

CHAPTER 1

The Origins of Managed Health Care

LEARNING OBJECTIVES

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

MANAGED CARE: THE EARLY YEARS (PRE–1970)

Sometimes cited as the first example of a health maintenance organization (HMO), the Western Clinic in Tacoma, Washington, began in 1910 to offer, exclusively through its own providers, a broad range of medical services in return for a premium payment of \$0.50 per member per month. The program was available to lumber mill owners and their employees, and it served to ensure a flow of patients and revenues for the clinic. A similar program that was later developed in Tacoma expanded to 20 sites in Oregon and Washington.

In 1929, Dr. Michael Shadid established a rural farmers' cooperative health plan in Elk City, Oklahoma. Participating farmers purchased shares for \$50 each to raise capital for a new hospital; in return, they received medical care at a discount. Because of the medical community's opposition to this new concept, Shadid lost his membership in the county medical society and was threatened with suspension of his license to practice medicine. Some 20 years later, however, he was vindicated through an 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.

As Starr noted,¹ health insurance itself is of relatively recent origin. In 1929, Baylor Hospital in Texas agreed to provide some 1,500 teachers with prepaid care at its hospital, an arrangement that represented the origins of Blue Cross. The program was subsequently expanded to include other employers and hospitals, initially through single hospital plans. Starting in 1939, a number of state medical societies, such as that in California, created Blue Shield plans to cover physician services. At the time, commercial health insurance was not a factor.

The formation of the various Blue Cross and Blue Shield plans, as well as the beginning of many HMOs, in the midst of the Great Depression came about not because consumers were demanding insurance against the risk of medical expenses or because nonphysician entrepreneurs were seeking to establish a business, but rather because providers wanted to maintain and enhance patient revenues. Many of these developments were threatening to organized medicine. In 1932, the American Medical Association (AMA) adopted a strong position against prepaid group practices, favoring instead indemnity-type insurance that protects the policyholder from expenses by reimbursement. The AMA took this stance in response to the prepaid group practices in existence at the time (although few in number) and to 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 health care delivery system. The AMA's opposition set the tone for continued state and local medical society resistance to prepaid group practice at the state and local medical society levels.

The period immediately surrounding World War II saw the formation of several HMOs, some of which remain prominent today. They represent a diversity of origins, as the initial impetus came variously from employers seeking benefits for their employees, providers seeking patient revenues, consumers seeking access to improved and affordable health care, and even a housing lending agency

seeking a reduction in the number of foreclosures. The following are examples of early HMOs:

- The Kaiser Foundation Health Plans were started in 1937 by Dr. Sidney Garfield at the request of the Kaiser construction company. The purpose was to finance medical care for workers 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 shipbuilding plants in the San Francisco Bay area.
- In 1937, the Home Owner's Loan Corporation organized the Group Health Association (GHA) in Washington, D.C., to reduce the number of mortgage defaults by families who had large medical expenses. It was a non-profit consumer cooperative, with the board of directors elected periodically by the enrollees. The District of Columbia Medical Society opposed the formation of GHA, seeking to restrict hospital admitting privileges for GHA physicians and threatening to expel those physicians from the medical society. A bitter antitrust battle ensued that culminated in the U.S. Supreme Court's ruling in favor of GHA. In 1994, GHA was facing insolvency despite an enrollment of some 128,000 members. Humana Health Plans, a for-profit publicly traded corporation, acquired GHA but has since disbanded it. The membership now belongs to the Kaiser Foundation Health Plan of the Mid-Atlantic.
- In 1944, in response to the needs of New York City seeking coverage for its employees, the Health Insurance Plan (HIP) of Greater New York was formed.
- In 1947, consumers in Seattle organized 400 families, who contributed \$100 each, to form the Group Health Cooperative of Puget Sound. Predictably, the Kings County Medical Society opposed the cooperative.

These pioneer prepaid group practices encountered varying degrees of opposition from local medical societies.

The early independent practice association (IPA) model HMOs, which contract with physicians in independent fee-for-service practice, were developed as a way of competing with group-practice-based HMOs. The basic structure was created in 1954, when the San Joaquin County Medical Society in California formed the San Joaquin Medical Foundation in response to competition from the Kaiser Foundation Health Plans. The San Joaquin Medical Foundation established a relative value fee schedule for paying physicians, heard grievances against

physicians, and monitored the quality of health care. It received a license from the state to accept a set monthly fee (i.e., capitation payment) to provide for each person enrolled in the plan all the health care services that he or she needed, making it the first IPA model HMO. Only in later years did nonprovider entrepreneurs form for-profit HMOs in significant numbers.

THE ADOLESCENT YEARS OF MANAGED CARE: 1970–1985

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

The major boost to the HMO movement during this period was the enactment in 1973 of the federal Health Maintenance Organization Act. That act authorized start-up funding and, more important, ensured access to the employer-based health insurance market. The act evolved from discussions that Dr. Paul Ellwood had in 1970 with the officials of the U.S. Department of Health, Education and Welfare (which later became the U.S. Department of Health and Human Services). Ellwood had participated in designing the Health Planning Act of 1966 during the presidency of Lyndon Johnson.

Ellwood, sometimes referred to as the father of the modern HMO movement, was asked in the early years of the Nixon administration to devise ways of constraining the increases in the Medicare budget. His conversations with federal officials led to a proposal to reimburse HMOs for Medicare beneficiaries' health care through a capitation system (a proposal that was not enacted until 1982) and laid the groundwork for what became the HMO Act of 1973. The emphasis on HMOs at this time reflected the perspective that the fee-for-service system, by rewarding physicians for providing more services rather than for providing appropriate services, incorporated the wrong incentives. Also, the term "health maintenance organization" was coined then as a substitute for prepaid group practice, principally because it had greater public appeal.

The main features of the HMO Act were these:

- It made grants and loans available for the planning and start-up phases of new HMOs as well as for service area expansions for existing HMOs.
- It overrode state laws that restricted the development of HMOs if the HMOs met federal requirements for certification.
- Most important of all, it required employers with 25 or more employees that offered indemnity coverage also to offer up to two different types of federally qualified HMO options if the plans made a formal request. For workers under collective bargaining agreements, the union had to agree to the offering. Many HMOs were reluctant to exercise the mandate, fearing that making such a request would antagonize employers and cause them to discourage employees from enrolling. However, many other HMOs used the dual-choice provision to at least advertise themselves to employer groups.

The statute also established the process under which HMOs could elect to obtain federal qualification. Unlike state licensure, which is mandatory, federal qualification had always been at the discretion of the individual HMO. To obtain federal qualification, HMOs had to satisfy a series of requirements, such as meeting minimum benefit package standards set forth in the act, demonstrating that their provider networks were adequate, having a quality assurance system in place, complying with standards of financial stability, and establishing an enrollee grievance system. Some states emulated these requirements and adopted them for all HMOs that were licensed in the state, regardless of federal qualification status.

Plans that requested federal qualification did so for four principal reasons. First, qualification represented a “seal of approval” that was helpful in marketing. Second, the required offering of HMO options ensured that HMOs that were federally qualified would have 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, only those HMOs that obtained federal qualification could receive the federal grants and loans that were available during the early years of the act.

The slowness of the federal government in issuing the regulations implementing the act also delayed HMO development. Employers knew that they would have to contract with federally qualified plans. Even those that supported the mandate had to wait until the government determined which plans would be qualified and established the processes for implementing the dual-choice provisions. In 1977, however, at the beginning of the Carter administration, issuance of the regulations became a priority, and rapid growth ensued.

Federal qualification is no longer law, but its impact on the early establishment and growth of HMOs cannot be underestimated. Politically, several other aspects of this history are noteworthy. For example, although differences arose on specifics, congressional support for legislation promoting HMO development came from both political parties. Also, there was no widespread state opposition to the federal override of restrictive state laws. In addition, most employers did not actively oppose the dual-choice requirements, although many disliked being required to contract with HMOs by the federal government. Perhaps most interesting of all was the generally positive interaction between the public sector and the private sector, with government fostering HMO development both through its regulatory processes and its purchase of health care coverage under its employee benefits programs.

Among the other managed care developments that took place during the 1970s and early 1980s was the creation of the preferred provider organization (PPO), a plan that contracts with a limited number of independent providers to obtain services for its members at a discount. It is generally believed that the PPO originated in Denver, where, in the early 1970s, Samuel Jenkins, a vice president at the benefits consulting firm, the Martin E. Segal Company, negotiated discounts with hospitals on behalf of the company's Taft-Hartley trust fund clients. Utilization review also evolved outside the HMO setting between 1970 and 1985, although it has earlier origins:

- In 1959, Blue Cross of Western Pennsylvania, the Allegheny County Medical Society Foundation, and the Hospital Council of Western Pennsylvania performed retrospective analyses of hospital claims to identify utilization that was significantly above average.
- Around 1970, California's Medicaid program began to require preadmission authorization for routine hospitalizations and concurrent review in conjunction with medical care foundations in the state, starting with the Sacramento Foundation for Medical Care. Such foundations were not-for-profit organizations usually created by local organized medicine or medical societies for purposes of conducting utilization review and, later, creating independent practice association types of HMOs.
- The 1972, Social Security Amendments authorized the federal Professional Standards Review Organization (PSRO) program to review the appropriateness of care provided to Medicare and Medicaid beneficiaries. Although its effectiveness has been debated, the PSRO program established an organizational infrastructure and data capacity on which both the public and

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

- In the 1970s, a handful of large corporations initiated programs for preauthorization and concurrent review for inpatient care.

Developments in indemnity insurance, mostly during the 1980s, included (1) encouraging persons with conventional insurance to obtain second opinions before undergoing elective surgery and (2) adopting “large case management” (i.e., the coordination of services for persons with conditions that require expensive medical care, such as selected accident patients, cancer patients, and very low birth weight infants). Also during the 1980s, work site wellness programs became more prevalent as employers, to varying degrees and in varying ways, instituted such programs as the following:

- Screening (e.g., for hypertension and diabetes)
- Health risk appraisal
- Exercise promotion (whether by providing access to gyms, conveniently located showers, or running paths, or by simply providing information)
- Stress reduction
- Classes (e.g., smoking cessation, weight lifting)
- Nutrition, including the serving of healthy food in the cafeteria
- Weight loss
- Mental health counseling

MANAGED CARE GROWS UP: 1985 TO 2000

The period between 1985 and 2000 saw a combination of innovation, maturation, and restructuring. Growth in HMOs was rapid and reached a peak in 2000 but began to decline after that, as will be discussed in a later section.

Innovation

In many communities, physicians and hospitals collaborated to form integrated delivery systems (IDSs). These had two principal forms. The first form was a single

legal entity made up of hospitals and hospital-employed physicians. The other form was a physician–hospital organization (PHO), principally as a vehicle for contracting with managed care organizations. Typically, most PHOs sought to enter into fee-for-service arrangements with HMOs and PPOs, although for a period, a number sought full-risk capitation. Full-risk capitation, as discussed in Chapter 3, involves the IDS or PHO accepting a fixed amount of money per member per month for all health care expenses. However, with the failure of many such full-risk arrangements in the years 1999 and 2000, acceptance of full-risk capitation has sharply declined. Further, productivity problems that arose when physicians went from private practice to being employed caused a number of hospital-based IDSs to abandon the physician employment model.

For several reasons, PHOs did not become important elements of the managed care environment. Their reimbursement systems, for example, did not support the primary managed care goals of cost containment and efficient care. The typical PHO allowed all physicians with admitting privileges at the hospital to participate in the plan rather than selecting the more efficient ones, and it also required physicians to use the hospital for outpatient services (e.g., laboratory tests) that might have been available at lower cost elsewhere, hurting its price competitiveness. Finally, some PHOs were poorly organized, had inadequate information systems, operated under inexperienced management, or lacked the necessary capital for investment. In the end, PHOs with these kinds of problems were not able to sustain the financial risks.

The development of carve-out companies—organizations that have specialized provider networks that offer specific services, such as mental health care, management of a particular disease (e.g., congestive heart failure, diabetes), chiropractic treatment, and dental services—occurred during this period. The carve-out companies market their services primarily to HMOs and large self-insured employers. In recent years, some of the large health plans that contracted for such specialty services have reintegrated them back into the main company (so called carve-in or in-sourcing). One reason for the reintegration was the view that carved-out services made it difficult to coordinate services (e.g., between physical and mental health).

Advances in computer technology have made other innovations possible. Vastly improved computer programs, marketed by private firms or developed by managed care plans for internal use, can generate statistical profiles of the services rendered by physicians. These profiles serve not only as a means to assess the efficiency and the quality of the care that each physician provides but also as a basis for the adjustment of payment levels to providers who are paid under capitation

or risk-sharing arrangements that reflect the severity of illness among each provider's patient group.

Computer technology is responsible for a virtual revolution in the processing of medical and drug claims. The increasingly widespread use of electronic processing rather than paper submission and manual entry has substantially lowered administrative costs and broadened access to far superior information; when dispensing a prescription, for example, the pharmacist can now receive information about eligibility of the member for coverage, amount of copay or coinsurance required on a drug-by-drug basis, and potential adverse effects and interactions. Management information systems can be expected to improve in the next few years as providers, almost universally, submit claims electronically. Requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for administrative simplification have accelerated the movement toward inexpensive electronic interchange for the basic transactions in managed care, including:

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

Maturation

Maturation during this period can be seen from several vantage points. The first was the extent of HMO and PPO growth. In the mid-1980s, HMOs grew fastest, but by the early 1990s, PPOs began to grow even faster. By the late 1990s, HMOs actually began to decline, whereas PPOs continued to grow. During the entire period, conventional health insurance continually declined. In parallel to enrollment trends in the commercial sector, Medicare HMO enrollment grew from 1.3 to 6.3 million between 1990 and 1999.

Another phenomenon was the maturation of external quality oversight activities. Starting in 1991, the National Committee for Quality Assurance (NCQA; see Chapter 7) began to accredit HMOs. The NCQA was launched by the HMOs' trade association in 1979 but became independent in 1991, with the majority of board seats being held by employer, union, and consumer representatives. Many employers are requiring or strongly encouraging NCQA accreditation of the HMOs with which they contract, and accreditation came to replace federal qualification as the seal of approval. NCQA, which initially focused only on

HMOs, has evolved with the market, for example, to encompass mental health carve-outs, PPOs, physician credentialing verification organizations, and others. In addition to NCQA, other bodies that accredit managed care plans have also developed, as described in Chapter 7.

Performance measurement systems (report cards) continue to evolve, the most prominent being the Health Care Effectiveness Data and Information Set (HEDIS), which was developed by the NCQA. The HEDIS data set has evolved and grown on a regular basis, and a list of current HEDIS measures is found in Chapter 7. Other forms of report cards have appeared since then and continue to develop as the market demands increasing levels of sophistication.

Another form of maturation is the focus of cost management efforts, which used to be almost exclusively inpatient hospital utilization. Practice patterns changed during this period, and inpatient utilization declined. Although inpatient utilization still receives considerable scrutiny, greater attention began to be paid to ambulatory services such as prescription drugs, diagnostics, and care by specialists. Perhaps even more important is that the high concentration of costs in a small number of patients with chronic conditions resulted in significantly more attention being paid to disease management, as discussed in Chapter 4.

Restructuring

Perhaps the most dramatic development was the restructuring that began in the late 1980s, reflecting the interplay between managed care, the health care delivery system, and the overall health care marketplace. The definition distinctions blurred as payers created hybrid products, as will be discussed in Chapter 2. Staff- and group-model HMOs declined in number and formed IPA components, and in some cases even eliminated the medical group or staff model itself. HMOs expanded their offerings to include PPO and point-of-service (POS) products, and some PPOs obtained HMO licenses. HMOs also found themselves contracting with employers on a self-funded rather than an at-risk basis, meaning that the risk for medical costs remained with the employer. The major commercial health insurance companies also dramatically increased their involvement in managed care by both acquiring local health plans and starting up HMOs and PPOs. In short, the managed care environment became even more complicated.

Another change was in the role of the primary care physician (PCP), who assumed responsibility for overseeing the care of the HMO member. In a traditional HMO, the role of the PCP has been to manage a patient's medical care, including access to specialty care. This proved to be a mixed blessing for PCPs, who some-

times felt caught between pressures to reduce costs on the one hand, and the need to satisfy the desires of consumers on the other. The growing popularity of PPOs as compared with HMOs appears to have led to a shift away from PCP-based plans during this time. In some HMOs, for example, the requirement for PCP authorization to access specialty services, known as the “gatekeeper” requirement, began to be eliminated. That said, many plans (including PPOs) still provide for lower copays if a member receives care from a PCP rather than a specialist.

Finally, consolidation was, and continues to be, notable among both health care plans and providers. Among physicians, there continues a slow but clear movement away from solo practice and toward group practice. As for hospitals, a substantial amount of consolidation on a regional or local level occurred, creating large local and regional systems. Consolidation in the provider sector occurred largely in the mid- to late 1990s and continues today, although at a slower rate.

Health plan consolidation has been constant during this period and continues today. Smaller local health plans have been acquired or, in some cases, have ceased operations because of a number of forces. Large employers with employees who are spread geographically have generally been moving toward national companies at the expense of local health plans. For smaller plans, the financial strain of having to continually upgrade computer systems and other technology can become excessive. Smaller plans may also find themselves unable to negotiate the same discounts as larger competitors; smaller plans in unique markets, such as in rural areas or where physician loyalty is high, may continue to thrive, but beginning in this period and continuing today, it is getting harder for smaller plans to succeed.

Even larger health plans have been targets for acquisition, primarily in the for-profit sector. During this period, some, but not all, Blue Cross Blue Shield plans converted to for-profit status. Blue Cross Blue Shield plans, which had been dominant, began to lose market share during this time. However, they adapted to the changing market, and by the mid-1990s had begun to regain it in their managed care products.

MANAGED CARE IN RECENT TIMES: 2000–2007

The economic boom of the mid- to late 1990s changed the dynamics in the managed health care industry. As a result of unemployment dropping below 4%, corporate profits being strong, and the economy growing, employers found it increasingly necessary to compete for employees. The anti-managed care rhetoric

of political campaigns, combined with media “horror stories,” helped fuel negative public sentiment about managed care as discussed in the next section. The result was a movement away from traditional managed care and toward less managed types of health plans.

HMOs declined to 66.1 million in 2004 but rose again to 77.7 million by 2006, fueled in large part by increasing Medicare enrollment. Medicare HMOs themselves had declined to 4.6 million by 2003 because HMOs exited the market after sustaining significant losses, but they too rose again to 8.8 million by 2007 (not counting an additional 17 million Medicare beneficiaries enrolled in stand-alone prescription drug plans). By comparison, approximately 81 million people enrolled in PPOs by 2006. However, insurance carriers sell hybrid products that combine elements of HMOs and PPOs, making statistical compilations difficult.

Market growth in the Blue Cross Blue Shield system has been considerable as a result of many factors, including its generally broad provider networks, the managed care backlash (discussed in the next section), and the Blue’s improved ability to offer national accounts as compared with the prior decade. In any given state, the Blue plan often has the highest market penetration of any health plan.

Consolidation of payer companies continued to the point that by 2007, four commercial for-profit companies accounted for over 45% of covered individuals: CIGNA, Aetna, United Health Care, and WellPoint. WellPoint itself is made up largely of for-profit Blue Cross Blue Shield plans, though it also has non-Blue commercial business. Consolidation also continued in the not-for-profit sector, again primarily (but not exclusively) in Blue Cross and Blue Shield plans.

The Managed Care Backlash

Anti-managed care sentiment, commonly referred to as the “managed care backlash,” became a defining force in the industry in the 1990s. Political speeches, movies and television shows, news articles, and even cartoons increasingly began to portray managed care in an unflattering light. There were several reasons for this.

Because managed care had significantly lower costs than traditional health plans, it became a dominant form of health care coverage when many employers put their employees (and dependents) into managed care as their only type of coverage. As more and more people were enrolled in managed care plans, the number of problems rose as well. Many individuals did not want to be in a managed care plan but had no choice (or no affordable choice).

Some of the problems were more like irritants, such as mistakes in paperwork or claims processing in health plans with information technology (IT) systems that

were unable to handle the load. Other problems were highly emotional, though not actually a threat to health, such as denial of coverage for care that was genuinely not medically necessary (e.g., an unnecessary diagnostic test). Finally, a major source of contention with many consumers was the requirement that they obtain prior authorization from their PCP to access specialty care. A few problems, however, were real, or at least potential threats to health, such as denial of coverage for truly necessary medical care or difficulties in accessing care. Although uncommon, problems of this nature quickly generate bad publicity, and bad news travels fast.

The managed care industry was not simply an innocent victim of bad publicity, though. As managed care companies grew, their ability actually to manage the delivery system was often poor. Where decisions on clinical issues were once done with active involvement of medical directors, the rapidly growing health plans became increasingly bureaucratic. Rapid growth also led to greater inconsistencies in decision making about benefits coverage. The public's perception that decisions were being made by "bean counters" or faceless clerks may not have been completely fair or accurate, but neither was it completely inaccurate. Decision-making authority was often delegated and not necessarily done with a sense of compassion or flexibility.

Perhaps the most serious charge leveled against the managed care industry was the accusation that health plans *deliberately* refused to pay for necessary care to generate profits and make executives and shareholders rich, something that was emphasized by media stories of multi-million-dollar compensation packages for senior executives in the managed health care industry. Of course, financial incentives drive almost all aspects of health care to varying degrees, but this was a particularly damaging charge that health plans faced.

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

Another frequently cited reason for the managed care backlash is American's desire for choice. People simply do not want to be told that they cannot go to any provider and still receive full coverage for their care. This attitude caused many HMOs to expand their networks aggressively and also drove the shift from traditional HMOs to less restrictive forms of coverage such as PPOs. The traditional indemnity

type of health insurance remained unaffordable, however. Another example of the movement toward less restrictive forms of coverage is that a number of HMOs abandoned the PCP model (the so-called gatekeeper model discussed in Chapter 2) to one of “open access,” allowing members to access any provider in the network, though usually with lower copays for primary care than for specialty care.

During this time, the managed care industry kept pointing out the good things that it was doing for members, such as coverage for preventive services and drugs, the absence of lifetime coverage limits, coverage of highly expensive care, and so forth. But it was of no use; as a reporter for a major newspaper once said to one of this chapter’s authors, “We don’t report safe airplane landings at LaGuardia either.”

The managed care backlash has now become mostly an echo. The volume of HMO jokes has declined, news stories about coverage restrictions or withheld care are now uncommon, and there is little or no state or federal attention paid to placing restrictions on managed care plans.

The Return of Health Cost Inflation

The rapid increases in health care costs experienced in the late 1980s and early 1990s had slowed considerably by the mid-1990s, but health cost inflation returned by the turn of the century. Managed care had been a significant contributor to holding down the rate of rise, but many of the fundamental reasons for increased health care costs remain today. The health economy is too complex to say that increasing health care costs are due to any single reason, or even a small number of reasons. Where health cost inflation was once caused as much by unnecessary utilization as by anything else, other factors have always been present. The loosening of some of the controls traditionally associated with managed care, combined with richer benefits, certainly contributed to rising health costs, but numerous other factors have also been in play. Examples of other such factors are the following:

- Drug therapy advances and prescription drug costs
- Increasing numbers of outpatient procedures
- Continuing large variations in medical practice behavior
- High incomes for some types of providers (regardless of efficiency or quality)
- Greater consumer demands on the health care system
- Our high rate of lawsuits, causing physicians to practice defensive medicine
- High administrative costs
- Shifting demographics, including the aging of the population
- Expectations for a long and healthy life, regardless of costs
- The cost of complying with government mandates

These usual suspects are not the only ones pushing health cost inflation, however. Two relatively new categories are establishing themselves as major drivers of cost inflation: (1) rapidly developing (and usually expensive) medical technology, and (2) genomics. Examples of new medical technology are the implantable cardiac defibrillator, drug-eluting vascular stents, new orthopedic implants, and miniaturization of devices, to name a few. In the arena of genomics, the appearance of so-called specialty pharmacy, injectable drugs that are proteins manufactured through DNA replication, has led to treatments that may not be used frequently but that are hugely expensive when they are, commonly costing in excess of \$10,000 per patient per year. The discovery of various alleles (i.e., genes) for cancer that help guide physicians as to the best therapy depending on the genetic profile (e.g., for breast cancer) are all adding to cost inflation.

MANAGED HEALTH CARE TODAY

At the same time that health benefits costs began rising, the economy began to soften, and increasingly, US companies have become confronted with competition from abroad—from companies that do not face the insurance costs of their American counterparts. These two forces led not to a return to traditional managed care, but rather to an increase in cost sharing with consumers through higher payroll deductions for health insurance premiums and, more important, in the form of changes in the benefits. Levels of copayments and coinsurance have been rising and in many cases have become more complex. For example, physician office visit copays that were once commonly \$5 are now \$20 or more, or may now be coinsurance (in which the consumer pays a percentage of the cost rather than a fixed copayment), as well as a deductible (in which the consumer must pay all costs until the deductible has been met). Pharmacy benefits that were once simple copays now have widely differing levels of copayment tiering and significant deductibles. Ironically, cost sharing was the primary method of cost control available to indemnity insurance prior to the advent of managed health care.

The most recent significant development is the rise of the consumer-directed health plan (CDHP), including such variants as health savings accounts (HSAs) and other types of high-deductible health plans (HDHPs) as more fully described in Chapter 2. Two hallmarks of CDHPs are greater cost sharing by consumers, combined with the notion that consumer choice and consumer accountability have greatly increased in importance. CDHPs are also associated with pretax funds to help pay for some costs. Health plans are working to better provide information to consumers about the quality and cost of the care they are seeking,

and to help consumers choose physicians and hospitals and better understand their health care options. Informing consumers through information or “data transparency” and providing financial budgeting tools and other forms of information are currently the focus of much effort in all health plans, not just CDHPs.

The other major development was passage of the Medicare Modernization Act (MMA). In addition to a new drug benefit for Medicare beneficiaries, the MMA created new forms of Medicare managed care, collectively referred to as Medicare Advantage. Likewise, many states continue to turn to managed care for their Medicaid programs for low-income individuals. Both Medicare and Medicaid are discussed further in Chapter 6.

Managed care has not simply gone to higher cost sharing combined with improved information to assist in decision making. For example, new pay-for-performance programs are being tested and implemented to align financial incentives for providers with quality goals, as discussed in Chapter 3. Practice behavior by physicians continues to change, and as care management becomes more sophisticated, managed care companies have placed more emphasis on chronic and/or highly expensive medical conditions, with less focus on routine care, as discussed in Chapter 4.

CONCLUSION

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

NOTES

1. P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

This chapter is adapted from P.D. Fox and P. R. Kongstvedt, “Chapter 1: An Overview of Managed Care,” in *The Essentials of Managed Health Care*, 5th edition, ed. P. R. Kongstvedt (Sudbury, MA: Jones & Bartlett Publishers, 2007).