

CHAPTER

1

A History of Managed Health Care and Health Insurance in the United States

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STUDY OBJECTIVES

- Understand the evolution of health insurance and managed health care, including the forces that drove this evolution
- Understand current trends in managed health care, including how market dynamics continue to change over time
- Understand the public policy and market performance issues faced by managed health care in the past
- Understand the current environment for health insurance and managed health care in the United States

DISCUSSION TOPICS

1. Discuss why proto-HMOs were formed in the first place.
2. Discuss how managed care activities by non-HMO health plans seek to constrain health care costs and promote wellness.
3. Discuss how important it is that managed health care plans demonstrate that they offer quality care, and why that is the case.
4. Discuss the salient forces leading to the rise and fall of various types of managed health care plans. Speculate on how current and future forces might lead to further changes.
5. Discuss how the relationship between the government and the managed health care industry changed over the years.

■ INTRODUCTION

Health insurance and managed health care are inventions of the 20th century. In the late 19th century, a few insurers offered insurance policies to cover the cost of care for workplace accidents and for employee disability. Some of these insurance policies eventually evolved into coverage for care unrelated to a workplace accident but not until several decades later.

More so than other types of insurance, health insurance and managed care also have been in a never-ending state of change and turbulence, a state of “permanent whitewater.”

This chapter explores the historical roots and evolutionary forces that have resulted in today’s system. The reader should note that dates are concrete for such events as the passage of laws or the establishment of organizations, but only approximate time periods apply to trends.

■ 1910 TO THE MID-1940S: THE EARLY YEARS

The years before World War II saw the appearance of two distinct models of providing and paying for health care besides purely out-of-pocket. The first of these were early forms of what we would now call a health maintenance

organization (HMO), a term that was not coined until the early 1970s. The other was the appearance of the first Blue Cross and Blue Shield (BCBS) plans. The key characteristic of these proto-HMOs was that it combined the functions of insurance and the health care delivery system, while the key characteristic of the early BC and BS plans was their exclusive use of existing hospitals and privately practicing physicians.

Prepaid Medical Group Practices

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

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

Also in 1929, Drs. Donald Ross and H. Clifford Loos established a comprehensive prepaid medical plan for workers at the Los Angeles Department of Water and Power. The plan covered physician services and hospitalization, and from the beginning had a focus on prevention and health maintenance.³ For that reason, some consider it to be the first real HMO, although as noted previously, that term was not in use at the time. Drs. Ross and Loos were also expelled from their local medical society. The Ross-Loos Clinic was purchased in 1980 by the Insurance Company of North America, a forerunner of the CIGNA insurance company, and was closed when CIGNA divested its owned medical facilities in the late 1990s.

In 1932 the American Medical Association (AMA) adopted a strong stance against prepaid group practices,^{*} favoring, instead, indemnity type insurance, which had minimal presence at the time. The AMA's position was in

response to both the small number of prepaid group practices in existence at the time and the findings in 1932 of the Committee on the Cost of Medical Care—a highly visible private group of leaders from medicine, dentistry, public health, consumers, and so forth—that recommended the expansion of group practice as an efficient delivery system. The AMA's stance at the national level set the tone for state and local medical society opposition to prepaid group practice, which continued for many years.

Despite this opposition, prepaid group practices continue to emerge, reflecting a diversity of origins with the initial impetus coming, variously, from employers, providers seeking patient revenues, consumers seeking access to improved and affordable health care, and even a housing lending agency seeking to reduce the number of foreclosures. They encountered varying degrees of opposition from local medical societies. Two prominent examples are the Kaiser Foundation Health Plan and the now defunct Group Health Association of Washington, D.C.

The organization that evolved into the Kaiser Foundation Health Plan was started in 1937 by Dr. Sidney Garfield at the behest of the Kaiser Construction Company. It sought to finance medical care, initially for workers and families who were building an aqueduct in the southern California desert to transport water from the Colorado River to Los Angeles and, subsequently, for workers who were constructing the Grand Coulee Dam in Washington state. A similar program was established in 1942 at Kaiser ship-building plants in the San Francisco Bay area.

In 1937 the Group Health Association (GHA) was started in Washington, D.C., at the behest of the Home Owner's Loan Corporation to reduce the number of mortgage defaults that resulted from large medical expenses. It was created as a nonprofit consumer cooperative with a board that was elected by the enrollees.[†] The District of Columbia Medical Society vehemently opposed the formation of GHA. It sought to restrict hospital admitting privileges for GHA physicians and threatened expulsion from the medical society. A bitter antitrust battle ensued, culminating in the U.S. Supreme Court's ruling in favor of GHA. In 1994, faced with insolvency despite an enrollment of some 128,000, GHA was acquired by Humana Health Plans, a for-profit, publicly traded corporation. It was subsequently divested by Humana and incorporated into Kaiser Foundation Health Plan of the Mid-Atlantic.

The Blues

In 1929, the same year that saw the establishment of both the Ross-Loos Clinic's prepaid health plan and Dr. Shadid's rural farmers' cooperative health plan, Baylor Hospital in Texas agreed to provide some 1,500 teachers with prepaid

^{*}The AMA was also generally opposed to multispecialty groups of any kind, prepaid or not.

[†]Its governance structure was quite similar to that required for the new consumer-owned and -operated plans (CO-OPs) enabled under the Patient Protection and Affordable Care Act (ACA) of 2010.

inpatient care at its hospital, an arrangement that represented the origins of Blue Cross. The initial single-hospital program was subsequently expanded to include the participation of other employers and hospitals. Hospitals and state hospital associations elsewhere followed suit by creating other Blue Cross plans. These new plans were usually sponsored by a local or regional hospital association and included all of its member hospitals. Their motivation was to establish a revenue stream for participating providers during the Great Depression.

The forerunner of Blue Shield appeared in the Pacific Northwest in 1939 and offered coverage of physician services, stimulated in part by lumber and mining companies that wanted to provide medical care for injured workers. It made arrangements with physicians, who were paid a monthly fee for their services through a service bureau.⁴ State medical societies soon began to emulate the model across the country.

The earliest BC and BS plans thus resembled other early types of prepaid care, except that they relied on providers in independent private practices rather than having dedicated delivery systems. Because they included more than one hospital or one medical group, providers could not each be paid on an equal prepayment basis, so payment was typically based on charged fees. In order to define the payment terms between a Blue Cross plan and a hospital, hospitals created cost-based charge lists, the forerunners of today's hospital chargemaster (the price list a hospital creates for all services for which it charges, discussed in Chapter 5). Blue Shield plans developed payment rates for defined procedures.* Unlike the early prepaid group practices, BCBS plans paid for, but did not provide, the care, which is why we consider them an early form of health insurance, although technically speaking they are "service plans," as described in Chapter 2.

Over time many Blue Cross plans merged with their local Blue Shield counterparts, although some remain separate even now. Most of these were statewide, although there were (and still are) notable exceptions, for example, in Pennsylvania and New York State, both of which have several BC and BS plans. These early BCBS plans, collectively referred to as the "Blues," operated independently from each other and continue to do so. Today, however, a state's BCBS plan may be part of a single larger entity, which can be either a for-profit company or a nonprofit or noninvestor-owned company.

In a few cases the Blues plans competed with each other, but mostly they respected each other's geographic boundaries. Increasingly, they have entered each other's territory and do compete, although only one may use the

BCBS logo in a defined territory. Hospitals and physicians retained control of the various Blues plans until the 1970s when they changed to a community governance model, a customer-owned model (e.g., a mutual insurer), and in recent decades some have converted to publicly owned, for-profit corporations. The formation of the various BCBS plans in the midst of the Great Depression, as well as that of many HMOs, reflected not consumers' demanding coverage or nonphysician entrepreneurs' seeking to establish a business, but rather providers' wanting to protect and enhance patient revenues.

■ THE MID-1940s TO MID-1960s: THE EXPANSION OF HEALTH BENEFITS

World War II generated both inflation and a tight labor supply, leading to the 1942 Stabilization Act. That Act imposed wage and price controls on businesses, including limiting their ability to pay higher wages to attract scarce workers. However, the Act did allow workers to avoid taxation on the employer contribution to certain employee benefits plans, including health benefits, which gave impetus to the growth of commercial health insurance. Before World War II, only 10% of employed individuals had health benefits from any source, but by 1955 nearly 70% did, although much of it was for hospitalizations only.

HMO formation also continued, albeit at a slow pace. For example, two large HMOs were created that remain prominent today:

- In 1944, at the behest of New York City, which was seeking coverage for its employees, the Health Insurance Plan (HIP) of Greater New York was formed. In 2006 HIP and New York-based Group Health Incorporated (GHI) merged to form EmblemHealth.
- In 1947 consumers in Seattle organized 400 families, who contributed \$100 each, to form the Group Health Cooperative of Puget Sound. Predictably, opposition was encountered from the Kings County Medical Society.

The 1950s also saw the appearance of HMOs resembling today's independent practice association (IPA) model, in which the HMO contracts with physicians in private fee-for-service (FFS) practices rather than having dedicated providers. These were a competitive reaction to group practice-based HMOs. The basic structure was created in 1954 when the San Joaquin County Medical Society in California formed the San Joaquin Medical Foundation to compete with Kaiser. The foundation established a relative value fee schedule for paying physicians, heard grievances against physicians, and monitored quality of care. It became licensed by the state to accept enrollee premiums and, like other HMOs, performed the insurance function. However, HMOs and insurance companies faced different regulatory

* Current Procedural Terminology (CPT) charge codes, which define the procedures for which doctors and other providers bill, was finally created by the AMA in 1966. The AMA has updated and maintained it ever since.

requirements in most states and were often regulated by different state agencies because HMOs both provided or contracted for the delivery of care and had risk for medical expenses, whether the HMO was based on a medical group or doctors in independent practice. That remains the case today.

The other noteworthy event in this time period occurred in 1945 with the passage of the McCarran-Ferguson Act, which exempted insurance companies from federal oversight, resulting in the obligation falling to the states. It also provided limited antitrust immunity for certain activities such as pooling of claims data for underwriting purposes as long as these activities were regulated by the state. This exemption was used primarily by property/casualty and disability insurers. It may also have been used by early health insurers, but by the 1970s and 1980s, states did not allow them to do so.

■ THE MID-1960s TO THE MID-1970s: THE ONSET OF HEALTH CARE COST INFLATION

In the early 1960s President John F. Kennedy proposed what eventually became Part A of Medicare, financed through taxes on earned income similar to Social Security, that would cover mostly hospital services. The Republicans in Congress subsequently proposed to cover physician services as well in what became Part B of Medicare. It was financed through a combination of general revenues and enrollee premiums. Following Kennedy's assassination, President Lyndon B. Johnson worked aggressively to achieve some of the late president's goals, including covering persons age 65 and over. In 1965 Congress passed two landmark entitlement programs: Medicare for older adults (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act) for selected low-income populations (i.e., those who met income, asset, and family composition requirements).^{*} The benefits and provider payment structures of Medicare were similar to those of BCBS plans of the time, with separate benefits for hospital and physician services, a bifurcation that still characterizes Medicare today.

The combination of Medicare, Medicaid, private insurance (whether by commercial carriers or BCBS plans), and other programs that pay for medical care (e.g., workers' compensation and Veterans Administration) resulted in the majority of health care being paid for by third-party payers. To illustrate, in 1960, 55.9% of all health care costs

nationally, regardless of source of coverage, were paid out of pocket, a figure that declined steadily as follows:

- 1965 – 42.9%;
- 1970 – 33.3%;
- 1980 – 22.9%;
- 1990 – 19.1%; and
- 2000 – 14.2%.⁵

The third-party payment system severs the link between who provides, who receives, and who pays for medical care, thereby generating both increased fees and greater utilization. The question often is whether the additional services are always medically necessary. This was often attributed primarily to Medicare, but, in fact, it was the total of all third-party payments that was inflationary, particularly when added to the impact of advances in technology and rising expectations regarding the health care sector. As an illustration, national health expenditures as a percent of Gross Domestic Product (GDP) rose from 5.2% in 1960 to 5.8% in 1965, the year before Medicare was implemented, and reached 7.4% in 1970.⁶

There are, however, isolated examples of early attempts to control costs beyond seeking discounts, including the following:[†]

- In 1959 Blue Cross of Western Pennsylvania, the Allegheny County Medical Society Foundation, and the Hospital Council of Western Pennsylvania performed retrospective analyses of hospital claims to identify utilization that was significantly above the average.⁷
- Around 1970 California's Medicaid program initiated hospital precertification and concurrent review in conjunction with medical care foundations in that state, typically county-based associations of physicians who elected to participate, starting with the Sacramento Foundation for Medical Care.
- The 1972 Social Security Amendments authorized the federal Professional Standards Review Organization (PSRO) to review the appropriateness of care provided to Medicare and Medicaid beneficiaries. Although the effectiveness of the PSRO program has been debated, it established an organizational infrastructure and data capacity upon which both the public and private sectors can rely. In time the PSRO became known as the Peer Review Organization (PRO) and, subsequently, the Quality Review Organization (QRO), which continues to provide oversight of clinical services on behalf of the federal and many state governments. In some cases the QRO entered into contracts to provide review services for employers or health plans. While the methods used by these organizations evolved along

^{*}The original Medicaid Act covered only families with dependent children (as well as individuals with disabilities and older adults), while excluding childless singles and married couples. Eligibility has since been expanded over time. Also, the 1972 Social Security amendments extended Medicare coverage to individuals with work histories who were considered disabled, although there was a waiting period of more than 2 years after the onset of disability.

[†]What these activities are and how they are performed is described in Chapter 7.

with their acronyms, their focus remained essentially the same.

- In the 1970s a handful of large corporations initiated precertification and concurrent review for inpatient care, much to the dismay of the provider community. Some companies took other measures such as promoting employee wellness, sitting on hospital boards with the intent of constraining their costs, and negotiating payment levels directly with providers.⁸

Although unrelated to costs and initially only peripherally related to health insurance, another significant event occurred at the end of this period: the passage in 1974 of the Employee Retirement Income Security Act (ERISA). Although the focus of ERISA was initially on retirement benefits, it addressed employers' pretax employee benefits. Among other things, ERISA established appeal rights for denial of benefits and established new regulations for employers that self-funded their benefits plans in order to avoid state regulation and taxes. ERISA is discussed periodically throughout this book and more fully in Chapter 29.

The problem of health care costs' rising faster than the economy as a whole, thereby absorbing an increasing share of the GDP, increasingly became a subject of public discussion. Throughout the 1960s and into the early 1970s, HMOs played only a modest role in the finance and delivery of health care, although they were a significant presence in a few communities such as the Seattle area and parts of California. In 1970 the total number of HMOs was in the 30s, the exact number depending on one's definition. That would soon change.

■ THE MID-1970s TO MID-1980s: THE RISE OF MANAGED CARE*

Between 1970 and 1977, national health expenditures as a percent of GDP rose from 7.4% to 8.6%. The acceleration in health care costs, driven at least in part by the third-party FFS payment system, became a widely discussed problem. For example, the cover of the May 28, 1979, issue of *Time* magazine features a photo of a surgeon wearing an outsized dollar bill for a surgical mask, with the headline "Medical Costs: Seeking the Cure."[†] Seeking the cure led to the next major development: managed care as we know it today. In particular, this period saw the growth of HMOs; the appearance of a new model, the preferred provider organization (PPO); and a broad increase in utilization management by insurers.

*This section assumes the reader knows what an HMO and a PPO is. If that is not the case, the reader may wish to first review Chapter 3 or at least look the terms up in the Glossary.

[†]The cover story itself was a very lucid distillation of many of the causes of health care cost inflation, which by then had risen to 9.5% of the GDP (half what it is at the time of this book's publication). The story also makes approving note of a new approach: HMOs.

HMOs

The HMO Act was passed in 1973.⁹ It authorized startup grants and loans and, more importantly, ensured access to the employer-based insurance market. It evolved from discussions that Paul Ellwood, MD, had in 1970 with the political leadership of the U.S. Department of Health, Education, and Welfare (which later became the Department of Health and Human Services).¹⁰ Ellwood had been personally close to Philip Lee, MD, Assistant Secretary for Health during the presidency of Johnson and participated in designing the Health Planning Act of 1966.

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

The main features of the HMO Act were the following:

- Grants and loans were available for the planning and startup phases of new HMOs as well as for service area expansions for existing HMOs.
- State laws that restricted the development of HMOs were overridden for HMOs that were federally qualified, as described below.
- Most important of all were the "dual-choice" provisions, which required employers with 25 or more employees that offered indemnity coverage to also offer two federally qualified HMOs, one of each type: (1) the closed panel or group or staff model and (2) the open panel or IPA/network model, if the plans made a formal request of the employer.[‡]

Some HMOs were reluctant to exercise the mandate, fearing that doing so would antagonize employers, who would in turn discourage employees from enrolling. However, the dual-choice mandates were used by most HMOs of the time to get in the door of employer groups to at least become established. Because the federal mandate only applied to one HMO of each type, opportunities to exercise the mandate became scarce. The federal dual-choice provision expired in 1995 and is no longer in effect.

The statute established a process under which HMOs could elect to be federally qualified. Plans had to satisfy a series of requirements, such as meeting minimum benefit

[‡]Types of HMOs are described in detail in Chapter 2.

package standards set forth in the Act, demonstrating that their provider networks were adequate, having a quality assurance system, meeting standards of financial stability, and having an enrollee grievance process. Some states emulated these requirements and adopted them for all state-licensed HMOs.

Obtaining federal qualification had always been at the discretion of the individual HMO, unlike state licensure, which is mandatory. Plans that requested federal qualification did so for four principal reasons:

- First, it represented the equivalent of a “Good House-keeping Seal of Approval” that was helpful in marketing.
- Second, the dual-choice requirements ensured access to the employer market.
- Third, the override of state laws—important in some states but not in others—applied only to federally qualified HMOs.
- Fourth, federal qualification was required for the receipt of federal grants and loans that were available during the early years of the Act.

Federal qualification no longer exists, but it was important when managed care was in its infancy and HMOs were struggling for inclusion in employment-based health benefits programs, which account for most private health coverage in the United States.

The HMO Act also contained provisions that, at the time, retarded HMO growth. This stemmed from it being a compromise in Congress between members having differing objectives. One camp was principally interested in fostering competition in the health care marketplace by promoting plans that incorporated incentives for providers to constrain costs. The second camp, while sharing the first objective, saw the HMO Act as a precursor to health reform and sought a vehicle to expand access to coverage for individuals who were without insurance or had limited benefits. Imposing requirements on HMOs but not on indemnity carriers, however, reduced the ability of HMOs to compete.

Of particular note were requirements with regard to the comprehensiveness of the benefit package as well as open enrollment and community rating. The open enrollment provision required that plans accept individuals and groups without regard to health status. The requirement for community rating of premiums (see Chapter 22 for a discussion of community rating) limited the ability of plans to relate premium levels to the health status of the individual enrollee or employer group. Both provisions represented laudable public policy goals; the problem was that they had the potential for making federally qualified HMOs noncompetitive because the same requirements did not apply to the traditional insurance plans against which they competed. This situation was largely corrected in the late 1970s with the enactment of amendments to the HMO Act that reduced some of the more onerous requirements. Other provisions of

the HMO Act have been revised over time as well, but there is no need to delve into them here.

Politically, several aspects of this history are of interest. First, although differences arose on specifics, the congressional support for legislation promoting HMO development was bipartisan. Also, there was no widespread state opposition to the override of restrictive state laws. In addition, most employers did not actively oppose the dual-choice requirements, although many disliked the federal government telling them to contract with HMOs.* Perhaps most interesting was the positive interaction between the public and the private sector, with government fostering HMO development both through its regulatory processes and also as a purchaser under its employee benefits programs. The federal government in effect promoted competition in health care financing and delivery by instituting a regulatory process.

HMOs focused on both managing utilization and changing the payment system to better align the goals of the HMO with those of providers. Group and staff model HMOs relied primarily on salaried doctors, thus eliminating FFS incentives to increase utilization. HMOs that contracted with private physicians rather than using its own physicians often used capitation in which the physician received a set monthly payment for each member enrolled in their panel of patients, regardless of how many services were provided. This approach was used principally for primary care physicians (PCPs), who, in addition either individually or collectively, had other financial incentives to control referrals to specialists. In this way, the FFS incentives to increase utilization were replaced with financial incentives to control utilization. Provider payment in managed health care is discussed in Chapter 5.

In all types of HMOs, members were required to go through their PCP in order to receive coverage for specialty or hospital care. HMOs routinely required precertification for all elective hospital admissions and actively monitored inpatient stays with the goal of reducing the amount of unnecessary utilization. By avoiding unnecessary admissions, increasing the use of outpatient surgery in place of inpatient stays for the same procedure, and reducing the average length of stay, HMOs wrung considerable unnecessary utilization out of the system.

As HMOs grew, hospitals that had provided discounts to BCBS plans now offered similar or superior discounts to HMOs in return for the HMOs’ directing patients their way. In markets in which hospitals competed, some hospitals feared losing business if they did not contract with HMOs. New forms of payment emerged such as per diem payments,

* If an employer offered an HMO but that HMO had not exercised the mandate, another HMO could do so. As a result, employers would sometimes ask their preferred HMO to go ahead and mandate them so as to avoid having yet another plan to offer.

capitation, and case rates, as described in Chapter 5. HMOs, with their narrower networks, were the most aggressive in using these new forms of payment, and negotiations between payers and hospitals became more sophisticated. A similar dynamic played out with other providers, including physicians. Structural aspects of payer networks, including HMOs, are discussed in Chapter 4.

The HMO Act was largely successful. During the 1970s and 1980s, HMOs grew and began displacing traditional health insurance plans. What was not anticipated when the original HMO Act was passed was that it was the IPA model HMOs that grew the fastest, having greater enrollment by the late 1980s than group and staff model HMOs, a difference that has increased over time. This dynamic accelerated as commercial insurers and BCBS plans acquired or created their own HMOs.

In 1982 Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which authorized the Medicare program to pay HMOs on a capitated basis provided that they met Medicare's participation requirements. The intent, largely achieved, was that these HMOs, by virtue of their ability to control health care costs, could offer more comprehensive benefits than Medicare. For example, these new Medicare HMOs typically offered lower amounts of cost-sharing than did traditional Medicare, as well as coverage of prescription drugs and selected preventive services that traditional Medicare didn't cover at all. However, there has been considerable debate over whether the ability of HMOs to offer additional benefits within the Medicare capitation amount was due to efficiencies or to their attracting disproportionately healthy patients.*

Also in 1982, the federal government addressed the other major entitlement program when it issued a waiver to the state of Arizona that allowed it to rely solely on capitation, and not have a FFS alternative, in their Medicaid program.¹¹ A number of states had previously made major efforts, in some cases under federal demonstration waivers, to foster managed care in their Medicaid programs, but had not done so for the entire program.

HMOs were increasingly accepted by consumers, particularly due to the added benefits such as coverage of preventive services, child and women's preventive health visits, and prescription drugs, none of which were typically covered by traditional insurance or BCBS plans of the time.[†] In response, the traditional carriers and BCBS plans began adding prevention and drug coverage to their non-HMO products.

* More recently, Medicare adopted "risk adjusters" to health plan payments that relate the payment amount to the estimated health status of a plan's individual enrollees.

† The comprehensive benefits, including preventive services that HMOs were required to provide, were unique at the time, but HMOs were not required to offer coverage of prescription drugs. They did so to attract enrollees.

Preferred Provider Organizations and Utilization Management

Other managed care developments also occurred during the 1970s and early 1980s. Of note was the evolution of preferred provider organizations (PPOs). PPOs are generally regarded as having originated in Denver, where in the early 1970s Samuel Jenkins, a vice president of the benefits consulting firm of The Martin E. Segal Co., negotiated discounts with hospitals on behalf of its Taft-Hartley trust fund clients.¹² Hospitals did so in return for the health plans' having lower cost sharing for its users, thereby attracting patients who would otherwise have used competitor hospitals that were not in the network.

The concept soon expanded to include physicians and other types of providers. The term PPO came about because hospitals and doctors who agreed to discounted fees were therefore considered to be "preferred." People covered under the PPO faced lower cost-sharing if they saw a PPO provider than an "out-of-network" provider. In most cases they did not need authorization from a PCP "gatekeeper" to access care from other providers. This was in contrast to the typical HMO in which there was no coverage for benefits for nonemergency services from health care providers who were not in the network (with the exception that services were covered if the enrollee was temporarily outside of the HMO's service area), and all specialty care required PCP authorization.

PPO providers also agreed to certain cost-control measures such as complying with precertification requirements for elective hospitalizations, meaning that the doctor must notify the PPO before any elective admission and the patient must meet clinical criteria in order for the stay to be covered. Precertification programs remain common today. Second-opinion programs were also instituted, which entailed requiring a patient to obtain a second opinion from a different surgeon for certain elective procedures before they would be covered. Second-opinion programs are rarely mandated anymore.

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

Finally, the utilization controls in HMOs contributed to major practice pattern changes, including shifting care from

the inpatient to the outpatient setting and shortening the length of hospital stays. Shortening length of stay was also strongly encouraged by legislation enacted in 1982 mandating that Medicare change its payment mechanism in the traditional program from cost-based to paying a fixed amount per admission within a given class or grouping of diagnoses. This, and other methods of paying hospitals, is discussed in Chapter 5.

■ **THE MID-1980s TO 2000: GROWTH, CONSOLIDATION, MATURATION, AND BACKLASH**

From the mid-1980s through the mid-1990s, managed health care experienced rapid growth, expanding into all health sectors as traditional indemnity health insurance declined, creating a new set of strains on the health care sector. At the same time, new organizational forms appeared, companies began to specialize in certain managed care activities, and the industry began to consolidate.

Managed Care Expands Rapidly

HMOs and PPOs grew rapidly, with commercial HMO enrollment increasing from 15.1 million in 1984 to 63 million in 1996 and 104.6 million in 1999.¹³ Initially PPOs lagged behind, but by the early 1990s enrollment was roughly equal, and by 1999 PPOs had 39% market share compared to HMOs at 28%. In the mid-1980s traditional indemnity insurance accounted for three-quarters of the commercial market; by the mid-1990s it was less than one-third of the market and would decline to single digits by 2000.¹⁴

A new product was also introduced during this period, the point of service (POS) plan, which combined elements of an HMO but with limited payment when out-of-network providers were used. Typically, a POS plan was like a PPO except that enrollees were required to select a single PCP (although they could change at any time), who authorized most referral services if the member wanted full coverage instead of the cost-sharing associated with out-of-network or nonauthorized services. Initially very popular, POS plans would stall out due to high costs and never exceeded HMO growth. These and other hybrid products make statistical compilations difficult, however. As new types of plans appeared, the taxonomy of health plan types both grew and blurred when the term managed care organization (MCO) came to represent HMOs, POS plans, PPOs, and multiple hybrid arrangements.*

Medicare and Medicaid also witnessed significant managed care growth. Medicare managed care (see Chapter 24) grew from 1.3 to 6.8 million between 1990 and 2000.¹⁵ During the same time period, Medicaid managed care (see

Chapter 25) grew from 2.3 million, or 10% of Medicaid beneficiaries, to 18.8 million, or 56%.¹⁶ These two programs would show a different pattern subsequently, however.

As is the case with dandelions, rapid growth is not always good. Some HMOs outstripped their ability to run the business, overburdening management and their IT systems. In those MCOs, service eroded and mistakes increased. More ominously, the industry began to see a few health plan failures or near-failures.

Consolidation Begins

Beginning in the early 1990s consolidation increasingly occurred among both MCOs and health systems. Entrepreneurs, sensing financial opportunities, began to acquire or start HMOs. Consolidation took place as those entrepreneurs cashed out their investments. In other cases, they acquired smaller plans in order to build a regional or national company, enhancing their ability to have their stocks publicly traded. Financially troubled MCOs made good acquisition targets, allowing larger plans to acquire market share without spending much money. Although uncommon, MCOs that were getting close to failure might be seized by a state insurance commissioner who would then either sell it to another company or liquidate it and divide the membership up among the remaining, healthier MCOs.

Smaller plans were at a disadvantage. Large employers with employees who are spread geographically increasingly favored national companies at the expense of local health plans. For smaller plans, the financial strain of having to upgrade computer systems continually and to adopt various new technologies mounted. In addition, unless they had a high concentration in a small market, smaller plans found themselves unable to negotiate the same discounts as larger competitors, exacerbating the financial strain. At some point many of them simply gave up and sought to be acquired.

Not all mergers and acquisitions were large companies acquiring small ones. It also occurred among large companies. To illustrate, Aetna acquired U.S. Healthcare in 1996, NYLcare in 1998, and Prudential's health insurance business in 1999, all companies with a large presence in the market.¹⁷ By 1999 the multistate firms, including Kaiser Permanente and the combined BCBS plans, accounted for three-quarters of national enrollment.

Another trend was health plans' converting from not-for-profit to for-profit status. United Health Care, the second largest health plan nationally with 34 million enrollees in 2011,¹⁸ started as a nonprofit health plan in Minnesota. WellPoint, the largest health plan with 34.2 million enrollees in 2011, originated when Blue Cross of California converted to for-profit status and subsequently acquired several other Blues plans, which also converted to for-profit status. The Blues plan in Indiana also converted, renaming itself Anthem, and subsequently acquired other Blues plans. These conversions required the creation and funding of foundations, commonly

*The acronym "MCO" is itself now in decline, including its use in this book.

known as “conversion foundations,” with the assets of the nonprofit plan, many of which are among the largest grant-giving foundations in their respective states. In 2004 Anthem combined with WellPoint, which effectively doubled the size of the merged for-profit BCBS plan. Today, the for-profit/not-for-profit split in the health payer sector is roughly 50-50, with the two largest nonprofit plans being Health Care Services Corporation, part of the Blues structure,* with 12.4 million enrollees, and Kaiser Permanente, with 8.8 million.¹⁹

Among physicians a slow but discernable movement away from solo practice and toward group practice also occurred. An increasing amount of consolidation among hospitals also occurred on a regional or local level in the 1990s, with over 900 mergers and acquisitions taking place during this period.²⁰ Hospital consolidation was commonly justified in terms of its potential to rationalize clinical and support systems.

A clearer impact, however, has been the increased market power to negotiate favorable payment terms when negotiating with commercial health plans, as is discussed in Chapters 4 and 5. Consolidation reached the point where a significant number of systems in effect had local hegemones, usually for most services but sometimes only in selected services that health plans needed to offer. By being willing to enter only into comprehensive contracts with health plans for all services that the system offered, not just those that were unique or dominant in the area, considerable leverage in negotiations was gained. The result of consolidation by both health plans and providers was competition became muted. Instead of competition among multiple buyers and sellers, what evolved was closer to what economists call “bilateral monopolies,” with both health plans and providers in local markets having little choice but to reach agreements with each other.

Integrated Delivery Systems Appear

Provider consolidation was not the only response to managed care. In many communities hospitals and physicians collaborated to form integrated delivery systems (IDSs), principally as vehicles for contracting with MCOs and with HMOs in particular. Types of IDSs are discussed in Chapter 2 and therefore are not described in detail here.

Most IDSs were created as rather loose organizations made up of a hospital and its medical staff, the most common of which was the physician-hospital organization (PHO). Most PHOs, and IDSs generally, allowed all physicians with admitting privileges at the hospital in question to participate rather than selecting the more efficient ones. Indeed, under the FFS method of payment, physicians with high utilization benefited the hospital financially and, thus, could not be excluded. Conversely, physicians were commonly required to

use the hospital for outpatient services (e.g., for laboratory tests) that might be obtained at lower cost elsewhere, also hurting the ability of the IDS to be price competitive. Most IDSs of the time suffered at least initially from organizational fragmentation, payment systems to individual doctors that were misaligned with the goals of the IDS, inadequate information systems, management that was inexperienced, and a lack of capital.

That would not stop many of them from wanting to “cut out the middleman” and become risk-bearing organizations themselves, a decision they would soon regret. Provider organizations lobbied hard to be allowed to accept risk and contract directly with Medicare. The Balanced Budget Act of 1997 (BBA 97)[†] allowed them to do so as provider-sponsored organizations (PSOs) if they met certain criteria (see Chapter 2). Large provider systems and physician practice management companies also accepted global capitation risk from HMOs. With a few exceptions they failed spectacularly, losing millions of dollars in a few short years. The federal waiver program for PSOs expired, although not until well after most had failed, and only a handful exist today as state-licensed entities that are also “grandfathered” by Medicare. Outside of California, the number of provider systems contracting to accept full risk for medical costs has dropped dramatically.

IDSs and provider systems often pursued another route to accepting full risk by forming a licensed HMO. The existence of a hospital or hospitals, physicians, and a licensed HMO and/or PPO under one corporate umbrella is called vertical integration, and for a while it was touted as the future of health care. Like so many futures confidently predicted by pundits, it mostly didn’t come to pass because provider-owned HMOs mostly failed for the same reasons PSOs failed. But not all of them failed. Some health systems managed their subsidiary HMOs just like a stand-alone HMO would be managed, and did quite well. HMOs started by large, well-run medical groups also did quite well and continue to do well today. The rest sold, gave away, or closed their HMOs.

Utilization Management Shifts Focus

The focus of utilization management, which had been almost exclusively on inpatient care, shifted to encompass the outpatient setting as well, including prescription drugs, diagnostics, and care by specialists. Perhaps even more important is that the high concentration of costs in a small number of patients with chronic conditions resulted in significantly more attention being paid to high-cost cases and on disease management, as discussed in Chapters 7 and 8. The health plan focus on these patients was new, although

* HCSC encompasses, among other companies, the BCBS plans in Illinois, Texas, Oklahoma, and New Mexico.

[†]The BBA 97 also reduced payments to Medicare HMOs, and many believe this is what led to a decline in Medicare HMO enrollment in the early 1990s.

the extent of concentration of costs (i.e., the proportion of costs represented by the most expensive patients) has remained relatively stable over the years.

The role of the PCP also changed. In a traditional HMO, that role was to manage a patient's medical care, including access to specialty care. This proved to be a mixed blessing for PCPs, who at times felt caught between pressures to reduce costs and the need to satisfy the desires of consumers, who may question whether the physician has their best interests at heart in light of a perceived financial incentive to limit access to services. The growth of PPOs as compared to HMOs also led to a shift away from PCP-based "gatekeeper" types of plans under which a referral had to be obtained to access nonemergency specialty care. However, most plans (including PPOs) continued to have lower copays if members received care from a PCP than if they received care from a specialist, thus retaining a primary care focus.

The focus of utilization management was also sharpened through the growth of carve-out companies, which are organizations that have specialized provider networks and are paid on a capitation or other basis for a specialized service. Among services that lend themselves to being "carved out" are pharmaceutical benefits (Chapter 11), mental and behavioral health (Chapter 12), disease management (Chapter 8), chiropractic, and dental. The carve-out companies market principally to payers and large self-insured employers because they are generally not licensed as insurers and thus are limited in their ability to assume risk. In recent years some of the large health plans that contracted for such specialty services have reintegrated them back into the health plan in part because the carved-out services made it difficult to coordinate services (e.g., between physical and mental health).

Industry Oversight Spreads

Health insurance and managed care have always been subject to oversight by state insurance departments and (usually) health departments. The 1990s saw the spread of new external quality oversight activities. Starting in 1991 the National Committee for Quality Assurance (NCQA; see Chapter 15) began to accredit HMOs. The NCQA had been launched by the HMO's trade associations in 1979 but became independent in 1990 with the majority of board seats being held by employer, union, and consumer representatives. Interestingly, this board structure was proposed by the Group Health Association of America, which represented closed-panel HMOs at the time. Many employers require or strongly encourage NCQA accreditation of the HMOs with which they contract, and accreditation came to replace federal qualification as the "seal of approval." NCQA, which initially focused only on HMOs, has evolved with the market to encompass, for example, managed behavioral health care organizations (MBHOs), PPOs,

physician credentialing verification organizations, primary care medical homes, and more. They will likely accredit new organizational types as they appear. This is also the case with the two other bodies that accredit managed health care plans as described in Chapter 15, URAC* and Accreditation Association for Ambulatory Health Care (AAAHC), also known as the Accreditation Association.

Performance measurement systems (report cards) also came about, the most prominent being what was once called the Health Plan Employer Data and Information Set (HEDIS®),† which was developed by the NCQA at the behest of several large employers and health plans. The HEDIS data set has evolved over time. A summary of the data set current at the time of publication is in Chapter 15, and the most current version is available on NCQA's website at www.ncqa.org. Other forms of report cards also appeared and continue to evolve as a result of the market demanding increasing levels of sophistication.

At the federal level, Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A decade earlier a provision in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allowed individuals who lost eligibility for group coverage to continue group coverage for up to 18 months, although they could be required to pay the full cost plus 2% themselves. The initial focus of HIPAA was to provide a means for individuals to have continued access to coverage once they exhausted their COBRA benefit. It was only partially successful because the coverage was usually expensive, particularly for a young person who could commonly obtain coverage as an individual for less than the group rate, which reflected all individuals in the group, including older ones. Furthermore, having to pay the full cost of coverage often occurred as a result of someone losing his or her job, resulting in diminished income. More important to the industry, however, were the standards that HIPAA created for privacy, security, and electronic transactions. The standards are discussed in Chapters 18, 23, and 29.

The Managed Care Backlash²¹

Anti-managed care sentiment, commonly referred to as the "managed care backlash," became a defining force in the industry. As a society, we expected managed care to reduce the escalation of health care costs but became enraged at how it did it. In retrospect, why that happened is obvious because managed health care was the only part of the health care sector that ever said "no." The emotional overlay accompanying health care outstrips almost any other aspect of

*URAC is its only name and is no longer an acronym. At one time it stood for Utilization Review Accreditation Commission.

†HEDIS now stands for the Healthcare Effectiveness Data and Information Set.

life. The health problem of a spouse or child causes feeling in ways that a house fire or losing one's employment does not.

The roots of the backlash date back to the early 1990s. Most employers heretofore had allowed their employees to choose between an HMO and a traditional health insurance plan but required them to pay a substantially higher payroll deduction if they chose the traditional health plan. However, to control costs, many employers began putting all or most employees into a single managed care plan without offering the choice of an indemnity plan.

One source of contention with some consumers, particularly those who had not chosen to be in an HMO, was the requirement that they obtain authorization from their PCP in order to access specialty care. Arguably, this provision both reduces costs and increases quality by assuring that PCPs are fully apprised of the care that their patients receive. Conversely, consumers under the care of a specialist who was not in the HMO's network were required to transition their care to an in-network doctor, which was resented by individuals who had not voluntarily chosen to be in an HMO.

But there was more to the backlash. As noted earlier, rapid growth increased the risk of problems arising. Some of the problems were largely irritants, such as mistakes in paperwork or claims processing in health plans with IT systems that were unable to handle the load. Rapid growth also affected the ability to manage the delivery system. Where clinically oriented decisions on coverage were once done with active involvement of medical managers, some rapidly growing health plans became increasingly bureaucratic and distant from their members and the providers, causing them to be seen as cold and heartless, and the errors and delays in payment as intentional.

Rapid growth also sometimes led to inconsistencies in coverage decisions. The public's perception that decisions regarding coverage of clinical care being made by "bean counters" or other faceless clerks may not have been fair or accurate in the opinion of managed care executives, but neither was it always without merit. Some HMOs, particularly those whose growth outstripped their ability to manage, did delegate decision-making authority to individuals who lacked adequate training or experience and were not supported by the comprehensive algorithms that are common today. Furthermore, some plans were accused of routinely and intentionally denying, or delaying payment of, certain types of claims, caving in only when the member appealed, a charge vigorously disputed by the plans. In the turbulence created by rapid growth, entrepreneurial for-profit plans, and ragged administrative functions, it is simply not possible to know how often this occurred, if it did. Regrettably, the managed care industry during this period did a poor job of self-policing and lost the confidence of large segments of the public. Other problems were emotional and not a threat to health, such as

denial of payment for care that was not medically necessary,* for example, an unnecessary diagnostic test. For doctors and patients who are unaccustomed to *any* denial of coverage, it was easy to interpret this as overzealous utilization management, and in some instances utilization management was, indeed, overzealous. How often this occurred is impossible to know, not only because of the turbulence of the era but also because standard practices were only first coming into being and there are no studies on which to rely.

Finally, while uncommon, some problems did represent potential threats to health, such as denial of authorization for payment of a covered benefit for truly necessary medical care or difficulties in accessing care, thereby causing subsequent health problems. In some cases the denial of coverage was due to its not being a covered benefit; certain experimental transplants would not be covered, for example. This occurred with indemnity health insurance as well, but it was not viewed the same way. The public expects low premiums but coverage for all medical-related services, including ones that might be judged unnecessary or outside of the scope of the defined benefits.

Furthermore, whether a service is medically necessary or simply a convenience can be a matter of interpretation or dispute. Is a prescription for a drug to help with erectile dysfunction medically necessary? What about a growth hormone for a child who is short because his or her parents are short, not from a hormonal deficiency? Should fertility treatments be unlimited? Some interventions may be medically necessary for some patients but not for others; for example, in a patient with droopy eyelids but no impairment of vision, surgery is primarily cosmetic, although it often progresses until it is medically necessary because vision is impaired. Issues such as these potentially arise with each new and expensive medical intervention.

The most damning of all accusations was that health plans were *deliberately* refusing to pay for necessary care in order to enrich executives and shareholders, a perception enhanced by media stories of multimillion-dollar compensation packages of senior executives. Putting aside the fact that financial incentives drive almost all aspects of health care to varying degrees, as discussed in Chapters 5 and 9, this charge was particularly pernicious for health plans, particularly given the increasing number of for-profit plans.

When there are enough instances of serious problems, they make good fodder for news using the well-proven reporting technique of "identifiable victim" stories in which actual names and faces are associated with anecdotes of poor care or benefits coverage problems. That problems portrayed in the news may or may not have been represented fairly from the viewpoint of the health plan was

*The term "medical necessity" in the context of benefits coverage is discussed in Chapters 7 and 20.

irrelevant. When added on top of disgruntlement caused by minor or upsetting (though not dangerous) irritants caused by health plan operations, the public is not liable to be sympathetic to managed care, particularly with the consensus that few insurance companies are loved.

Politicians were quick to jump on the bandwagon, especially during the debate over the Health Security Act of 1993, proposed by President Bill Clinton but not enacted. Many states passed “patient protection” legislation such as prudent layperson standards for emergency care, stronger appeal and grievance rights, and requirements for HMOs to contract with any provider willing to agree to the HMO’s contractual terms and conditions. (Whether the so-called “any willing provider” provision protects consumers is, at best, debatable.)

A good example of these laws was the prohibition of a “gag clause” in an HMO contract with a physician in which an HMO’s contract supposedly prevented a physician from telling a patient what their best medical options were. So prevalent was that belief that it made the cover of the January 22, 1996, edition of *Time* magazine, showing a surgeon being gagged with a surgical mask and the headline reading “What Your Doctor Can’t Tell You. An in-depth look at managed care—and one woman’s fight to survive.”^{*} The Government Accountability Office (GAO), a part of the U.S. Congress, investigated the practice at the request of then-Senators Trent Lott, Don Nickles, and Larry Craig and issued their report on August 29, 1997. The GAO reviewed 1,150 physician contracts from 529 HMOs and could not find a single instance of a gag clause or any reported court cases providing guidance on what constitutes a gag clause.²² This had no impact on public perception.

The popular press continued to run regular “HMO horror stories.” For example, the cover of the July 12, 1998, issue of *Time* magazine shows a photo of a stethoscope tied in a knot and a headline that read “What Your Health Plan Won’t Cover . . .” with the word *Won’t* in bold red letters. In another example, the November 8, 1999, cover of *Newsweek*

magazine featured a furious and anguished woman in a hospital gown, with the words “HMO Hell” displayed across the page. HMOs were disparaged in movies, cartoons, jokes on late-night TV, and even the comics sections of newspapers. The number of lawsuits against HMOs increased, many alleging interference in doctor’s decision making and practice of medicine. Many also alleged that capitation incented physicians to withhold necessary care, although this charge is refutable based on a series of research studies, as discussed in Chapter 5.

In a futile attempt to counter the rising tide of antipathy, the managed care industry kept trying to point out the good things it was doing for members such as coverage for preventive services and drugs, the absence of lifetime coverage limits, and coverage of highly expensive care, but there was nothing newsworthy about that. A reporter for a major newspaper, who did not himself contribute to the backlash, said at the time to one of this chapter’s authors, “We also don’t report safe airplane landings at La Guardia.”

HMOs expanded their networks and reduced how aggressively they undertook utilization management. Some HMOs eliminated the PCP “gatekeeper” requirement, thereby allowing members open access to any specialist, albeit at higher copayment levels than applied visits to their PCP. To borrow words used a decade earlier by President George H.W. Bush in his inaugural address, HMOs became “kinder and gentler,” with a concomitant increase in health care costs.

The managed care backlash eventually died down. The volume of HMO jokes and derogatory cartoons declined, news stories about coverage restrictions or withheld care became uncommon, and state and federal lawmakers moved on to other issues. But the HMO’s legacy of richer benefits, combined with the general loosening of medical management and broad access to providers, collided with other forces by the end of the millennium, and health care costs once again began to rise. As they rose, the cost of health benefits coverage rose as well, leading to an increase in the uninsured and greater cost-sharing for those with coverage.

^{*}The cover story was called “Medical Care: The Soul of an HMO” and was about a woman’s fight with a California HMO over coverage for a procedure known as autologous bone marrow transplantation for her disseminated breast cancer. Coverage authorization was denied because it was considered experimental and investigational by a majority decision of a committee of the HMO’s private oncologists. The story reported a considerable amount of communication, meetings, phone calls, medical visits, and so forth, as well as the salaries and bonuses of HMO executives. It does not mention a “gag clause” or any similar term.

The woman succeeded in getting the procedure covered and an arbitration panel awarded her family punitive damages from the HMO, one of a number of lawsuits that finally forced HMOs and insurers to pay for this procedure. Unfortunately, the woman died soon after the procedure was done. Rigorous scientific study of autologous bone marrow transplantation eventually found that it was worse than conventional treatment alone, and it is no longer performed. The story highlights another dynamic in the U.S. health system: the practice of medicine by judge and jury.

■ 2000 TO 2010: COSTS RISE AND COVERAGE DECLINES

HMO commercial enrollment market share peaked in 1999 at 104.6 million, or 28% of the market. It declined thereafter, reaching 78.5 million in 2004 (24% market share) and hovering between that and 76 million (21% market share) since then. POS plans, which had enjoyed 24% market share in 1999, also steadily declined, down to 8% by 2010. PPOs, on the other hand, gained market share—from 39% in 1999 up to 58% by 2010.²³ Commercial market shares are shown in **Figure 1-1**.

Medicare managed care enrollment reversed itself and declined to 5.3 million by 2003, largely as a result of a provision in the Balanced Budget Act of 1997 that reduced what

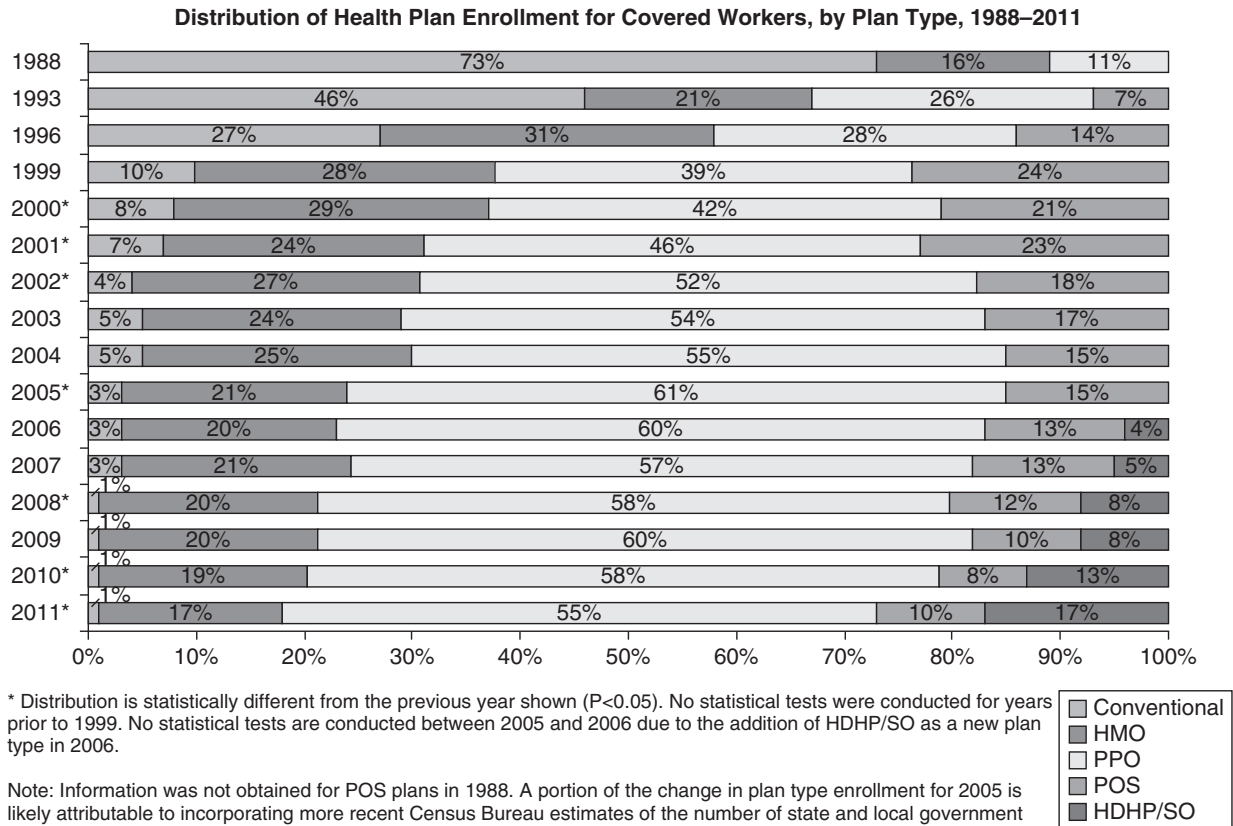


FIGURE 1-1 Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2011

Source: “Employer Health Benefits 2011 Annual Survey, (#8225),” p. 61. <http://ehbs.kff.org/pdf/2011/8225.pdf>. The Henry J. Kaiser Family, September 2011. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a nonprofit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

Medicare paid the health plans. That changed as a result of the enactment in 2001 of the Medicare Modernization Act (MMA). The MMA created the first major benefit expansion in Medicare since its initial passage in 1965: the Part D drug benefit. It also changed the name of the Medicare managed care program from Medicare + Choice to Medicare Advantage (MA) and changed substantially the methodology for payment to private Medicare plans (MA is discussed in detail in Chapter 24). New MA plans began enrolling members in 2004, reversing the decline and growing to over 12 million by 2011.²⁴ HMOs remain the largest form of MA plans, however, as illustrated in **Figure 1-2**. The principle effect of the MMA was to increase payment from several percentage points below what standard Medicare would have paid in the fee-for-service system to several points above. For 2010, it is estimated that MA plans will receive payments that are an average of 8.7 percent above what Medicare would have spent had the enrollees remained in standard Medicare.²⁵ The Patient Protection and Affordable Care Act (ACA), discussed later, reduces payment levels over a several-year period to closer to parity with the Medicare FFS program.

Medicaid had a much smoother trajectory. Cash-strapped states increasingly turned to private managed Medicaid organizations, and Medicaid plans grew from 18.8 million enrolled in 2000 to 26.9 million people by 2004, representing 61% of all Medicaid beneficiaries.²⁶ Managed Medicaid is discussed in detail in Chapter 25.

Health Care Costs Again Exceed Economic Growth

By 2003 national health expenditures as a percent of GDP had reached 15.9%, a huge increase since 1977, when they amounted to 8.6%. They rose slowly until 2007, reaching 16.2%, but as the economy declined the amount consumed by health care rose to 17.6% in 2009, only 2 years later. However, even before then, rising health care costs became a major political and economic issue because of the percent of government spending going to health care generally and Medicare and Medicaid specifically, the reduced affordability of private insurance, and the impact on the overall economy stemming from health care representing an ever increasing share of GDP.

The health economy is too complex to ascribe the persistent rise in health care to any single attribute or even a

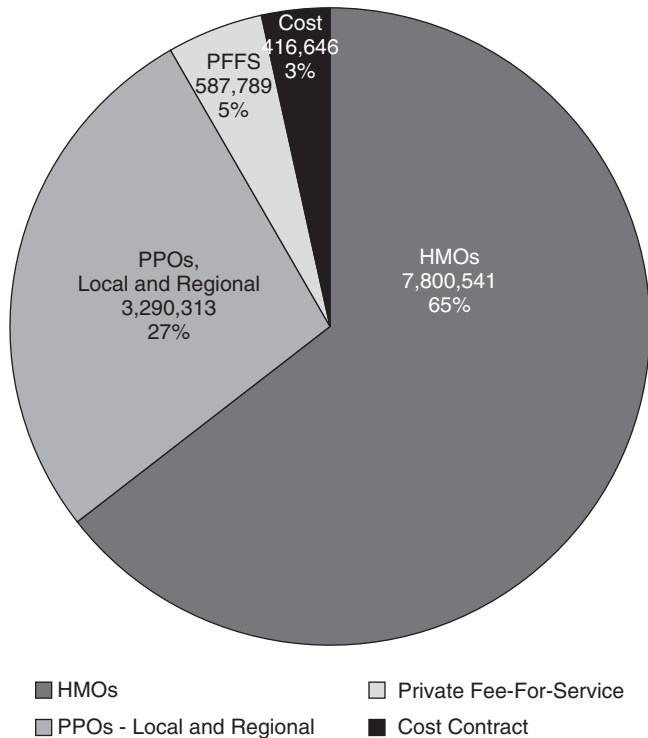


FIGURE 1-2 Medicare Advantage Enrollment, Totals and Percent February 2011

Source: Created by authors using CMS Monthly Enrollment by Plan Report as of March 3, 2011. www.cms.gov/MCRAAdvPartDEnrollData/EP/list.asp#TopOfPage.

constellation of attributes. At its most basic, health care costs are the results of price × volume (i.e., utilization). Price increases by large health systems and by drug and device manufacturers have been substantial in recent years, as discussed in Chapters 4, 5, and 11, respectively. Increased utilization of both existing and new technologies has also been a major factor, especially in the area of outpatient procedures, as discussed in Chapter 7. Increased demand for services has also played a major role. In some cases that demand is created by consumers, although how much of that results from direct-to-consumer advertising, billboards, news stories, and the like is difficult to determine. In any event, consumers have heightened expectations, appropriate or not. There is also compelling evidence that provider-induced demand occurs when physicians own or otherwise benefit financially from a technology that they can order such as imaging, as discussed in Chapters 4 and 7.

New and expensive technologies—often of largely unknown effectiveness—appear regularly. Because the third-party payment system insulates the provider and patient from costs, such new technologies are usually priced to deliver high margins. The practice of defensive medicine, due to the threat and reality of malpractice suits, contributes to cost increases, although various analyses indicate that it is

a minor factor in the aggregate. The aging of the population has an increasing role to play, one that is magnified by our ability to sustain life through more aggressive treatments.

Another factor, the authors believe, is that the managed care backlash discussed earlier led to health plans’ being more reticent to question the necessity of procedures or to intervene in any way that could have the appearance of practicing medicine. While hard to quantify, we are paying a price for telling managed health care to “back off.” One area where plans have continued to innovate and intervene is in the care of patients with significant chronic illnesses because these patients account for a disproportionately high percentage of medical expenses, as discussed further in Part III of this book.

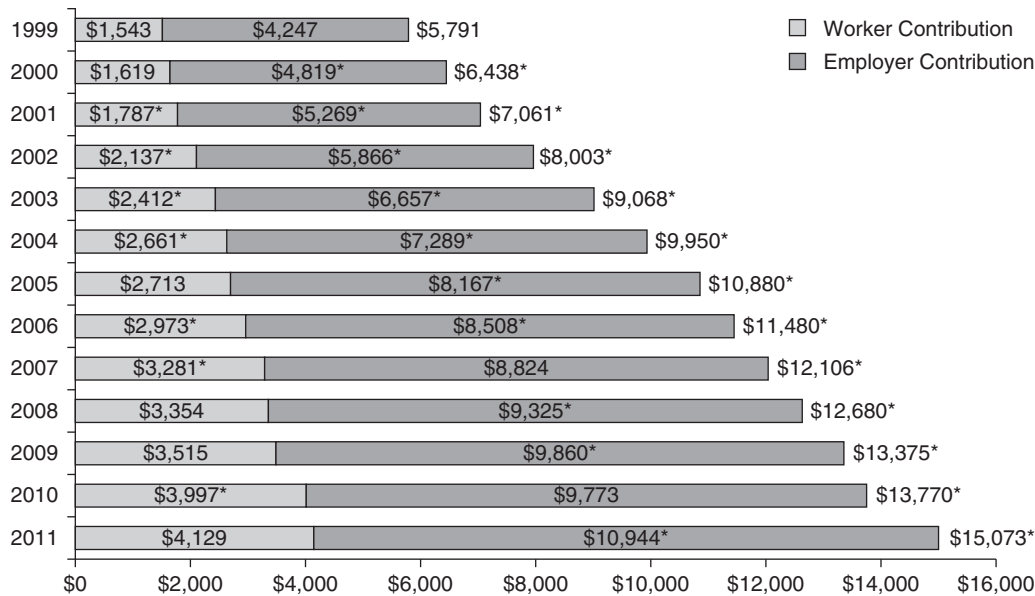
Finally, administrative costs in both provider organizations and health plans have always been a factor, something that will be ameliorated by electronic medical records and by the availability of information on health plans that will facilitate comparison shopping and the purchase of insurance in new ways, such as over the Internet, that will, in particular, reduce spending on insurance agent commissions. And as of 2011, the ACA placed limits on the percentage of the premium that can be used for sales, administration, governance, and profit. These factors are explored in Parts III and IV of this book.

Out-of-Pocket Spending Increases

As health care costs increase, so does the cost of insurance coverage. In the commercial market, employers continue to pay approximately 70% of the cost, with the remainder coming from payroll deductions, as illustrated in **Figure 1-3**.

Increasing payroll deductions were not the only way in which costs to consumers rose. In an effort to limit premium increases, employers also began to increase deductibles (the amount an individual must pay before any coverage goes into effect). By 2010 more than 17% of large firms and nearly half of all small firms had an annual deductible of \$1,000 or more.²⁷ Cost-sharing also increased for routine visits and prescriptions. Where once the typical office copayment was \$5, it is now \$20 for visits to a PCP and \$40 for visits to specialists. In addition, coverage of prescription drugs usually had a single copayment regardless of the drug in question, but drug benefits are now typically subject to complex tiered copayments, depending, for example, on whether the drug is generic or brand and whether or not it is on the formulary. This reversed the downward trend in the percentage of total costs paid out of pocket that was noted earlier in the chapter.

The middle of this decade also saw the appearance of consumer-directed health plans (CDHPs), also known as high-deductible health plans (HDHPs), which confer savings in federal income taxes. They take several forms, including health savings accounts (HSAs), health care payment accounts (HPAs), and HDHPs without such accounts. The



*Estimate is statistically different from estimate for the previous year shown (P<0.05).

FIGURE 1-3 Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999–2011

Source: “Employer Health Benefits 2011 Annual Survey, (#8225),” p.69. <http://ehbs.kff.org/pdf/2011/8225.pdf>. The Henry J. Kaiser Family, September 2011. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a nonprofit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

main benefit to the enrollee is savings in both taxes and premiums. HDHPs and CDHPs, which are more fully discussed in Chapter 2, have deductibles equal to or higher than \$1,200 for singles and \$2,400 for families in 2011.*

Embedded in CDHPs is the notion that consumer choice and accountability need to be enhanced. The initial focus was to provide members with better information regarding quality and cost of care along with information to help them understand their health care. However, they are controversial because, whatever the resulting savings, people with high incomes disproportionately benefit, and persons with high medical expenses, notably those with chronic conditions, face higher out-of-pocket expenses, often year after year.

Managed care has not ceded the field to sole reliance upon the use of cost-sharing combined with improved information to assist in decision making. For example, pay-for-performance programs have been implemented to align financial incentives to providers with quality goals, as discussed in Chapter 5. Also, the concept of value-based insurance design (VBID; also referred to as value-based insurance benefits design, or VBIBD) has come to the fore. As discussed in Chapter 7, it refers to lowering the economic barriers to access created by cost-sharing for treatment of people with selected chronic conditions, for example, eliminating any copayments for certain drugs

for a member with congestive heart failure in order to increase compliance and avoid clinical deterioration resulting in hospitalization.

Increasing Numbers of Uninsured

The maximum level of cost-sharing is 100%, which is what the uninsured face, and their numbers have increased throughout the decade as a result of many factors, including fewer small employers offering coverage, the decline in the number of manufacturing jobs, an increase in the number of individuals who declined employer-based coverage because of increasing payroll deductions, and people unable to get coverage because of medical conditions or increasingly high premiums. The percentage of Americans without health insurance rose from 14% in 1999 to 17% in 2009.²⁸ This was a specific problem addressed by Congress in 2010.

The Patient Protection and Affordable Care Act

The ACA was signed into law on March 23, 2010. It is nearly a thousand pages long and is the most sweeping health care law since 1965 when Medicare and Medicaid were enacted. It affects the entire health care sector, but its greatest impact is on the payer industry and on access to health benefits coverage for all Americans. Because the ACA is so sweeping, it is not possible to cover it all within the confines of this book. Provisions of the ACA that are important to understand are addressed throughout this book, and Chapter 30 is specifically focused on it.

* Federal tax law prescribes that the deductible be at least at these levels in order to qualify for tax benefits, with the actual dollar amount being set by the Treasury Department each year.

Some provisions of the new law were already in effect at the time of publication, although the major coverage expansions will not occur until 2014. However, passage of the ACA does not mean that Congress will have no more to say. Members of Congress are divided on the topic of health reform, and changes in the balance of power are likely to have an impact on the ACA just as it has had on all major laws since our nation was founded. It is, therefore, possible that aspects of the ACA described in this book will be changed significantly by the time you read it. Consequently, the reader will need to keep up to date through other sources. There is no shortage of opinions about the ACA, and a great deal of information and misinformation exists everywhere one turns. The Kaiser Family Foundation (not related to Kaiser Permanente), in particular, is an excellent source for unbiased information that is easily accessible. It can be accessed by navigating to www/kff.org and clicking on the appropriate links, or directly by navigating to <http://healthreform.kff.org> (current at the time of publication). Access to that and other useful links are also available by going to www.kongstvedt.com and choosing “Useful Links” or directly by navigating to www.kongstvedt.com/useful_urls.html.

■ CONCLUSION

Managed health care has made significant contributions to the delivery system, many positive but also some negative. HMOs, for example, were the source of considerable evidence that many procedures that were once performed on an inpatient basis only could be performed in an outpatient setting with favorable outcomes. HMOs also showed that inpatient length of stay could be reduced without deleterious effect. These changes over time became the norm of practice. Likewise, their early emphasis on prevention is laudable and is now the law. Of note, the early HMOs were the source of considerable research on quality of care, far more so than the unmanaged fee-for-service medical system. This research contributed to policymakers and large employers becoming comfortable contracting with them. Furthermore, it helped accelerate the overall broadening of quality measurement and management beyond the hospital setting to which it had been confined earlier.

Related to that, the initial and ongoing public and regulatory mistrust of managed health care and health insurers in general led to the creation of standard measures such as HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey (both are discussed in Chapters 14 and 15). CAHPS began as a consumer satisfaction survey solely for Medicare HMOs but has become more widely used. The focus on quality and the increasing use of measurement also led to the concept of value-based payment such as pay-for-performance and other models, described in Chapter 5. A related concept is data transparency for consumers, allowing individuals to see the performance

scores for both providers and health plans, something once considered a “black box.”

Despite these contributions, managed health care plans have often been described as managing cost rather than care. To the extent that this accusation is valid, some of the blame must be ascribed to large employers to which the health plans are highly responsive, as they must be. Employers facing erosion in their own financial condition due to rising health care costs demand that health plans do something about it, but then seek plans with large networks and focus only minimally on health care processes. As a result, many large employers look to constrain costs by increasing enrollee cost-sharing and having employees pay a larger share of the premium. Recently, however, a few large employers with high local concentrations of employees have been looking to narrower networks once again.

On a negative note, the managed care industry did not respond well to the backlash. It did not at the time make sufficient efforts at self-regulation, although many health plans were supportive of the NCQA. But at first, it handled the backlash primarily as a public relations problem. In opposing legislation introduced to address the backlash, it also opposed what most people viewed as sensible legislation, notably the layperson emergency rule and the right to appeal coverage denials to an independent body, resulting in the impression that it was putting money ahead of patient care. This impression was exacerbated by ongoing examples of spectacular wealth derived by entrepreneurs when they sold their HMOs to the public or to a larger company.

One other disappointment was the result of managed health care’s response to the market. Many, including the authors of this chapter, historically promoted competition among health plans as a means to restrain the ever-rising health care costs by using different systems of care that would compete on quality as well as costs. However, this potential has gone substantially unrealized as PPOs, as well as open-panel or IPA types of HMOs, have dominated the market as health plans sought very broad networks in order to be attractive to consumers. The effect is that, in most markets, the overlap in participating providers among health plans is so great that the provider network becomes a matter of lesser importance to the enrollee.

Rising costs meant rising levels of uninsured, and was the impetus behind the passage of the ACA in 2010, the most sweeping health care legislation since Medicare and Medicaid. Whether or not the ACA will accomplish its intended goals is unknown, but it is fair to say that its primary and initial focus is on access to health insurance, and not on restraining costs. As this book goes to press, the issue of cost containment is again being featured prominently in the media. Unfortunately, everyone has his or her “silver bullet”; for example, if we could only solve the malpractice problem *or* if we could only get patients to pay

higher cost-sharing so that they would be more inclined to seek efficiencies in services delivery *or* if provider payment could be changed to avoid the incentives in fee-for-service to deliver more, and more expensive, care *or* fill-in-your-favorite-solution-here. Each of these has a place as part of a comprehensive strategy, as do other approaches such as promoting wellness and addressing the problem of untested, questionable, expensive, and marginally effective technologies. Little addressed, however, is the significant problem of each part of the health care system seeking to protect its turf and income, commonly resorting to political processes to do so.

Is the American public prepared to tackle the cost issues? Health plans can only do so much on their own. In the short run they must respond to the desires of their customers—individuals, employers, or unions—who themselves may neither be willing to address the issues nor be well informed. They must also respond to state and federal regulators, a requirement rapidly evolving under the ACA, and those regulators also may be unwilling or unable to address the issues. Managed health care has and will continue to make important contributions but it is not the panacea some had hoped for. However, panacea or not, we are not likely to return to a world of unmanaged and unexamined health care. Managed health care, like the entire health sector and our society overall, will continue to evolve.

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