
GrantWatch

I. ESSAY

Managed Care: Promise And Concerns

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The rapid adoption of managed care—one of the most significant changes to our nation's health care financing and delivery system in recent years—has unknown consequences for patients, physicians, and health care institutions. Enrollment in managed care is swiftly increasing, new models of managed care are developing, and numerous national and state health care reform proposals are relying on managed care principles for improving the health care system, yet little is known about how these changes will affect health care costs, access, and quality. As a nonpartisan information resource with a long-standing commitment to improving health care services, The Commonwealth Fund is uniquely positioned to contribute unbiased, objective information on the currently unanswered questions raised by managed care. Under the auspices of its Health Care Reform Program, established in July 1993, The Commonwealth Fund is focusing on the need to expand knowledge about managed care organizations. It has committed approximately \$2.5 million to projects on managed care since the program began.

This essay reviews recent trends in managed care, outlines critical questions raised by these trends, and describes some of the projects under way with support from The Commonwealth Fund. It is hoped that this information will be helpful to other funders that share an interest in developing and providing information needed to ensure that the evolving health care system guarantees access to high-quality care for all.

While the course of congressional action on health care reform remains uncertain, it is clear that interest in capitated health care delivery systems is strong and growing. Models of managed care are in widespread use in both the private and public sectors. Health maintenance organizations (HMOs) are being promoted by employers, who are rapidly moving away

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from traditional indemnity insurance coverage and providing incentives for their employees to join managed care plans. State Medicaid programs are moving more and more of their beneficiaries toward managed care plans.

The proliferation of the managed care concept is readily apparent. In 1976 six million people were enrolled in the 175 HMOs then in operation; by 1992 those numbers had grown to 550 HMOs serving a total of forty-two million enrollees.¹ Today only 5 percent of persons in the privately insured population are enrolled in fee-for-service insurance plans without utilization review.² Whether or not the US. health care system achieves comprehensive reform, this is a movement that demands closer scrutiny.

Health care reform, if enacted at the federal or state level, seems certain to accelerate the trend. Yet relatively little is known about how managed care would affect health care costs, quality of care, continuity of care, and the fiscal stability of health care institutions. Neither purchasers of care—including employers and government—nor patients have the kind of information that would help them to make sound decisions among managed care plans, which appear to vary widely in cost, quality, and responsiveness to patients. Nor do hospitals, physicians, academic health centers, or other parts of the health sector have the information necessary to adapt to this changing environment.

The Evolution And Growth Of Managed Care

Although the term *health maintenance organization* was coined in the 1970s, the concept of prepaid health services dates back to the early 1900s, when public awareness of the increasingly prohibitive costs of health care prompted the development of innovative approaches to financing and delivering health care services. World War II accelerated the expansion of prepaid health plans, as Kaiser Industries expanded the Kaiser Permanente health plan, established in 1938, to provide health services to its burgeoning shipbuilding work force. Kaiser Permanente and other early prepaid plans such as Group Health Cooperative of Puget Sound and the Health Insurance Plan of Greater New York, all of which continue today, have earned high marks for improving access to and continuity of care while also controlling costs.

Predominantly not-for-profit organizations, these early plans operate as either staff- or group-model HMOs. Staff models, such as Group Health Cooperative of Puget Sound, employ full-time salaried physicians to provide care in HMO-owned facilities. Group models, such as Kaiser, provide the facilities and equipment but contract with a medical group practice for physician services. Physicians in group-model HMOs are paid a fixed capitated fee and often enter into profit-sharing arrangements.

By the late 1950s two other models of managed care, individual practice associations (IPAs) and network-model HMOs, emerged in response to physicians' concerns about perceived threats posed by group- and staff-model HMOs. IPA-model HMOs contract with individual physicians or single-specialty groups, who agree to provide services to enrollees in their own offices. IPA physicians may continue to see fee-for-service patients and contract with other plans; they are reimbursed in a variety of ways ranging from capitated payments to agreed-upon fee schedules. In contrast, network-model HMOs contract with one or more large, multispecialty group practices, which have nonexclusive relationships with the HMO and also provide services within their own offices. Network providers typically are reimbursed by capitation, under which they receive a fixed monthly payment per person enrolled with them.

A rapid expansion of the managed care industry was facilitated by the HMO Act of 1973, an effort on the part of the federal government to control costs and provide more comprehensive coverage. That legislation, in effect until 1982, provided start-up grants and loans for the development of HMOs and required large employers to offer HMO coverage to their employees in areas where it was available. Managed care plans began to multiply and evolve into new hybrid forms, and enrollment increased significantly. Few oversight or evaluation mechanisms were in place, however, to measure and record the effects of this substantial change in financing and delivering health care services.

In the past few years the managed care industry has experienced three major and dramatic shifts. The first has to do with the variety of managed care models, the second with their ownership, and the third with governments' interest in expanding the enrollment of public plan beneficiaries in managed care.

First, while group- and staff-model HMOs have grown at a slow, steady pace, the IPA model has expanded rapidly. Nearly half of managed care enrollees are now in IPA plans.³ Meanwhile, two new types of health plans, preferred provider organizations (PPOs) and point-of-service plans, have developed. PPOs are managed care plans that contract with a network of providers, typically on a discounted fee-for-service basis, and offer enrollees financial incentives to use their services. Use of out-of-network providers costs more for the patient and is sometimes restricted. Point-of-service plans allow enrollees to choose whether to use providers inside or outside of the network at the time care is needed. Enrollees are usually charged a substantial copayment for choosing the latter. These new plans are popular with enrollees, given the possibility for greater choice and flexibility.

The second major change dates from the mid-1980s, when the orientation of the managed care industry changed from predominantly nonprofit

to largely for-profit. In 1982, for example, only 18 percent of managed care providers were for-profit entities; by 1988 that proportion had grown to 67 percent.⁴ There also has been a consolidation of ownership of managed care plans and a trend toward ownership by insurance companies and investors, instead of hospitals and other health care providers.

The third major change has come as state governments look to managed care as a critical part of their solution to rising Medicaid costs and uninsured populations. From 1983 to 1993 the percentage of Medicaid patients enrolled in managed care ballooned from 1 percent to 15 percent.⁵ Several states, such as Kentucky, Tennessee, and Oregon, have already made commitments to converting their entire Medicaid programs into managed care plans.

These three changes have clearly contributed to the industry's rapid growth and are highly relevant to any widespread effort at health care reform. Yet most of the research to guide policy dates back to the late 1970s and early 1980s, when the profile of managed care was very different from what it is today. The large and undisciplined managed care system continues to enroll more people every day. This growth poses serious, unanswered questions.

Managed Care: Unanswered Questions

The proponents of managed care base their arguments on theoretical assumptions about its impact on the costs and delivery of care. These assumptions include the belief that managed care can control costs through more efficient delivery of care, that the care provided is more appropriate, and that services can be better coordinated through regular access to providers.⁶ Proponents also contend that managed care provides incentives for consumers to use less care, reduces health care costs, and stimulates a reduction of excess capacity.

Managed care also has its detractors, including those who argue that reliance on managed care implies a continuing strong role for insurance companies and entrepreneurial, profit-driven health care organizations. For those who oppose a major role for government in the financing of health care, managed care raises the specter of rationing, lower quality, less freedom to choose physicians, interference with physicians' clinical autonomy, reduced access to specialty care and teaching hospitals, and increased government regulation.⁷

Getting answers to several key questions could help to sort out the true value of managed care for patients, policymakers, and providers.

Are managed care organizations delivering high-quality health care?
Do patients participating in these plans have access to well-trained physi-

cians, including specialists and teaching hospitals where appropriate? Do patients have a regular source of care and assured continuity of care? Are medical outcomes consistent with professional standards? Are patients satisfied with their choice of physicians and perceived quality of care? A continuing concern of patient advocates is that managed care may have built-in incentives to underuse services, particularly specialty care, and that patient care may therefore be affected by the plan's interest in cost savings.

Does the way in which physicians are paid affect the quality of care and costs? The various models of managed care primarily reflect differences in the way physicians are contracted with and paid, including how much financial risk physicians assume for providing expensive or extensive care. It is not known whether or how these different arrangements affect patient care.

Does sponsorship of the organization affect the commitment to high-quality care for all patients? Sponsorship options range from being for-profit to being wholly nonprofit, owned by providers or insurance companies. In general, nonprofit entities continue to receive high ratings for patient satisfaction, yet as more health plans operate for profit, this may change.

Are managed care plans more efficient than fee-for-service arrangements? Many HMOs have demonstrated an ability not only to control costs but also to make money. Is this the result of greater efficiencies or the product of policies that skim for healthy enrollees and skimp on payments to providers? While many HMOs demonstrate reduced costs related to lower rates of hospitalization and emergency room use, are these savings sustained over time?⁸

Do some managed care models perform better than others? Little is known about how the various types of plans compare on quality of care, access, and costs. Even within a given type of managed care plan, performance may vary considerably.

Are managed care organizations committed to providing services to low-income patients and those with complex medical problems? Because the earliest HMOs were established to serve employee groups, their enrollees have tended to be younger and healthier than the general population. As states have introduced Medicaid managed care, however, many HMOs have begun to compete for patient populations that they previously avoided. Medicaid patients tend to be sicker, to have complex medical and social problems, and to be from minority populations.

Does managed care weaken the position of traditional health care providers, including teaching hospitals, specialty hospitals, and community-based providers?⁹ There is concern that health care providers with a history of commitment to teaching, research, and serving the poor

will not be able to compete successfully with managed care plans.

Does managed care threaten physicians' professional autonomy and compromise their ability to provide high-quality patient care? Physicians express concerns about the impact on their practice of changing hospital privileges and patient referral patterns and about the threat of nonphysician providers, who may displace physicians under a new system.

Commonwealth's Role: An Information Resource

To answer these questions, The Commonwealth Fund's Health Care Reform Program has focused on the need to expand knowledge about managed care organizations. Work got under way in 1993 on a managed care survey, a financial analysis of the profitability of IPAs and network-model HMOs, and an examination of the way in which academic health centers are responding to managed care.

The fund's major initiative was a three-city survey of patients' experiences with managed care. The survey included 3,000 persons in Boston, Los Angeles, and Miami who were polled from January to March 1994. All respondents were between the ages of eighteen and sixty-four, were employed, and had the option of enrolling in an HMO or PPO through employer-financed health insurance coverage.¹⁰ Half of the sample in each city was enrolled in an HMO or a PPO, the other half in a fee-for-service indemnity plan.

The survey findings—which include new information on who joins managed care plans, perceptions of the quality of care, the current instability of health coverage, differences in satisfaction with services and care between fee-for-service and managed care enrollees, and the importance of having some choice of plans and providers—will be formally released in late 1994. The survey points strongly to the need for more information regarding instability of coverage and continuity of care and for a closer look at variations in patient satisfaction and the effect of different plan models.

Two other Commonwealth Fund projects now under way are complementing this effort. A financial analysis of major IPA and network managed care organizations in Boston, Philadelphia, and Los Angeles is aimed at identifying the financial stability and profitability of different HMOs. Case studies of seven academic health centers are being conducted to examine the way they are responding in different kinds of managed care environments.

Recognizing that the nation is moving rapidly toward a restructuring of how care is provided and paid for, The Commonwealth Fund's Health Care Reform Program advisory committee and the foundation's staff believe that managed care is an aspect of health care reform that warrants further and

immediate attention. Priority areas for investigation of managed care over the next year will include (1) physicians' perceptions of their ability to practice medicine that is in the best interests of their patients; (2) the commitment of managed care plans to serving low-income populations, underserved minorities, and other patient populations likely to have complex health problems and their ability to do so; (3) the effects of sponsorship on the quality of care provided; and (4) whether the high U.S. standards of medical care, innovation, and scientific advancement can be maintained under managed care.

Two recently approved projects will help to move The Commonwealth Fund forward in these areas of study. A survey of physicians' experiences and attitudes toward managed care will be conducted in the fall of 1994. In a project cofunded by The Henry J. Kaiser Family Foundation, case studies of Medicaid managed care in five states will be conducted, along with surveys of patients' experiences in those states. (See "Grants," page 189 of this volume of *Health Affairs*, for more details.)

Through its Health Care Reform Program, The Commonwealth Fund hopes to provide new and unbiased information about what works in managed care, and under what circumstances. Analyzing and communicating project findings are crucial aspects of this work. The Health Care Reform Program is well positioned to do this, given the diverse backgrounds and perspectives of its advisory committee, which represents the medical profession, business, government, and academia.

Conclusion

Regardless of the outcome of national reform efforts, serious changes in our health care system are taking place under the rubric of managed care. Its rapid growth raises many concerns regarding quality of care, commitment to patient satisfaction, and ability to meet the needs of patients. Providing the knowledge and understanding to help those guiding a movement already well under way could be a strategic contribution to steadying the course of American medical care. Foundations can serve as information resources and from this important position can help to advance the public's and policymakers' understanding of the intricacies of managed care and health care reform.

NOTES

1. Group Health Association of America, *Patterns in HMO Enrollment*, 1993 Edition (Washington: GHAA, June 1993), 5,7.
2. C.B. Sullivan and T. Rice, "The Health Insurance Picture in 1990," *Health Affairs* (Summer 1991): 109.
3. K. Davis et al., *Health Care Cost Containment* (Baltimore: The Johns Hopkins University Press, 1990).
4. *Ibid.*, 142.
5. U.S. General Accounting Office, *Medicaid: States Turn to Managed Care to Improve Access and Control Costs*, Report no. GAO/HRD 93-86 (Washington: GAO, March 1993).
6. AC. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993): 24-48; and R.H. Miller and H.S. Luft, "Managed Care Plan Performance since 1980: A Literature Analysis," *Journal of the American Medical Association* 271, no. 19 (1994): 1512-1519.
7. E. McCaughey, "No Exit: What the Clinton Health Care Plan Will Do for You," *The New Republic* (7 February 1994): 21-25.
8. Congressional Budget Office, *The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures* (Washington: CBO, July 1992).
9. Community-based providers include community practice networks and health plans whose principal purpose is providing care to underserved populations. Community and migrant health centers and family planning clinics are examples.
10. Respondents in the HMO group included those in group-, staff-, network-, and IPA-model managed care plans.