CHAPTER 1

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

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LEARNING OBJECTIVES

- Understand how health insurance and managed care came into being
- Understand the forces that have shaped health insurance and managed care in the past
- Understand the major obstacles to managed care historically
- Understand the major forces shaping health insurance and managed care today

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INTRODUCTION

Health insurance and managed health care are inventions of the 20th century. For a long time, they were not considered to be "insurance" but rather "prepaid health care"—i.e., a way of accessing and paying for healthcare services rather than protecting against financial losses. From its inception, this set of arrangements has been in a never-ending state of change and turbulence. This chapter explores the historical roots and evolutionary forces that have resulted in today's system. The dates mentioned in this chapter are specific for such events as the passage of laws and the establishment of an organization but only approximate for trends.

1910 TO THE MID-1940s: THE EARLY YEARS

The years before World War II saw the development of two models of providing and paying for health care besides the patient simply paying for the service. The first were early forms of what is now called a health maintenance organization (HMO), though this term was not actually coined until the early 1970s. Such a model relied on an organization that was capitated (i.e., that charged a preset amount per member, or per enrollee, per month) and that provided services directly through its facilities and personnel, thereby combining the functions of financing and delivery. The second was the early Blue Cross and Blue Shield plans, which paid for services provided by contracted community doctors and hospitals, which also regularly served patients not covered by these plans.

Prepaid Medical Group Practices

The Western Clinic in Tacoma, Washington, is often 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 (capitation) payment of $0.50 per member per month.[1] The program, which was offered to lumber mill owners and employees, served to assure the clinic a flow of patients and revenues.

1929 was a remarkable year in the history of health plans. 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 suspension of his license to practice. Some 20 years later, however, he was vindicated by a favorable out-of-court settlement resulting from an antitrust suit against the county and state medical societies.

Also in 1929, Doctors Donald Ross and H. Clifford Loos established a comprehensive prepaid medical plan for workers at the Los Angeles Department of Water and Power. It covered physician and hospital services. From the outset, it focused on prevention and health maintenance.[3] For that reason, some consider it to be the first real HMO. Doctors Ross and Loos were also expelled from their local medical society for their actions.

Despite opposition from the American Medical Association (AMA), prepaid group practice formation continued for many reasons, including employers' need to attract and retain employees, providers' efforts to secure steady incomes, consumers' quest for improved and affordable health care, and even efforts by the housing lending agency to reduce the number of foreclosures caused by health-related personal bankruptcies. Two prominent examples from this time period are the Kaiser Foundation Health Plan in California and the Group Health Association of Washington, D.C., which subsequently became part of the Kaiser system. They, too, were opposed by local medical societies.

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 Owners' 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.

* 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.

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

1929 also saw the origins of Blue Cross (BC), when Baylor Hospital in Texas agreed to provide some 1500 teachers with prepaid inpatient care at its hospital. The program was later expanded to include participation by other employers and hospitals. State hospital associations elsewhere created similar plans. Each was independent of the others, as they are today. In 1939 the American Hospital Association (AHA) adopted the Blue Cross emblem and created common standards. The symbol and was subsequently transferred to the Blue Cross Association (BCA) in the early 1960s, and the AHA ended its involvement with the BCA a decade after that.

The first type of organization that would become the basis for Blue Shield (BS) plans elsewhere, though it was not itself a BS plan, originated in the Pacific Northwest in 1939, when lumber and mining companies sought to provide medical care for their injured workers. Those companies entered into agreements with physicians, who were paid a monthly fee through a service bureau—a type of organization that would evolve into the service plans found at the core of most BC and BS plans today (see the *Health Benefits Coverage and Types of Health Plans* chapter).[4]

Beyond establishing the first appearance of the organizational type that would be adopted by BS plans, the appearance of the first *actual* BS plan is somewhat difficult to establish due to differences among sources. One source states that the BS logo first appeared in Buffalo, New York, as early as 1930.[5] Most sources state that the first official BS plan was the California Physicians' Service plan created by the California Medical Association in 1939.[6-8] In all events, other state medical societies soon emulated this model. Like the BC plans, the new BS plans were independent of both each other and the BC plans in their respective states, but were nevertheless associated with them.

The earliest BC and BS plans were also considered to offer prepayment for health care. However, unlike the prepaid group practices and cooperatives, BC and BS plans relied on providers in independent private practices rather than employing physicians or contracting with a dedicated medical group. To define the payment terms between a BC plan and a hospital, hospitals created cost-based charge lists, the forerunners of today's hospital chargemaster, and BS plans

developed payment rates for defined procedures based on profiles (i.e., statistical distributions of what physicians charged).*

Initially, BC plans provided coverage only for hospital-associated care (including skilled nursing home care), while BS plans provided coverage for physician and related professional services (such as physical and speech therapy). Over time, many BC plans merged with their local BS counterparts to become joint BCBS plans, although some remain separate even now. Most of these BC and BS plans were statewide and did not compete with each other, albeit with some exceptions; for example, Pennsylvania and New York both have several BC and/or BS plans. From the beginning, the BC and BS plans, collectively referred to as the "Blues," operated independently from each other. In the past few decades, however, a significant number of BC and BS plans have merged.

Historically, in only a few cases did the Blues plans compete with each other; rather, they mostly respected each other's geographic boundaries and cooperated in selling to multistate accounts. More recently, they have begun to enter each other's territory and now do compete, although only one may use the BC and/or BS logo in a defined territory.

Hospitals and physicians retained control of the various Blues plans until the 1970s. In that decade, these plans changed to either a community governance model with a self-perpetuating nonprofit board not controlled by the providers or a structure under which the board was elected by the insureds (i.e., a mutual insurer). In recent decades, many Blues have converted to publicly owned for-profit corporations.

Importantly, the formation of the various BC and BS plans in the midst of the Great Depression, as well as the emergence of many prepaid group practices, was not driven by consumers' demands for coverage or entrepreneurs' seeking to establish a business but rather by providers' desire to protect their incomes.

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

In the United States, World War II produced 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

* The chargemaster is the price list a hospital creates for all services for which it charges. The Current Procedural Terminology (CPT) charge codes, which define the procedures for which doctors and other providers bill, were created by the AMA in 1966; the AMA has maintained this list ever since. The chargemaster, CPT codes, and fee schedules are addressed in the *Provider Payment* chapter.

attract scarce workers. However, the act did allow workers to avoid taxation on employer contributions to certain employee benefits, including health benefits. Also, health benefits were not constrained by wage controls. The twin effects of favorable tax treatment and the exemption from wage controls fueled the growth of commercial health insurance as well as greater enrollment in the Blues. Before World War II, only 10% of employed individuals had health benefits from any source, but by 1955 nearly 70% did, although many of these plans covered only inpatient care.

HMO formation and enrollment growth also continued, albeit at a slower pace. Newly formed plans included (1) the Health Insurance Plan (HIP) of Greater New York, created in 1944 at the behest of New York City, which wanted coverage for its employees,* and (2) Group Health Cooperative of Puget Sound (GHC), organized by 400 Seattle families, each of whom contributed $100. GHC remains a consumer cooperative to this day.

The McCarran-Ferguson Act, passed in 1945, exempted insurance companies from federal regulation. As a result, regulation of health insurance devolved to the states. The McCarran-Ferguson Act also provided limited antitrust immunity for certain activities such as pooling of claims data for pricing purposes. In the absence of federal authority, the regulation of insurance companies and premium levels became the responsibility of the states, which varied widely in their level of oversight.

In the 1950s, as a competitive reaction to group practice–based HMOs, HMOs evolved that resemble today's independent practice association (IPA) model. In an IPA, an HMO contracts either directly with physicians in independent practice or indirectly with an organization that in turn contracts with these physicians. In contrast, early HMOs had their own dedicated medical staffs. The basic IPA structure was created in 1954 to compete with Kaiser when the San Joaquin County Medical Society in California formed the San Joaquin Medical Foundation. The Foundation paid physicians using a relative value fee schedule, which it established; heard consumer grievances against physicians; and monitored quality of care. This organization became licensed by the state to accept enrollee premiums and, like other HMOs, performed the insurance function, but under a different regulatory structure than standard insurance. In most states, HMOs—then and now—have faced different regulatory requirements than insurance companies.

* HIP subsequently merged with New York–based Group Health Incorporated (GHI) to form EmblemHealth.

THE MID-1960S TO MID-1970S: THE ONSET OF HEALTHCARE COST INFLATION

In the early 1960s, President John F. Kennedy proposed what eventually became Part A of Medicare. This program, which was financed through taxes on earned income (i.e., not investment income) similar to Social Security, was intended to cover mostly hospital services. The Republicans in Congress then proposed to cover physician and related professional services as well, in what became Part B of Medicare. This program 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 domestic goals, including covering persons age 65 and older. In 1965, Congress established two landmark entitlement programs: Medicare for the elderly (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act) for selected low-income populations. In 1972, the Medicare Act was amended to cover selected disabled workers (but not their dependents), mostly those who had permanent disabilities starting 29 months after the onset of the disability. The benefits and provider payment structures of Medicare of the time were similar to those of BC and BS plans, with separate benefits for hospitalization paid through Medicare Part A and physician services paid through Medicare Part B. This system remains in place for traditional (i.e., for beneficiaries not enrolled in capitated health plans, as described below) Medicare today.

The combination of Medicare, Medicaid, private insurance, and medical care (other federal programs, for example) resulted in the majority of health care being paid for by third-party payers. The third-party payment system severs the financial link between the provider of the service and the patient—a disconnect that fostered increases in both the price of services and their utilization.

These developments marked the beginning of a long history of healthcare cost inflation, attributable to the combination of the third-party payment system, advances in medical science, and increased demand by consumers. To illustrate, in 1960, 55.9% of all healthcare costs nationally were paid by the patient, but that percentage has declined steadily, leveling out at 11–12% by 2012.[9] At the same time, national health expenditures as a percentage of the gross domestic product (GDP) rose from 5.2% in 1960 to 5.8% in 1965, the year before Medicare was implemented; it reached 7.4% in 1970 and 17.2% in 2012.[10]

Nevertheless, isolated examples of early attempts to control costs beyond seeking provider discounts can be cited:

- 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 average.[11]

- 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 volunteered to participate, starting with the Sacramento Foundation for Medical Care.*
- The 1972 Social Security Amendments authorized professional standards review organizations (PSROs) to review the appropriateness of care provided to Medicare and Medicaid beneficiaries. In time, PSROs became known as peer review organizations (PROs), and then as quality review organizations (QIOs). QIOs continue to oversee clinical services on behalf of the federal and many state Medicaid agencies today.
- In the 1970s, a handful of large corporations initiated precertification and concurrent review for inpatient care, 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.[12]

Although unrelated to costs, and initially only peripherally related to health benefits plans or 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 on retirement benefits, it also addressed employers' pretax employee health benefits. Among other things, ERISA established appeal rights for denial of benefits, requirements for handling benefits claims, and various other new regulations for employers that self-funded their benefits plans, topics that are addressed further in the chapters titled *Health Benefits Coverage and Types of Health Plans* and *Sales, Governance, and Administration*.

The problem of healthcare costs rising faster than costs in the economy as a whole, thereby consuming an ever larger share of the GDP, increasingly became a subject of public discussion in the 1970s. Throughout the 1960s and into the early 1970s, HMOs played only a modest role in the financing and delivery of health care, although they were a significant presence in a few communities such

* Precertification, also known as prior authorization, requires that health plan approval be obtained for a service to be covered; concurrent review entails requiring approval to continue the service, such as determining whether the hospitalized patient still needs to be in the hospital.

as in the Seattle area and parts of California. In 1970, the total number of HMOs ranged between 30 and 40, with 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 percentage of GDP rose from 7.4% to 8.6%. The acceleration in healthcare cost increases, driven in large measure by a high percentage of the medical dollar being paid for by insurance, private or public (notably Medicare and Medicaid), rather than by the patient became widely discussed and led to the next major development: managed health 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; and widespread adoption of utilization management by health insurers.

HMOs

In 1973, the U.S. Congress passed the HMO Act.[13] This legislation evolved from discussions that Paul Ellwood, MD, had in 1970 with the leadership of the U.S. Department of Health, Education, and Welfare (which later became the Department of Health and Human Services)[14] as the Richard M. Nixon administration sought ways to address the rising costs of the Medicare program.

These discussions resulted in a proposal to allow Medicare beneficiaries the option of enrolling in HMOs, which were to be capitated by the Medicare program—a change that was not actually adopted until 1982. However, the legislative debate resulted in the enactment of the HMO Act of 1973. The desire to foster prepaid HMOs reflected the view that third-party (insurance) payments on a fee-for-service basis gave providers incentives to increase utilization and fees. Ellwood is also widely credited with coining the term "health maintenance organization" at that time as a substitute for "prepaid group practice" because it had greater cachet.

The HMO Act included three important features:

- It made federal grants and loan guarantees available for planning, starting, and/or expanding HMOs.
- The federal legislation superseded state laws that restricted the development of HMOs.
- The "dual choice" provision required employers with 25 or more employees that offered indemnity coverage to also offer at least one group or

staff model and one IPA-model federally qualified HMO, but only if the HMOs formally requested to be offered. (Types of HMOs are described in detail in the *Health Benefits Coverage and Types of Health Plans* chapter.)

The dual choice mandate was used by HMOs of the time to get in the door of employer groups to become established. Because the federal mandate applied to only one HMO of each type, opportunities to exercise the mandate were limited, although employers were free to offer as many HMOs as they liked. The dual choice requirement expired in 1995. Nevertheless, even more than the other provisions, the dual choice mandate is widely regarded as providing a major boost to the HMO industry at a time when it was in its infancy.

To be federally qualified, HMOs had to satisfy a series of requirements such as meeting minimum benefit package standards, demonstrating that their provider networks were adequate, having a quality assurance system, meeting standards of financial stability, and having an enrollee grievance process. Many states ultimately adopted these requirements for all state-licensed HMOs.

Unlike a state license to operate, federal qualification as an HMO was voluntary. However, many HMOs became federally qualified to avail themselves of the HMO Act's features and because such qualification represented a type of "Good Housekeeping Seal of Approval" that employers and consumers would trust. Although federal qualification no longer exists, it was an important step when managed care was in its infancy and HMOs were struggling for inclusion in employment-based health benefits programs. The expiration of federal qualification inspired the creation of health plan accreditation as a replacement "seal of approval."

The HMO Act imposed requirements on HMOs that were not levied on indemnity health insurers. Examples of requirements that applied to HMOs but not to standard insurance included the following:

- A level of comprehensiveness of benefits, including little cost sharing* and the coverage of preventive services, that exceeded what insurers at the time typically offered
- The holding of an annual open enrollment period during which HMOs had to enroll individuals and groups without regard to health status
- Prohibiting the use of an individual's health status in setting premiums

* Cost sharing is the amount of a covered benefit that is paid by the enrollee and has three major forms: (1) deductibles, an amount paid before any benefits are paid; (2) coinsurance, the percentage of the bill above any deductible for which the patient is responsible; and (3) copayments, a fixed dollar amount for which the patient is liable for a particular service or product (e.g., prescription drugs). Cost sharing and other benefits design issues are discussed in the *Health Benefits Coverage and Types of Health Plans* chapter.

These provisions applied only to federally qualified HMOs, making them potentially uncompetitive compared to traditional health insurance plans. The HMO Act was amended in the late 1970s to lessen this problem.

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 the rapid growth in IPA-model HMOs. By the late 1980s, enrollment in IPAs exceeded enrollment in 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, most of which followed the IPA model.

The original concept of using federally qualified HMOs in the Medicare program finally came into being in 1982 with the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA). The intent, which was largely achieved, was that the ability of HMOs to control healthcare costs would encourage these plans to offer more comprehensive benefits than traditional Medicare. For example, the new Medicare HMOs typically required less cost sharing than did traditional Medicare and offered coverage of prescription drugs and selected preventive. However, considerable debate arose as to whether HMOs were able to offer the additional benefits within the Medicare capitation amount because they were more efficient or because of favorable selection (they attracted a disproportionate share of healthy patients).

Also in 1982, the federal government granted a waiver to the state of Arizona that allowed it to rely solely on capitation, and not offer a fee-for-service alternative, in the state's Medicaid program.[15] 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 statewide. That practice is now widespread. (Medicare managed care is discussed in the *Medicare and Medicaid* chapter.)

HMOs were increasingly accepted by consumers, due not only to their lower premiums and reduced cost sharing but also because of their more extensive benefits, such as coverage of preventive services, children's and women's preventive health visits, and prescription drugs, most of which were not covered by the typical traditional insurance or BCBS plans of the time. In contrast, HMOs were not required to offer coverage of prescription drugs but most did so to attract enrollees. In response to the competition from HMOs, many traditional insurance carriers and BCBS plans began to add coverage of prescription drugs and preventive services to their non-HMO products.

Preferred Provider Organizations and Utilization Management

The growth of HMOs led to the development of another type of managed care plan: preferred provider organizations (PPOs). PPOs are generally regarded as

having originated in Denver, Colorado. In that city in the early 1970s, Samuel Jenkins, a vice president of Martin E. Segal Company, a benefits consulting firm, negotiated discounts with hospitals on behalf of its self-insured clients.[16] Hospitals granted discounts in return for enrollees having lower cost sharing if they used the contracting hospitals, thereby attracting patients away from competitor hospitals.

The concept soon expanded to include physicians and other types of providers. The term PPO arose because hospitals and doctors who agreed to discounted fees were considered to be "preferred" by the health insurance plan. People covered under the PPO faced lower cost sharing if they saw a PPO provider rather than a noncontracted, or "out of network," provider.

Unlike most HMO coverage at the time, PPO benefits did not require authorization from the patient's primary care physician (PCP) to access care from specialists or other providers. PPO providers also agreed to certain cost-control measures. For example, they agreed to comply with precertification requirements for elective hospitalizations, meaning that for the service to be covered, the doctor had to obtain approval before ordering any elective hospital admission or selected high-cost outpatient service. Precertification programs remain common today. Second-opinion programs were also instituted, whereby patients were required to obtain a second opinion from a different surgeon for selected elective procedures to be covered. Second-opinion programs are rarely mandated today.

Another development in indemnity insurance, which occurred mostly during the 1980s, was the widespread adoption of large case management—that is, the coordination of services for patients with expensive conditions requiring treatment by multiple providers, but did not coordinate with each other. Examples include patients who had experienced accidents, cancer cases, patients with multiple chronic illnesses causing functional limitations, and very low-birth-weight infants.* Utilization review, the encouragement of second opinions, and large case management all entailed at times questioning physicians' medical judgments, something that had been rare outside of the HMO setting. These activities were crude by today's standards of medical management but represented a radically new role for insurance companies in managing the cost of health care. They sometimes met with ferocious opposition in the medical community, with physicians' complaining that the programs constituted "cookbook medicine" or interfered with the "right" of the doctor to make unfettered medical decisions.

* The lack of coordination of medical services remains a persistent problem in the healthcare system—one that managed care was supposed to alleviate, which it has done to a limited extent.

Utilization management by HMOs contributed to practice pattern changes, including shifting care from the inpatient setting to the outpatient setting and shortening the length of hospital stays. Shortening length of stay was also strongly encouraged by legislation enacted in 1982 under which the Medicare payment system no longer paid a hospital's actual cost (albeit with upper limits on payments that affected particularly expensive hospitals) but instead paid a fixed amount per admission within a given class or grouping of diagnoses—an approach that some private health plans also adopted.

THE MID-1980s TO THE LATE 1990s: GROWTH AND CONSOLIDATION

From the mid-1980s through the mid-1990s, managed care grew rapidly while traditional indemnity health insurance declined, creating new strains on the U.S. healthcare system. At the same time, new forms of managed care plans and provider organizations appeared, and the industry matured and consolidated. That growth was not trouble free, however.

Managed Care Expands Rapidly

HMOs grew rapidly, growing from 3 million in 1970 to over 80 million in 1999.[17] Initially, PPOs lagged behind, but by the early 1990s enrollment was roughly equal: By 1999, PPOs had a 39% market share, compared to HMOs at 28%. This growth came at the expense of traditional indemnity health insurance. In the mid-1980s, traditional indemnity insurance accounted for three-fourths of the commercial market; by the mid-1990s, it represented less than one-third of the market and that share would decline to single digits by 2000.[18]

A new product was also introduced during this period—the point-of-service (POS) plan. In a POS plan, members had HMO-like coverage with little cost sharing if they both used the HMO network and accessed care through their PCP; unlike in a "pure" HMO, however, they still had coverage if they chose to get non-emergency care from out-of-network providers but were subject to higher cost sharing if they did. Members typically had to designate a PCP, who approved any referral to specialists and other providers (e.g., physical therapists) except in emergency situations. Though they were initially very popular, POS plans would stall out due to their high costs. These and other hybrid products make statistical compilations related to managed care trends difficult. As new types of plans appeared, the taxonomy of health plan types expanded and lines were blurred,

with the term managed care organization (MCO) eventually coming to represent HMOs, POS plans, PPOs, and a myriad of hybrid arrangements. Medicare and Medicaid also witnessed significant managed care growth. Medicare enrollment in capitated plans—that is, plans such as HMOs that set premiums and assumed the risk for the delivery of services—grew from 1.3 million to 6.8 million between 1990 and 2000.[19] During that same time period, Medicaid managed care grew from 2.3 million (10% of Medicaid beneficiaries) to 18.8 million (56%).[20]

As is the case with dandelions, rapid growth is not always good. Some MCOs outstripped their ability to run their businesses, as evidenced by overburdened management and poorly functioning information systems, resulting at times in poor service and mistakes. In their quest to continually drive down utilization, some HMOs became increasingly aggressive. More ominously, the industry began to see health plan failures or near-failures.

Consolidation Begins

Beginning in the early 1990s, the pace of consolidation quickened among both MCOs and health systems. Entrepreneurs, sensing financial opportunities, acquired or started HMOs with the goal of profiting by later selling the HMO to a larger company. In other cases, they acquired smaller plans to build a regional or national company, enhancing their ability to issue stock. However, not all plans could be sold at a profit, and in some cases troubled MCOs made good acquisition targets, allowing larger plans to acquire market share at minimal expense. Although uncommon, MCOs that were getting close to failure might be seized by a state insurance commissioner, who would then either sell the MCO to another company or liquidate it and divide the membership among the remaining MCOs.

As the market consolidated, smaller plans were at a disadvantage. Large employers with employees who are spread out geographically favored national companies at the expense of local health plans. For smaller plans, the financial strain of having to upgrade computer systems continually and 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. At some point, many simply gave up and sought to be acquired.

Not all mergers and acquisitions were large companies acquiring small ones. This trend also affected large companies. By 1999, multistate firms, including Kaiser Permanente and the combined Blue Cross and Blue Shield plans, accounted for three-fourths of U.S. enrollment in managed care plans.

Another trend saw health plans convert from not-for-profit to for-profit status. For example, the largest publicly traded managed care company in the

United States is currently United Health Group, the corporate parent of United Health Care, which started as a nonprofit health plan in Minnesota. Likewise, US Health Care, a Pennsylvania HMO company, converted from nonprofit to for-profit status and was eventually acquired by Aetna.

Many years earlier, the actual Blue Cross and Blue Shield trademarks had become the property of the Blue Cross Blue Shield Association (BCBSA) representing member plans. The BCBSA created standards that member plans had to meet to license the Blues trademarks, including a prohibition on being a for-profit company.

Breaking with that tradition, in 1994 the BCBSA voted to allow member plans to convert to for-profit status.[21] The reasons leading to this shift were financial. Since their beginnings, Blues plans had been tax-exempt as "social welfare plans," but the Tax Reform Act of 1986 revoked that exemption because Congress determined that Blues plans were selling insurance in an open market.* At the same time, BCBS plans were losing market share and were not able to keep up with changing operational demands because of a lack of capital—something that publicly traded companies were able to obtain through the sale of stock. Converting to for-profit status would therefore have little impact on the Blues' tax status, but would allow them to access capital to improve their competitive position.

Blue Cross of California was the first to convert to for-profit status under its corporate name WellPoint. The Indiana Blues soon followed under the corporate name Anthem. Other Blues plans also converted and were subsequently acquired by WellPoint or Anthem, and in 2004 Anthem merged with WellPoint to create what is now the second largest commercial health plan company in the United States. These conversions required the creation and funding of foundations, commonly known as "conversion foundations," holding the assets of the nonprofit plan. Many of these entities are among the largest grant-giving foundations in their respective states.

Consolidation also took place among health plans that were not publicly traded, albeit at a slower rate. By the end of 2013, among the top 10 largest health plans, four were non-investor owned:[22]

- Kaiser Foundation Group, with group model HMOs in nine regions, is the third largest.
- Health Care Services Corporation (Health Care Services Corporation), the largest mutual health insurer (i.e., owned by its enrollees), which has BCBS plans in five states, is the sixth largest.

* The Tax Reform Act did, however, allow for some special tax treatments for nonprofit BCBS plans acting as "insurers of last resort."

- Highmark Group, with BCBS plans in three states, is the eighth largest.
- EmblemHealth in New York, a company formed through a combination of Group Health, Inc. (GHI) and the Health Insurance Plan of Greater New York,[23] is the 10th largest.

Provider Consolidation and the Appearance of Integrated Delivery Systems

Among physicians, there was a slow but discernable movement away from solo practice and toward group practice in the 1990s. There was nothing slow, however, about the amount of hospital consolidation that began on a regional or local level in the 1990s. According to a study conducted by the Rand Corporation, more than 900 mergers and acquisitions occurred during the 1990s, and by 2003 90% of the metropolitan areas in the country were considered "highly concentrated" in terms of healthcare systems.[24] Hospital and health system mergers and consolidations continued after that study was published.

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 that enables such entities to negotiate favorable payment terms with commercial health plans (see the chapters titled *The Provider Network* and *Provider Payment*). Consolidation also meant that health plans could no longer selectively contract with individual hospitals. Systems with "must have" hospitals or even "must have" services, such as very specialized cardiac or oncology services, could refuse to enter into contracts that did not cover all of the services that the health system offered. As a result hospital prices to private payers rose by a total of 20% nationally between 1994 and 2001 and by 42% between 2001 and 2008.[25]

Consolidation, both among health plans and providers, diminished competition to the point of bringing into question the viability of the competitive model in the delivery of healthcare services. Instead of competition among multiple buyers and sellers, what evolved was closer to what economists call "bilateral monopolies," with health plans and providers in local markets having little choice but to reach agreements with each other.

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 payers and with HMOs in particular. Types of IDSs are discussed in the chapter titled *The Provider Network*.

Most IDSs were rather loose organizations consisting of individual hospitals and their respective medical staff, the most common of which was the

physician–hospital organization (PHO). Most PHOs and IDSs required that health plans contract with all physicians with admitting privileges at the hospital that met the HMO's credentialing criteria, rather than with only the more efficient ones. Indeed, under the fee-for-service method of payment, physicians with high utilization benefited the hospital financially. Also, physicians were commonly required to use the hospital for outpatient services (e.g., for laboratory tests) that might be obtained at lower cost elsewhere.

Some hospitals chose to purchase PCP practices to increase their negotiating leverage with HMOs, although they did little to integrate those practices. 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, inexperienced managers, and a lack of capital. In addition, hospitals that had purchased physician practices quickly discovered that physician productivity declined once those doctors were receiving a steady income, albeit with incentives to enhance volume, and no longer felt the financial pressures of independent practice. In most cases, those practices became a financial drag on the hospital and were eventually spun off at a net loss.

At the time, none of these factors stopped many of the systems from seeking 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)* permitted them to do so as provider-sponsored organizations (PSOs) if they met certain criteria. With a few exceptions, these efforts failed and the PSOs lost millions of dollars in a few short years. The federal waiver program for PSOs expired, although not until most had failed, and only a handful exist today.†

Some IDSs and provider systems pursued another route to accepting full risk by forming a licensed commercial HMO. The existence of hospitals, physicians, and a licensed HMO and/or PPO under one corporate umbrella is called vertical integration. For a while, this model was touted as the future of health care. Like so many future scenarios confidently predicted by pundits, it mostly did not come to pass. Instead, provider-owned HMOs mostly failed for the same reasons PSOs failed—namely, the system was conflicted by, on one hand, the need to promote volume for patients under the fee-for-service system and, on the other

* The BBA 97 also reduced payments to Medicare HMOs, which many believe led to a decline in Medicare HMO enrollment in the early 1990s.

† The acronym "PSO" is now used by Medicare to mean "patient safety organization."

hand, the desire to be efficient in the delivery of services to capitated patients. Not all vertically integrated organizations failed, however. Those that did succeed typically managed their subsidiary HMOs as stand-alone entities. Many HMOs started by large, well-run medical groups also did well and continue to do so today. The rest were sold, given away, or ceased to operate.

Many large provider systems and physician practice management companies nevertheless accepted global capitation risk from HMOs, entailing their receiving a percentage of premium revenues (e.g., 80%) in return for being at risk for most covered medical services. Most of those also failed, with the exception of California, the number of provider systems contracting to accept full risk for medical costs dropped dramatically.

Utilization Management Shifts Focus

As hospital utilization became constrained, the focus of utilization management shifted to encompass the outpatient setting including prescription drugs, diagnostics (which have become increasingly expensive with the development of new technologies), and care by specialists. Perhaps even more important was the recognition of the large expense incurred by a small number of patients with chronic, and often multiple, conditions, resulting in significantly more attention being paid to these high-cost patients.

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 "gatekeeper" function was 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 might question whether the physician had their best interests at heart in light of a perceived financial incentive to limit access to services. Likewise, patients might resent the administrative hassle entailed in having to get the PCP's referral. The growth of PPOs as compared to HMOs also led to a shift away from PCP-based "gatekeeper" types of plans. However, most plans (including PPOs) continued to set lower copayments for services delivered by a PCP rather than by a specialist, thereby retaining a primary care focus.

The focus of utilization management was also sharpened through the growth of carve-out companies—that is, organizations that have specialized provider networks and are paid on a capitation or other basis for a specific service. Among services that lend themselves to being "carved out" are prescription drug benefits as well as behavioral health, chiropractic, and dental services. The carve-out companies market principally to health plans and large self-insured employers since

they are generally not licensed as insurers or HMOs and, therefore, 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, typically because the carved-out services made it difficult to coordinate services and/or because the plans had grown large enough to manage the services in question themselves.

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) began to accredit HMOs. This organization was launched by the HMOs' trade associations in 1979 but became independent in 1990. The majority of its board seats are now held by representatives of employers, unions, and consumers rather than health plans. 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 to serve their employees, and accreditation came to replace federal qualification as the "seal of approval." NCQA, which initially accredited only HMOs, has evolved with the market to encompass a wide range of plan types and services and continues to broaden its programs. This is also the case with the two other bodies that accredit managed health care plans: URAC* and the Accreditation Association for Ambulatory Health Care, also known as the Accreditation Association (AAAHC). (For further discussion of these organizations, see the *Utilization Management, Quality Management, and Accreditation* chapter.)

Performance measurement systems (report cards) were also introduced, with the most prominent being the Healthcare Effectiveness Data and Information Set (HEDIS).† HEDIS was initially developed by the NCQA at the behest of several large employers and health plans. Medicare and many states now require HEDIS reporting by plans, and the federal government's involvement in this effort has grown. Other forms of report cards appeared as well and continue to evolve as a result of the market demanding increasing levels of sophistication and accountability.

* 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 Healthcare Effectiveness and Data Information Set.

At the federal level, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. Among other provisions, it limits the ability of health plans to (1) deny insurance based on health status to individuals who were previously insured for 18 months or more and (2) exclude coverage of preexisting conditions (i.e., medical conditions that exist at the time coverage is first obtained). A decade earlier, a provision in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allowed individuals who lost eligibility for employment-based group coverage to continue that coverage for up to 18 months, although they could be required to pay the full cost plus 2% themselves.*

HIPAA was designed in part to provide a means for individuals to have continued access to coverage once they exhausted their COBRA benefits. COBRA had only limited success because the coverage was usually expensive. In particular, a young person could often obtain coverage as an individual for less than the group rate, which was priced to include all individuals in the group, including older ones, who on average consume more services. Furthermore, the cost of COBRA coverage was often unaffordable because the loss of employer coverage often occurred as a result of someone becoming unemployed. However, until guaranteed issue requirements went into effect in 2014 under the 2010 Patient Protection and Affordable Care Act (ACA), continued coverage under HIPAA was the only way a person with serious medical problems could purchase insurance. Even fewer people took advantage of the HIPAA coverage provisions than was the case with COBRA. More important to the industry were the standards that HIPAA created for privacy, security, and electronic transactions.

THE LATE 1990s TO THE EARLY 2000s: THE MANAGED CARE BACKLASH[26]

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

* Coverage also had to be offered to select other groups, such as persons who lose coverage as a result of being newly widowed or divorced as well as children who lose dependent status. These individuals are eligible for coverage for as long as 36 months.

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. At that time, most employers allowed their employees to choose between an HMO and a traditional health insurance plan, although their payroll deduction was typically higher if they chose the traditional health plan. Eventually, to control costs, many employers began putting 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 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. Also, 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—another burden resented by individuals who had not voluntarily chosen to be in an HMO.

There was more to the backlash, however. As noted earlier, rapid managed care 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 information systems that were unable to handle the expanded load. Rapid growth also affected the ability to manage the delivery system. Where clinically oriented decisions on coverage were once made with active involvement of medical managers, some rapidly growing health plans became increasingly bureaucratic and distant from both their members and their providers, causing the plans to be seen as cold and heartless and the errors, and delays in payment as intentional.

Sometimes, rapid growth led to inconsistent coverage decisions. The public's perception that decisions regarding coverage of clinical care were 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, especially 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 claims, caving in only when the member appealed—an accusation disputed by the plans. 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 or an additional day in the hospital. For doctors and patients who are unaccustomed to *any* denial of coverage, it was easy to interpret these actions as overzealous utilization management, which, indeed, they were in some instances. How often such denials occurred is impossible to know, not only because of the turbulence of the era but also because standardized medical 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 difficulties in accessing care or denial of authorization for payment for truly necessary medical care, thereby causing subsequent health problems. Sometimes, the denial was due to the care not being a covered benefit, as in the case of certain experimental procedures. This occurred with indemnity health insurance as well but was not viewed the same way. The public expects low premiums but demands coverage for all medically related services, including ones that might be judged unnecessary or outside of the scope of the defined benefits; the public also expects access to any provider an individual chooses to consult.

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 growth hormone therapy for a child who is short because her or his parents are short, not as a result of a hormonal deficiency? Should fertility treatments be unlimited? Some interventions may be medically necessary for some patients but not others. For example, in a patient with droopy eye lids but no impairment of vision, surgery is primarily cosmetic, although it often progresses until it is medically necessary because vision is impaired. The most damning of all accusations was that health plans were *deliberately* refusing to pay for necessary care 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, this charge was particularly pernicious for health plans in light of the increasing number of for-profit plans.

Serious, even if isolated, problems 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 problems accessing coverage. Whether the problems portrayed were fair was irrelevant. When added to the disgruntlement caused by minor or upsetting (although not dangerous) irritants caused by health plan operations, the public was not liable to be sympathetic to managed care, particularly given the backdrop 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, legislation proposed by President

Bill Clinton but not enacted. Many states passed "patient protection" laws specifying 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 "any willing provider" provision protects consumers is debatable, and not all states passed laws to require it. Most states did pass laws requiring prudent layperson standards and appeal rights, which later were incorporated into the Affordable Care Act.

Another example of a "patient protection" law that arose out of the managed care backlash was the prohibition of "gag clauses" in HMO contracts with physicians in which an HMO's contract supposedly prevented a physician from informing patients of their best medical options. So prevalent was the belief that such constraints existed that it made the cover of the January 22, 1996, edition of *Time* magazine; that cover showed a surgeon being gagged with a surgical mask and a 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), an agency of the U.S. Congress, investigated the practice at the request of then-Senators Lott, Nickles, and Craig and issued its report on August 29, 1997. The GAO reviewed 1150 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.[27] This report had no impact on public perception, however. Laws prohibiting "gag clauses" became widespread, and years later this element was also incorporated into the Affordable Care Act.

The popular press continued to run regular "HMO horror stories." For example, the cover of the July 12, 1998, issue of *Time* magazine showed a photo of stethoscope

* Prudent layperson emergency standards require coverage when an enrollee who is not medically trained visits an emergency room in a situation that is not a true emergency, but the enrollee could reasonably have thought it might be (e.g., chest pains caused by a indigestion but that could have been symptomatic of a heart attack).

† The cover story was called "Medical Care: The Soul of an HMO" and dealt with a woman's dispute with a California HMO over coverage for a procedure for her disseminated breast cancer, known as autologous bone marrow transplantation. Authorization was denied because the treatment was considered experimental and investigational by 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.

The woman sued and succeeded in getting the procedure covered, and an arbitration panel awarded her family punitive damages from the HMO. This case was only one of a number of lawsuits that finally forced HMOs and insurers to pay for this procedure. The woman died soon after the procedure was performed. Rigorous scientific study of autologous bone marrow transplantation eventually found that that the procedure 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.

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 image. HMOs were disparaged in movies, cartoons, jokes on late night TV, and even the comic sections of newspapers. The number of lawsuits against HMOs increased, with many alleging interference in doctors' decision making. Many also alleged that capitation incented physicians to withhold necessary care, although this charge lacked empirical support, as shown in a series of research studies discussed in the *Provider Payment* chapter.

In a futile attempt to counter the rising tide of antipathy, the managed care industry repeatedly tried to point out the good things it did 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 Airport."

In response to public complaints, HMOs expanded their networks and reduced how aggressively they undertook utilization management. Some eliminated the PCP "gatekeeper" requirement, thereby allowing members open access to any specialist, albeit at higher copayment levels than applied visits to the PCP. To borrow words used a decade earlier by President George H. W. Bush in his inaugural address, HMOs became "kinder and gentler," and healthcare costs began once again to rise faster than general inflation or growth in the GDP.

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. However, the HMOs' 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 the return of healthcare cost inflation resulted in the cost of health benefits rising as well, leading to an increase in the number of uninsured and greater cost sharing for those with coverage.

2000 TO 2010: HMOs AND POS PLANS SHRINK, COSTS GROW, AND COVERAGE ERODES

Economic growth was steady early in the first decade of the new millennium but slowed late in the decade, with GDP actually declining in 2008 and 2009 as the United States entered the "Great Recession." During that decade, healthcare

costs rose seemingly inexorably, with national health expenditures increasing from 13.8% to 17.9% of GDP.[28] The increases reflected a variety of factors, including the decline in HMO market share, looser utilization management, the adoption of new and expensive (and often unproven) technologies, increased consumer expectations, direct-to-consumer marketing, the provider community's quest for new sources of income, and the practice of defensive medicine by providers who feared malpractice suits. During this decade, many employers responded to the tight economic situations by increasing deductibles and other forms of cost sharing and, in some cases, dropping employee coverage altogether rather than by promoting more tightly managed care. For some people in the individual market, health insurance became unaffordable, and healthcare costs strained many family budgets.

The Decline of HMO and POS Market Share

HMOs' share of the commercial enrollment market stood at 29% in 2000. It declined thereafter, reaching 25% in 2004, and then hovered around 20–21% from 2005 to 2009, before dropping further to 13% by 2014. POS plans, which had enjoyed a 24% market share in 1999, also steadily declined but then leveled out at around 10% by 2009. PPOs, in contrast, gained market share—growing from 39% in 1999 to 61% by 2005, before declining slightly after 2009.[29]

Medicare managed care enrollment also reversed itself, declining from 6.4 million in 1999 to 4.6 million by 2003.[30] This trend occurred not because of the managed care backlash but rather largely as a result of a provision in the Balanced Budget Act of 1997 that reduced what Medicare paid the health plans, resulting in those plans' reducing benefits, which in turn made them less attractive to Medicare beneficiaries. However, the situation changed with the enactment in 2003 of the Medicare Modernization Act (MMA), which increased payment to managed care plans from below the estimated cost of delivering services in the fee-for-service system to an amount that in years leading to the ACA exceeded 10% of what Medicare would have spent had enrollees remained in the fee-for-service system. The MMA also changed the name of the Medicare managed care program from Medicare+Choice to Medicare Advantage (MA) and promoted new forms of managed care that were more like traditional insurance policies than like HMOs. In turn, enrollment grew to 11 million in 2010 and to 15.5 million in 2014, representing 29% of all Medicare beneficiaries.[31] HMOs remain the largest form of MA plan, however, accounting for approximately 78% of all MA enrollees.

The MMA also created the first major benefit expansion in Medicare since the passage of the initial legislation in 1965: the Part D drug benefit. Interestingly, rather than paying for the benefit on a fee-for-service basis as in traditional

Medicare, the government capitated private companies, some of which specialized in processing drug claims (such as ExpressScripts and CVS Caremark) and were known as pharmacy benefits managers (PBMs); others were insurers or HMOs that had the same capability. This method of administering the Part D benefit was intended to provide beneficiaries with a choice among competing plans. Existing MA managed care plans were also required to offer at least one plan that incorporated the drug benefit. Providing the new drug coverage benefit entirely through private companies was highly controversial, in part because it had never been done before. It was also regarded by some at the time as unworkable. Nevertheless, Medicare Part D's benefit has survived, albeit with administrative problems at the beginning.

Growth in the Medicaid managed care program followed a smoother trajectory. Cash-strapped states increasingly turned to private managed care plans, whose Medicaid enrollment grew from 18.8 million in 2000 to 42.2 million in 2011, representing 74% of all Medicaid beneficiaries.[32] Expanded Medicaid eligibility under the ACA is also increasing the number of people covered under managed Medicaid plans.

The Toll of Rising Healthcare Costs[33]

The toll of rising healthcare costs on the economy in the first decade of the new millennium was considerable. In the commercial group market, employers continued to pay approximately 70% of the cost, with the remainder coming from payroll deductions.* However, with healthcare costs rising so rapidly, employees' absolute dollar contribution rose considerably. Rising costs, along with a weakened economy, resulted in the percentage of Americans without health insurance rising from 14% in 1999 to 17% in 2009.[34] One reason for this trend was that some businesses, particularly small ones, found coverage to be unaffordable. Another reason was greater number of employees declining employer-sponsored coverage so as to avoid the payroll deduction. Although statistics vary, bankruptcies resulting from medical debt during this period were also widely estimated to account for more than half of all personal bankruptcies; whether this will change under the ACA is unknown at this time.

Increasing payroll deductions were not the only way in which costs to consumers rose. In an effort to limit premium increases, employers also increased cost sharing, especially the size of deductibles (i.e., the amount an individual must pay

* Larger employers typically contribute more than do smaller employers.

out-of-pocket before benefits are paid). By 2013, more than 28% of large firms and 58% of all small firms had an annual deductible of $1000 or more, whereas $250 was typical in the prior decade. Cost sharing also increased for both routine visits and prescriptions. Whereas once the typical office copayment was $5, it now averaged $23 for visits to a PCP and $35 for visits to specialists. In addition, coverage of prescription drugs once required a single copayment no matter which drug was purchased; in the 2000s, this benefit typically became subject to complex tiered copayments, with lower copayments required for generic drugs (where available) and higher levels of copayments required for brand-name drugs. Cost sharing in benefits design is addressed in more detail in the *Health Benefits Coverage and Types of Health Plans* chapter, and management of the drug benefit is discussed in the *Utilization Management, Quality Management, and Accreditation* chapter.

The middle of this decade also saw the appearance of high-deductible health plans (HDHPs) and related consumer-directed health plans (CDHPs), both of which confer savings in federal income taxes. The main benefit to the enrollee in such a plan is savings in taxes and premiums. The amount of the minimum deductible required to qualify for favorable tax treatment has varied over the years but amounted to $3300 per year in 2014 for individuals and $6550 for a families. Embedded in CDHPs is the notion that consumer choice and accountability should 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, such plans are controversial because, whatever the resulting savings, people with high incomes disproportionately gain from tax savings because they are in higher tax brackets, whereas persons with high medical expenses—notably those individuals with chronic conditions—face higher out-of-pocket expenses, often year after year.

2010 TO PRESENT: THE ACA AND THE ONGOING EVOLUTION OF THE U.S. HEALTHCARE MARKET

The Patient Protection and Affordable Care Act (ACA, also known as "Obamacare"), signed into law on March 23, 2010, is the most sweeping healthcare legislation passed in the United States since 1965, when Medicare and Medicaid were enacted. It is also the most important legislative development in the health insurance and managed care industry to occur in this millennium. It is not, however, the only development of note.

The Patient Protection and Affordable Care Act

At nearly 1000 pages in length, the ACA affects the entire healthcare sector, but its two areas of greatest impact are on the health plan industry and on access to coverage. Because the ACA is so sweeping, it is not possible to cover it all within the confines of this text, much less in this chapter. The specific provisions of the ACA that are most important to understand are addressed throughout this text. The ACA affects health insurance and managed healthcare plans in several ways, with many of the provisions being phased in over time. Particularly important provisions include the following:

- Health benefits plans are required to cover dependents until age 26.
- Health insurance and HMO coverage is required to be "guaranteed issue," meaning health plans cannot deny coverage or vary premiums based on preexisting conditions or health status. Premiums can, however, reflect geographic location, age (within prescribed limitations), and tobacco use. Guaranteed issue is confined to an annual limited period of "open enrollment" when individuals and groups can apply for coverage.*
- Health insurance "exchanges" are established by states, and by the federal government if a state either fails or refuses to do so. Such exchanges are largely computer-based systems where individuals and small businesses can purchase insurance from private health plans.
- All Americans not otherwise covered are required to purchase an approved private insurance policy or pay a penalty, with some exceptions, the most important being individuals deemed to be subject to undue hardship as a result. Individuals and families with incomes less than 400% of the poverty level who are not eligible for Medicaid can qualify for premium subsidies. Ironically, the idea of requiring that Americans obtain health insurance—which was vehemently opposed by most Republicans as an infringement on personal liberties—is commonly attributed to the Heritage Foundation, a conservative think-tank; the Foundation proposed this concept in 1989, and it was supported by many Republicans at the time.
- The Medicaid program was expanded to cover all families and individuals with incomes of less than 133% of the federally established poverty line, with the federal government paying states 100% of the cost of

* The ACA requires that open enrollment periods be no less than one month per year, which is typically a month in the fall for coverage beginning the following January 1. Nevertheless, states are free to require open enrollment on a more frequent basis. No state, however, requires continuous open enrollment—that is, enrollment throughout the year.

covering the expansion population in 2014–2016, declining gradually to 90% in 2020 and thereafter.

The ACA, which passed narrowly, was the subject of a hard-fought battle prior to its enactment and remains controversial. Lawsuits pertaining to its legitimacy reached the U.S. Supreme Court after being litigated in lower courts. The two main Supreme Court decisions, both reached on 5 to 4 votes, were that the mandate that individuals obtain health insurance was constitutional but not the requirement that states expand their Medicaid programs so dramatically as a condition for receiving *any* federal matching funding. According to the Kaiser Family Foundation, "As of June 2014, 27 states, including [the District of Columbia], were expanding Medicaid, three states were actively debating the issue, and 21 states were not moving forward." The nonparticipating states can elect to expand their Medicaid programs at any time.

In a later case heard by the U.S. Supreme Court, the court ruled that the ACA's provision that all benefits plans must cover contraception did not apply to certain types of closely held corporations that have religious objections to covering such care. At the time of publication, there were other outstanding legal cases.

Taken as a whole, the provisions of the ACA had the effect of expanding the number of individuals in both Medicaid and private healthcare plans—one reason why the health insurance industry was generally supportive of the legislation. Nevertheless, the ACA continues to face challenges, both political and legal, and the law may even be amended by the time this text reaches readers; for example, as of this writing, the U.S. Supreme Court has agreed to hear a case involving the federal government's ability to provide subsidies to eligible individuals who purchase coverage through an exchange operated by the federal government rather than a state, but it has not yet made a ruling.

The Healthcare Market Continues to Evolve

As significant as the ACA is, it is not the only change in the U.S. healthcare system in recent years. The four examples given here are in many ways reminiscent of events of 15 or more years ago.

Accountable Care Organizations and Provider–Payer Joint Initiatives

The ACA authorizes the creation of accountable care organizations (ACOs), which entails a provider entity assuming responsibility for the total costs of the Medicare

Part A and Part B benefits for a defined population of beneficiaries in the traditional Medicare fee-for-service program, with that entity sharing in any savings or losses relative to a target. The target is intended to approximate what would have been spent absent the ACO agreement. What is unique about this arrangement is that Medicare beneficiaries are attributed to the ACO based on past utilization patterns rather than their choosing to enroll. Those beneficiaries can use any Medicare participating provider, unlike in an HMO. In fact, the ACO is essentially invisible to the beneficiary. The ACO program was included in the ACA as a permanent (not a pilot) program, despite the fact that it was an untested model.

Some of the early ACOs have dropped out over what they perceive as long delays in the Government's provision of data that determine whether they met the expenditure targets. In addition, ACOs sometimes questioned the accuracy of the data. How successful the ACO program will be, and whether it is scalable nationally, remains to be seen.

Physician Employment by Hospitals

Group and staff model HMOs declined in prominence throughout the late 1980s and into the early 1990s as the market turned toward open-panel HMOs and PPOs. At the same time, many hospitals that felt threatened by managed care reacted by purchasing physician private practices, mostly those of PCPs but of some other specialties as well. The intent was to make it difficult for an HMO or PPO to exclude the facility in question from its network and to gain negotiating strength by employing the PCPs whom health plans most needed. For most hospitals, this expansion was a costly effort that was subsequently reversed.

This dynamic has returned in recent years as hospitals have consolidated to create major health systems. In many cases, the hospitals have once again purchased practices, increasingly attracting physicians who seek employment because they recently finished their training programs, require a steady income to repay student debts, or do not want the burden of practicing privately. One aspect of this burden is government efforts to induce providers to adopt electronic medical records, which are beneficial but costly and time consuming for the provider to learn to use when first installed.

As before, hospitals have purchased private practices, initially at least to further strengthen their already strong negotiating position with health plans and thereby obtain more favorable pricing agreements. However, while PCP practices continue to be acquired, there is now greater focus on specialties such as cardiology that rely heavily on ancillary services, particularly diagnostic tests that the hospital offers.

Employed physicians are expected to direct patients to use the health system's ancillary services instead of those with potentially lower cost. This expectation

creates a significant problem for both private payers and Medicare. To illustrate this dilemma, the traditional Medicare program pays more for services and procedures rendered by physicians at a hospital facility than if the same services and procedures were delivered by non-hospital-affiliated physicians in their offices. Proposals have been advanced to change Medicare's "site of service" differential, which some view as an anomaly, but as yet this has not occurred.

In many markets, individual healthcare systems may employ more than 1000 physicians—numbers that were unheard of the last time this strategy was attempted. The consolidation that is occurring brings into question the viability of the competitive model when large provider systems dominate the market, leaving insurers little opportunity to select the providers with whom they contract.

While hospital employment of physicians is by far the more significant dynamic, some health plans have also purchased existing physician practices. They have done so in some cases to ensure that they would have network physicians who were not employed by a hospital and in other cases to create an alternative for medical groups that did not want to become part of a large hospital system.

"Cutting Out the Middleman" Is Back

Provider interest is growing in "cutting out the middleman" (i.e., the insurance carrier) by developing health plans that providers fully own and control. Unlike the last time this phenomenon occurred, the providers in question are health systems with large panels of employed physicians rather than smaller hospitals dependent on physicians in private practice.

Compared to 15 years ago, more managers with health plan experience are available, and computer support systems are better. Theoretically at least, employing the physicians provides greater ability to manage care and costs. Whether this is enough to offset the other problems that provider-owned plans face is still unknown, with the most notable unresolved issue being the tension between being efficient and the need to generate revenues from fee-for-service patients. Although the number of people seeking insurance has expanded under the ACA, there is less room in the market for new entrants than there was the last time this strategy became popular.

The Narrowing of Networks

During the heyday of early HMO growth in the 1970s and early to mid-1980s, the expectation among many pundits (including the authors) was that managed care plans would select providers based on their efficiency, resulting in relatively small provider networks in comparison to the total number of physicians in a

geographic area. This by and large did not come to pass. Indeed, particularly after the managed care backlash, health plans broadened their networks by accepting any providers into their networks who met the health plan's terms and requirements.

Stimulated by the ACA, the strategy of having a broad network is now changing, at least for some health plans or for some of their products. Specifically, some health plans participating in the state and federal insurance exchanges are being selective in terms of who they accept as participating providers. In those cases, the networks for the products being offered in the exchanges are smaller than those offered to large employer groups. The goal of these health plans is to manage better the higher costs and utilization associated with providing coverage to individuals with significant medical problems who had not been able to obtain insurance before.

The limitations in network size have rankled many consumers and consumer activist organizations as well as some state regulators. Some states are considering requiring plans that participate in their exchanges to offer out-of-network benefits with higher cost sharing. So far, only a few states have required this type of expanded access for coverage sold through an exchange. As one of its provisions, the ACA reduced capitation payments to Medicare managed care plans from 10% or more above fee-for-service levels to amounts that are closer to parity. Instead of responding to this change in reimbursement by trimming benefits, many plans have sought to narrow the network by contracting with providers whom they view as efficient. This narrowing of networks has caused disgruntlement among enrollees accustomed to being able to go to almost any provider and has raised questions regarding whether some of the networks are too small, although Medicare closely regulates networks to assure reasonable access to providers. Consumers will likely increasingly have to decide whether to pay more for an inclusive network offering very broad provider choice, albeit not necessarily higher quality, or accept a more limited (albeit adequate) network.

CONCLUSION

Managed health care has affected the U.S. healthcare delivery system in significant ways—many positive, but some negative. HMOs, for example, demonstrated that many procedures that were once performed only on an inpatient basis could be performed equally well in an outpatient setting. HMOs also showed that inpatient length of stay could be reduced without ill effect. Over time, these changes have become the norm of practice, including in the fee-for-service

system. Likewise, HMOs' early emphasis on prevention is now reflected in certain laws including those pertaining to the ACA and Medicare.

The early HMOs were also the source of considerable research on quality of care, far more so than the unmanaged fee-for-service system. This research contributed to policy makers' 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 traditionally been confined.

The initial and ongoing public and regulatory mistrust of managed health care and health insurers in general led to the creation of standard measures to evaluate health plans. Most notable among these measures are the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey (see the *Utilization Management, Quality Management, and Accreditation* chapter).

Of note is the synergistic relationship between the public and private sectors. HMOs, which are private entities, have proved themselves to be viable mechanisms for delivering care to Medicare and Medicaid beneficiaries. Government at all levels has stimulated managed care growth in other ways as well. One of the earliest examples of a large employer contract with HMOs on a dual-choice basis was that between the U.S. Office of Personnel Management (OPM) and the Kaiser Foundation Health Plans, an approach that was subsequently adopted by many large employers. Today, federal, state, and local government employees constitute the largest accounts of many managed care plans. In addition, the HMO Act of 1973 spurred HMO development through grants, loans, and—most importantly—the dual choice mandate. Finally, many health plans have adopted Medicare's methodology for paying physicians and, less commonly, hospitals.

On a negative note, the managed care industry did not respond well to the managed care backlash of the late 1990s and the early 2000s. It did not at the time make sufficient efforts at self-regulation, although many health plans were supportive of the NCQA. At first, the industry handled the backlash as a public relations problem. In opposing legislation to address the backlash, MCOs opposed what most people viewed as sensible requirements, notably the layperson emergency rule and the right to appeal coverage denials to an independent body, giving the impression that the managed care industry was putting money ahead of patient care.

Rising costs meant rising numbers of uninsured individuals, which was the impetus behind the passage of the ACA in 2010. The lingering negative view of

health insurers and managed care played a prominent role in the debate and the ACA's ultimate passage. Whether the ACA will accomplish its intended goals is unknown, but it is fair to say that its primary focus is on ensuring access to health insurance and not on restraining costs.

The issue of cost containment continues to be featured prominently in the media. Unfortunately, everyone has his or her "silver bullet" to solve the costs problems: if we could only solve the malpractice problem *or* if we could only institute higher cost sharing so that patients would seek out efficient providers *or* if provider payment could be changed to avoid the incentives in fee-for-service plans to deliver more, and more expensive, care *or* fill-in-your-favorite-solution-here. Each of these measures 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. In the past several years, attention has also been focused on pricing by providers and drug manufacturers, but such reports usually generate only a brief flurry of indignation before fading away.

An inherent problem in controlling healthcare costs is that one person's cost is another person's revenues—and providers seeking to protect their incomes are better organized than are patients or, for that matter, the citizenry as a whole. In addition, at the time of needing services, patients have little concern with costs. For their part, politicians commonly issue demagogic statements identifying any limitation as "rationing," hampering informed public discussion.

Health plans can do only so much. In the short run, they must respond to the desires of their customers—individuals, employers, or unions—who themselves may be neither willing to address the issues nor well informed. Health plans must also respond to state and federal regulators as well as new ACA requirements, and those regulators may likewise be unwilling or unable to address cost concerns. Managed health care has and will continue to make important contributions, but it is not the panacea some had hoped for.

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