in addition to Medicaid-eligible patients. The state signed up so many people into the program, that by 1999 they realized that they were running dangerously short on funds (Coile 2000). Since Tennessee was facing a budget deficit, TennCare had to cut its costs. The state is now cutting benefits, raising premiums, and tightening eligibility (Kilborn 1999). One problem that led to TennCare’s high costs was capping enrollment. The state kept enrolling uninsurables, the most costly type of patient, but quit enrolling the previously uninsured, who were required to pay premiums. Thus, TennCare costs were rising, as their patient contributions remained stagnant. Another trouble for the program was the probability that many health plans were “dumping” their most sickly patients on TennCare, simply by denying coverage more frequently. According to the program’s director, Brain Lapps, the main problem with TennCare is that all of its patients want “everything for nothing” (Kilborn 1999). According to him, many recipients could help pay for their premiums and help reduce TennCare’s costs if they would “curb their use of cell phones and cigarettes” (Kilborn 1999).

However, TennCare did show a lot of promise. It was a huge first step in the direction of universal care, as many other states can now learn from Tennessee’s mistakes. Actually, the TennCare program is remarkably similar in theory to Clinton’s health care reform plan proposed in 1993 that brought so much criticism from Capitol

Hill. Regardless, there seems to be no reason why more states will not continue to move their Medicaid programs into managed care in the near future.

Chapter 7

The Future of Managed Health Care in America

In order to see what direction managed care will take in the near future, it is useful to consider some of the trends seen in the industry today. Whereas the primary goal of HMOs during the beginning of the managed care takeover was to have high enrollment rates, many HMOs are now focusing on their profitability. The industry is undergoing what is known as the “insurance cycle” (Coile 2000). When premiums were low, enrollment soared while profits suffered. In fact, in 1997, during some of the fastest enrollment growth the industry had seen, HMO losses nationwide totaled \$768 million (Deloitte & Touche and VHA 2000). Kaiser alone lost over \$500 million in 1998 and 1999, while the highly popular Oxford health plan nearly went under despite doubling its membership (Coile 2000). Due to these startling losses, many HMOs had to raise premiums and exit the low-profit markets (i.e. Medicare) in order to restore their bottom lines. The HMO industry is still working on improving its profitability even today, as premiums rose almost 10% between 1999 and 2000, and some experts predict that premiums will increase by nearly 20 % in 2001 (Appleby 2000 and Coile 2000).

However, it seems that HMOs’ strategy of focusing on profitability has backfired. First of all, HMO premium hikes have closed the price gap between HMOs and PPOs, which has given many people all the more reason to spend just a few extra dollars to get the freedom of choice associated with PPOs. Secondly, the premium hikes have drawn negative reactions from both physicians and employers. As a result, some employers are now starting to contract directly with physician groups, rather than going through a

managed care organization (Coile 2000). However, HMOs should perhaps be more concerned with upsetting physicians rather than employers. Many physician groups are now becoming too large to be pushed around by managed care organizations, and when a contract dispute occurs between physicians and plans, the media tends to favor physicians.

In some areas, HMOs are doing so poorly that some have said that HMOs are showing signs of a dying industry (Coile 2000). There are very few new HMOs entering the market, existing HMOs are consolidating into a few large firms, and new customer enrollment is down, with HMO enrollment hovering around 80 million for the past couple of years (Coile 2000). Furthermore, differentiation among many HMOs is lacking, and innovative companies such as Oxford are failing (Deloitte & Touche and VHA 2000).

However, HMOs are still surviving because they keep finding new ways to rid the health care system of inefficiencies. Many HMOs are now utilizing more physician assistants and nurse practitioners to take over the duties of highly paid doctors (Deloitte & Touche and VHA 2000). Moreover, many patients are now seeking alternative therapies, such as chiropractic and acupuncture, instead of traditional medicine. Both of these factors are further increasing the oversupply of physicians, which is forcing many physicians to continue to accept deep discounts from health plans (Deloitte & Touche and VHA 2000). Most importantly, if the economy slows down a great deal, which is becoming a possibility, HMOs may make a comeback due to their rigorous cost controls.

It should be clear by now that managed care as it now stands is a flawed system that probably needs to be altered in order to thrive. However, there is much debate over

how health care financing should ideally be structured. Some experts argue that a government-run system is the best answer. After all, government-run health care works all over the world, as the United States and South Africa are the only two industrialized countries without a national health care system (Baldor 1998). Furthermore, many argue that a national health care system could still allow our private sector to thrive. For example, in Canada the government is the only payer in the health care system, but all of the providers in the nation are in the private sector (Baldor 1998). Yet another stance in favor of government intervention claims that HMOs made their one-time impact on premiums, which will now rise sharply again without action from the government (Coile 2000).

However, it is difficult for many others, myself included, to believe that a government-run health care system is the best solution. Due to the country's general distrust of politicians, many people fear that a government-run system would be bureaucratic and expensive (Bennahum 1999). Moreover, market-driven solutions are usually more effective than government-enforced ones. As Robert Berenson and Walter Zelman said in their book *The Managed Care Blues and How to Cure Them*: "History shows that companies are less likely to get serious about quality when it is enforced by government than when survival in the marketplace demands it" (1998). Rather than regulating bad HMOs, we should support good HMOs, and they would drive out the bad ones. Nonetheless, if the number of uninsured Americans increases to an unacceptable level, perhaps near 25 %, then Washington may decide to act.

Is managed care then the best scenario for America's health care system?
Probably. Managed care benefits those who pay the largest part of the nation's medical

bill: the government and employers (Bennahum 1999). However, for managed care to exist in the long-term, the *quality* of the system needs to be improved while still maintaining its cost-effectiveness. In order to accomplish this, there are several major strategies that I believe plans, providers, and purchasers must focus on. Although there may not be any obvious short-term incentives for a couple of these strategies, all stakeholders involved need to realize that the goal is managed care's success in the long run.

First of all, I believe that quality health care must be rooted in non-profit health plans. It is simply contradictory to believe that both the patient's and the shareholder's interests can be met. As discussed in chapter 5, in order to maximize shareholder value, for-profit HMOs will ultimately have to skimp on care. Furthermore, for-profit organizations give physicians a very negative outlook on managed care, as many view these organizations as hypocritical. For-profit HMOs want doctors to act in the best interests of patients even while these HMOs are shifting money away from patients to investors (Berenson and Zelman 1998). What's more, non-profit HMOs are a better option for improving health care quality, because these organizations exist to serve the community, not Wall Street. The state of Minnesota has been a pioneer in deciding that non-profit care is integral to quality health care. Under state law, every health plan that operates in Minnesota must be of non-profit status (Bennahum 1999).

Secondly, managed care needs to continue to focus on preventative medicine. This is a technique that can serve to both improve quality and control costs. Not only does catching conditions early help people avoid painful illnesses and hospitalizations, but it helps to avoid the high costs associated with treating such diseases. Many HMOs are

realizing this, and are offering more prevention programs such as childhood immunizations and annual mammograms (Coile 2000). Although preventative treatments can often be costly, they are almost always less expensive than treating the disease that they are trying to discover.

The third important step to improving the quality of the health care system would be to have employees choose health plans rather than employers. As it stands, managed care organizations have more reason to lavish attention on human resources managers than on patients (Berenson and Zelman 1998). Human resources managers are the ones reaching agreements with health plans, and cost is generally the top factor when deciding what plan to purchase. In fact, less than half of employers even receive any data on health plan quality (Deloitte & Touche and VHA 2000). If employees decided what plans to purchase, patients would then have the same leverage to enforce quality possessed by consumers in most markets: the ability to leave (Berenson and Zelman 1998). Although this is a large step, it is a very important one because plans would begin to compete on quality rather than on price.

The fourth strategy in working towards increased quality of care is for health plans and purchasers to work on reaching long-term agreements. Currently, consumers are changing health plans so often that there is little reason for managed care organizations to focus on long-term care (Coile 2000). Many patients leave their plan before many preventative measures are taken. If HMOs had long-term contracts with patients, this would allow HMOs to utilize more prevention and early detection. Not only could this improve the quality of life for some people, but it is much less costly than expensive hospitalizations. Moreover, a patient who is using the same health plan will probably use

the same physician. This is beneficial because then the physician can really get to know a patient's history and conditions, and could perhaps be able to better diagnose any of the patient's illnesses. As discussed in chapter 4, a sound doctor-patient relationship is crucial to high quality health care.

The fifth strategy for improving managed care is for providers and managed care organizations to improve their relationship. In many areas of the country, plans and doctors are "at war," as they are involved in heated contract talks that sometimes lead to front-page stories in the local paper. Many feel that this type of conflict could eventually result in government intervention. Providers and insurers need to start viewing one another as partners, rather than vendors with whom they must contract (Berenson and Zelman 1998). This would be an important first step toward community-based health care, because there are so many benefits that could come from the cooperation of plans and providers. First of all, physicians are more capable than anyone in controlling costs, because they are the closest to patients and can best determine what a patient actually needs. Moreover, if physicians were deeply involved in managed care organizations, they could publish their own material of health plan quality. Just as they can be integral in controlling costs, doctors may also be the best people for judging a health plan's quality. What's more, if doctors were publishing reports on quality, they would have more merit when they blew the whistle on a plan that was undermining the quality of care (Berenson and Zelman 1998). Physician-plan cooperation would also lead to more coordinated care, which could reduce the number of costly oversights and duplications of effort.

Fortunately, a couple of managed care organizations have taken steps to try and improve their relationships with physicians. UnitedHealth, a Minneapolis-based HMO, has decided to completely abandon its pre-authorization process and will give doctors the final say on treatments. The HMO's rationale was that since 99% of physician requests were approved anyway, the pre-authorization procedure was worth neither the administrative costs it piled up nor the damage it was doing to provider relations (Coile 2000). Aetna is considering significant changes in the way it provides managed care to help settle a huge fraud and racketeering suit brought against it (Geyelin 2001). Aetna's main goal is to improve its relationship with doctors. Aetna, traditionally known as a hardball negotiator with physician groups, often received very poor ratings in the area of physician and patient satisfaction (Ball 2000). However, their hardball strategy backfired as other managed care organizations tried to improve these relationships, and benefited from doing so. Some of the changes Aetna is considering are ending the use of financial incentives such as bonuses and withholds, limiting the use of capitation, and stopping use of medical guidebooks created by actuarial firms who have little or no medical training (Geyelin 2001). Other HMOs are also trying to improve provider relationships. Since many HMOs have had losses in recent years, they are becoming more willing to share risk with providers (Coile 2000). Since physicians keep forming larger groups in order to have more negotiating clout, this is probably a good idea.

The sixth and final step in order to ensure the existence of managed care in the long-term is universal coverage. This will also prove to be the most difficult step to accomplish. Most sources put the number of Americans currently uninsured at around 40 million (Coile 2000, Deloitte & Touche and VHA 2000, and others). An obvious key to

a successful health care system is for everyone to have access to health care. However, there is much debate over how this problem should be addressed. A government-run system could definitely provide universal health coverage, but the disadvantages to this system have already been discussed. Some believe that all businesses should be required to provide insurance, with the government insuring those who are unemployed. The main problem with this idea is that many small businesses cannot afford to offer health insurance, and may go under as result (Appleby 2000). A couple of possible solutions to this dilemma are government subsidies for small businesses, or a universal pool for small businesses to purchase insurance as a group. Tennessee's TennCare program, discussed previously in chapter 6, made a serious attempt at universal coverage on the state level. Any proposed program with the goal of universal coverage should study TennCare's successes and difficulties. Regardless, the issue of how to provide insurance for all Americans needs to be addressed if managed care is to be the health care system of the future.

Adhering to the six previously mentioned recommendations should help managed care organizations improve the quality of care they offer without sacrificing their cost-efficiency. However, an HMO's reputation for high quality may be a marketplace loser because it attracts the highest cost cases (Berenson and Zelman 1998). Ideally, all HMOs would try to be known for quality, and this wouldn't even be an issue. However, if only a few HMOs became known for high quality, they might be penalized by attracting those who are seriously ill. As a remedy for this situation, a patient's health status could be figured into the price of insurance premiums. On the other hand, this is a very controversial topic, as many believe that the very ill should not be further persecuted by

having to pay higher premiums. If premiums are not going to be risk-adjusted, then there at least needs to be legislation limiting the ability of plans to attract only healthy patients (known as “selective marketing,” discussed in chapter 5). In addition to improving quality, the health care system needs to support managed care organizations that are committed to inclusiveness (Bennahum 1999).

Conclusion

The Census Bureau estimates that the number of people over the age of 65 will double by the year 2050 (Deloitte & Touche and VHA 2000). Since these people require the most medical attention, health care costs will rise sharply as well. Obviously, a method to control health care costs was not only needed for the spiraling premiums of the late 1980s, but will be integral in the health care system of the future. Even if the economy is in such great shape that covering these incredible medical costs is possible, a cost-control method would still be needed. We don't want to spend all of our money on health care; we also value education, recreation, and other things of that nature. The fee-for-service system as it existed would not have allowed us to face these incredible costs. Thus, managed care was given a chance.

Managed care set its sights on being the opposite of the fee-for-service system: organization instead of fragmentation, cost-consciousness for cost-unconsciousness, and accountability rather than autonomy (Berenson and Zelman 1998). The ideal managed care system would eliminate all inefficiencies from medicine, and provide high-quality, low-cost care. Managed care succeeded on at least one of these aspects: low costs. The United States spent \$350 billion less in 2000 on health care than was estimated by Congress in 1993 (Appleby 2000).

But while managed care undoubtedly decreased health care spending, it has a much spottier record when it comes to quality. Many physicians feel that managed care interferes with quality medical care by using techniques such as pre-authorizations. Whereas managed care organizations claimed that the quality of care would be improved,

many studies suggest that HMO quality indicators are roughly the same or slightly less than those of the fee-for-service industry (Deloitte & Touche and VHA 2000 and Easterbrook 1997). Moreover, there are often visible cases of a patient's rights being abused by the managed care system. However, managed care's major flaw has not been the harm it may have caused these few, but not improving quality for the many.

In order for managed care to solidify its status as the health care system of the future, its main focus needs to be quality improvement. There are six important strategies that need to be focused upon that could improve quality without sacrificing cost-efficiency: the shift from for-profit to non-profit care, preventative medicine, consumers choosing health plans rather than employers, long-term contract agreements between plans and purchasers, a more cooperative relationship between providers and plans, and the attainment of universal coverage. If everyone involved in health care delivery could focus on these tactics, managed care would no longer be the focus of physician, patient, and media criticism, but would be regarded as the idea that saved the nation's health care system from disaster.

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