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The essay entitled “Change and Growth in Managed Care” by Elizabeth Hoy, Rick Curtis, and Thomas Rice provides a valuable window on a rapidly changing marketplace. It shows the exceptional diversity of managed care plans and how new diversity is being created. In this response, we emphasize certain aspects of those trends and discuss some employer and carrier strategies that help drive developments in the commercial health insurance markets. Since a study such as “Change and Growth in Managed Care” describes and analyzes a dynamic marketplace, it inevitably raises more questions than it could possibly answer. Therefore, we end our comment by discussing some of the key questions regarding the impact of managed care on the health care system. We follow the usage Hoy and colleagues use, whereby managed care means network-based managed care and conventional insurance means indemnity insurance, with or without utilization management.

Key Trends In Managed Care

In the authors’ examination of the managed care arena, several trends stand out: (1) The 1987–1990 period saw a shift away from conventional insurance to managed care and, within conventional insurance, a shift from “unmanaged” care to some form of utilization management. Moreover, the content of utilization management has continued to change. (2) The flip-side of the decline of conventional insurance has been the rise of network-based managed care, with the pace of change quickening in the past few years. (3) Network-based managed care plans with out-of-plan coverage have experienced strong enrollment growth. The share of covered employees in these plans rose from 11 percent in 1987 to 18 percent in 1990, according to the Health Insurance Association of America.
America (HIAA), and at an even more rapid rate, according to a survey by the American Association of Preferred Provider Organizations (AAPPO). Included in this group are preferred provider organization (PPO) and point-of-service plans, whose combined rate of growth was more rapid than for “closed-panel” health maintenance organizations (HMOs) (those plans without an out-of-plan option).

PPO versus point-of-service. Once we look more closely at trends in particular types of managed care plans, however, the data sources cited by Hoy and colleagues tell somewhat different stories. While there is consistency among data sources in the rates of growth of HMOs, the rates of growth for PPOs are very different. According to AAPPO, PPO enrollment grew by 46 percent annually between 1987 and 1990. Yet, according to the HIAA survey of employers, during the same period, the PPO share of employee enrollment increased only from 11 percent to 13 percent, while the point-of-service share (not queried for in earlier surveys) went from zero to 5 percent. Even if all point-of-service enrollees could be considered PPO enrollees (which is not the case), the implied rate of growth in PPO enrollees in the HIAA Employer Survey would still be very different from the AAPPO survey.

At least three major reasons (aside from sampling error) could account for the differences between these two surveys. First, there is no standard definition of what a point-of-service plan means and hence what defines a PPO compared with a point-of-service plan. In some cases, a point-of-service plan means an HMO that offers enrollees some out-of-plan coverage, while in other cases, it means a PPO with a gatekeeper, along with significant incentives to use network providers. In still other cases, it can simply be a relabeled PPO, which by definition provides out-of-plan coverage, almost always with higher deductibles and copayments. Often employer surveys cannot be specific enough about what a plan means without prompting a decline in survey response rates.

Second, there are no industrywide standards for counting PPO, point-of-service, and conventional insurance plan enrollees. Some conventional insurance plans offer a PPO “rider,” where an enrollee may pay less if the enrollee uses the PPO network. It is not clear whether these employees, or any employee who does not use any health care services, would be counted as a PPO enrollee or as a conventional insurance enrollee. Where out-of-plan coverage is the same as conventional insurance, an enrollee would have nothing to lose in joining the PPO, even if the enrollee had little intention of using the PPO network providers. A third potential source of confusion may arise from the growth of single-service PPOs, such as those for psychiatric and substance abuse services, which may be melded to non-PPO coverage for general medical care.
Rapid developments in the managed care market are forcing a rethinking of ways to characterize, and collect statistics about, managed care plans. In the early 1980s, a PPO network might have consisted of a wide pool of providers, with only a moderate amount of utilization management and physician profiling, and only small differentials between using in- and out-of-network care. Over time, not only have new forms of PPOs emerged, but many “first generation” PPOs have disappeared. The substantive difference between some plans classified as PPOs and HMOs is becoming blurred. To a provider, the differences between a PPO and an individual practice association (IPA) may be slight if both the PPO and the IPA have similar fee schedules (rather than discounted charges) and well-developed utilization review and physician selection, profiling, education, and retention procedures. The differences are further reduced if the PPO selects primary care physicians as service gatekeepers, thus, according to some definitions, turning the PPO into a point-of-service plan. To an enrollee, a point-of-service plan with a primary care physician and strong deductible and coinsurance incentives to stay in the network may be indistinguishable from a PPO, and only slightly different from an IPA. While the type of risk facing the physicians may differ—usually physicians are not at risk for overly high expenditures in PPOs and accept some financial risk in HMOs—a provider may be more “at risk” in a PPO that drops high-utilizing physicians than in an IPA that puts physicians only partially at financial risk for selective spending overruns.

**Employer Strategies**

According to the HIAA Employer Survey, average family policy premiums for all employer insurance plans rose by about 56 percent between 1987 and 1990, while the consumer price index rose by only 13 percent. However, employees have assumed a somewhat greater proportion of the total premium payment, and while methodological issues need to be resolved to obtain precise measures of premium increases, employers’ real cost of health insurance premiums per employee has still risen substantially. This increase is reflected both in the rise in health care premiums as a proportion of wages and salaries and in employers’ increasing dissatisfaction with the cost of their health plans.

This rise in cost is obviously the dominant factor behind employers’ shift to managed care. However, employers have adopted a wide variety of managed care plans, at a pace that differs greatly from employer to employer. Part of this diversity is due to carrier strategies interacting with local market conditions (for example, whether or not a large HMO is already in place in a city). Part of the diversity also reflects the heteroge-
neity of employers’ circumstances, as well as different strategies pursued by different employers in the same circumstances.

What the numbers in “Change and Growth in Managed Care” cannot directly show is that the transition to managed care is often a process that unfolds over time. Many employers are switching not only from conventional insurance to managed care, but also from “looser” managed care—with wide provider choice and a small differential between in- and out-of-network care—to “tighter” managed care, with narrower provider networks, greater differentials between in- and out-of-network care, and, at times, higher coinsurance and deductibles for in-network care as well.

Transition strategies differ among employers. Some employers without a long-range plan first shift from conventional insurance to a PPO with a wide network of providers, low deductibles and copayments to the enrollee in network, and a small differential between in-network and out-of-network coverage. Such employers may discover that they are not saving much money and so move to more restrictive managed care. Among employers with longer-range transition plans, some inform enrollees that the move to managed care is not a one-time change, while others reveal such plans incrementally to enrollees.

For larger employers, which are more likely to have health care benefits specified in union contracts, the pace of transition to managed care is partly dependent on union negotiations. Such employers often begin the transition to managed care by first moving salaried and nonunion hourly employees from conventional insurance into managed care plans. Only subsequently will they try to move unionized workers into managed care plans via negotiating new union contracts. Subsequent shifts to newer forms of managed care plans may follow the same pattern, with salaried, nonunion employees making the first move. What may appear to be a lack of aggressiveness on the part of some large corporations in embracing managed care is often a reflection of labor/management relations.

Commercial Insurer Strategies

In just six years, some commercial insurers without prior HMOs have undergone a role change from simple bill payers and paper processors to managers of complicated delivery systems. During this period, carriers that had stayed out of the HMO market began purchasing and/or building HMO networks, in addition to creating PPO networks. At least three of the largest carriers—Metropolitan, Prudential, and CIGNA—have spent more than $200 million on creating nationwide network-based managed care plans. These networks are a market response to the demands of large, nationwide employers that want managed care provided by as few
carriers as possible.

**Trendsetters.** Hoy and colleagues’ discussion of “trend-setting” commercial carriers provides useful insights into managed care developments. The authors establish the breadth of the differences in managed care plan characteristics between the trendsetter and comparison carriers. Yet, because of the limitations of available survey data, it is not possible to establish the depth of some important differences. For example, the survey data indicate that the trendsetter carriers all own group/network-model HMOs, are the only ones to own mixed-model HMOs, and are far more likely to own all three models of HMOs. Yet we do not know if a carrier with billions in premiums has one small group/network-model HMO, one small mixed-model HMO, and many IPA models, or whether it has at least several very large HMOs in each category. This underscores the fact that, while the nine trendsetters have these leading-edge products and have 65 percent of premium income for HIAA members, the majority of enrollees in the nine carriers are not enrolled in network-based managed care plans.

The statistics show that the trendsetters as a group are adopting different strategies from other carriers, which is not surprising, given that inclusion in the group is dependent on having a broad range of managed care plans. More importantly, trend-setting insurers are also adopting quite different strategies from each other. For example, some carriers rely much more heavily on risk sharing than on physician profiling and education, while others eschew risk sharing in favor of provider selection, profiling, and periodic reselection, Still others combine the risk sharing and provider profiling in more equal proportions. As another example, some carriers are acquiring existing HMOs, while others are building PPOs from the ground up.

There also are major variations in managed care products within each carrier, in terms of network organization, provider incentives, and enrollee incentives and disincentives to change care-seeking behavior. This diversity is particularly great among large employers, because carriers will customize managed care plans for them. Moreover, each network has its own history: a carrier that has contained costs successfully through use of one network it has owned and operated for years may not do as well in a network it has recently acquired or built, since it may take several years to fully implement a management perspective and infrastructure within a newly acquired network.

The information in “Change and Growth in Managed Care” helps highlight what we still need to know. For example, while the authors show the growth of managed care, we do not know what impact it has had on health care use and cost compared with conventional insurance. Com-
pany executives may think they are saving money through managed care, but rigorous published empirical evidence for PPOs is slender, and for point-of-service plans such evidence is virtually nonexistent. Moreover, we do not know which elements of managed care, or combination thereof, are most effective in containing use and cost, let alone the effect on quality of care and enrollee satisfaction.

**Containing use and cost.** The authors suggest some components of managed care that would be more effective in containing health care use and expenditure. As a group, the trendsetters are more likely to have these components than is the comparison group. Trendsetters serve on average much larger accounts, and carriers’ offerings in part reflect the demands and constraints of their accounts. Are the differences in plans offered less a reflection of the carriers themselves than of the clients they serve? Or do the trendsetters already have enough market power in local markets to implement more “cost-effective” reimbursement and utilization management (including provider management) mechanisms? If the latter is the case, at what point does a carrier’s share of a geographic market or individual physician’s business translate into market power or ability to gain more “cost-effective” arrangements with providers?

Since, as the authors point out, broad national data collected in the HIAA managed care survey are ill suited for examining performance in local market areas, it is difficult to determine the local market power of trendsetters. For example, a key lever in altering physician behavior is the percentage of an individual physician’s business provided by a carrier’s enrollees, and one proxy for percentage of business is the number of enrollees per physician. HIAA carriers had sixty enrollees per physician in these insurer-sponsored HMOs (compared with twenty-five enrollees per physician in PPOs). In contrast, Group Health Association of America (GHAA) data indicate enrollee/physician ratios of 198 for group-model, 312 for staff-model, and 25 for IPA-model HMOs. Thus, HIAA HMO plans have market power comparable to IPA plans rather than to group or staff models.

Nevertheless, in examining the differences between the trendsetters and comparison group carriers, the essay provides ample reasons why size in local markets may help a carrier contain costs and hence gain a competitive advantage. For example, one would expect that a carrier with a larger market share could funnel relatively large numbers of enrollees to a select group of providers and hence more likely have a larger part of a network provider’s business. That carrier would have more leverage in negotiating use patterns and price with providers and therefore have more control over its costs. Similarly, for both HMOs and PPOs, carriers with larger market share should be more able to negotiate hospital per diems
rather than billed or discounted charges, while for PPOs, larger carriers are in a better position to negotiate physician fee schedules rather than discounts from usual and customary charges. While we only know the trendsetters are large, rather than knowing their local market share or share of individual providers’ business, the evidence Hoy and colleagues present is consistent with the hypothesis that size puts larger carriers in a stronger position vis-à-vis providers.

Moreover, in building networks, carriers with larger market shares can draw on a bigger base of conventional insurance data to obtain physician profiles for initial selection of network providers. For new and existing networks, larger carriers in an area not only can do much more rigorous physician profiling (because of a higher number of enrollees per physician), but also have the economic power to “educate” high-utilizing physicians and replace them if they do not respond to this “education.” Larger carriers have the resources to own their networks, giving them more clout to influence network provider practice patterns than carriers that rent networks possess.\(^{13}\) The need for enormous local market share in intelligently using data to select providers is often underestimated. For example, in reviewing the entire book of business for a very large California carrier, we found that the mean number of specific procedures, such as cholecystectomy, appendectomy, and hernia repair, per physician submitting bills for such procedures is less than two. Thus, unless information can be pooled across carriers or procedures, adequate data on use patterns and outcomes are available only for a small fraction of physicians.

Size also permits carriers to offer an employer a multiple-option plan and manage the care in each option. Such carriers can not only attract the business of employers seeking multiple-option plans, but can also protect their performance record from the effects of unfavorable selection, one of the most problematic aspects of offering multiple plan choices to enrollees.\(^{14}\) While the market situation is changing, in 1990, only 10 percent of HIAA-member carriers were in a position to offer a “one-stop shopping” combination of PPOs, HMOs, and conventional insurance, and fewer still could also offer point-of-service plans.\(^{15}\)

In the days of conventional insurance without utilization management, product differentiation was more difficult, permitting the survival of numerous smaller carriers. If significant market share in local markets brings with it important competitive advantages, this could have implications for the structure of the insurance industry. This development would not only lead to consolidation of networks within a market area, noted in the article, but would also likely lead to fewer carriers in the insurance industry, a trend observed in an unpublished HIAA paper cited by the authors. This suggests that, to survive, small or mid-sized carriers
would have to establish sizable market share in targeted local markets, probably in combination with a focus on smaller, local employer accounts that larger carriers may not pursue. Smaller carriers may also have to join managed care network consortia to reap the benefits of larger market share. Private Health Care Systems is an important example the authors cite of how small and medium-sized carriers can form a consortium to achieve some of the advantages of the major carriers.

Hoy, Curtis, and Rice focus on plans offered by commercial insurance carriers, but it is important to remember that the Blues and free-standing HMOs are also major players in the field. While the major HIAA carriers are larger than individual Blue Cross/Blue Shield plans, the latter have more concentrated enrollment patterns and much larger local market shares. Long-standing ties to providers may have led the Blues to be less aggressive in forming networks, but increased pressure from the HIAA firms in this study may lead to more competition in this area. Similarly, some HMOs also have large market share in particular markets. For example, in California, Kaiser has about twice the enrollment of the next-largest carrier. Both increased assertiveness by the Blues and ongoing pressure from large HMOs should hasten the process of concentration and reorganization in the industry.

“Change and Growth in Managed Care” emphasizes the importance some carriers place on provider selection and retention. Some carriers are becoming increasingly sophisticated in selecting providers for their networks, because carriers have accumulated more knowledge about individual providers’ practice patterns, are developing new criteria for evaluating performance, and have better data systems and infrastructure to allow quicker and more intricate analyses of these patterns. While the data indicate that trendsetter carriers are more likely to have dropped a provider from their networks, we do not know how many providers they have dropped and hence how important this action is to providers.

This leads to a series of obvious questions. What are the criteria for provider selection, how do they differ among carriers, and how are they changing over time? How much emphasis is placed on quality of care, and how does the carrier assess quality? How much consideration is given to providers who may deal with a sicker case-mix? If network physicians with conservative practice patterns gain more business, what will be the impact on conventional insurance use and expenditures? What share of a provider’s business does the carrier need to change practice patterns?

**Managed Care Outcomes**

“Change and Growth in Managed Care” shows that there is real
product differentiation and experimentation going on in the commercial health insurance market. Clearly, commercial carriers are no longer merely selling their ability to process paper, selling instead their ability to create and manage complicated systems of care. If all carriers provided the same product, there would be no basis for different players and multiple options. Aggressive action by the large carriers suggests that big business is demanding real cost containment and is willing to switch providers, carriers, and products to get it. Yet product diversity is not an end in itself. It reflects alternative strategies of containing ever-rising health care costs, and the jury is still out on what works and what does not, both at the individual employer level and societywide.

Some very basic questions about managed care remain unanswered. We do not even know if managed care saves money. If so, are different types of programs more effective than others? How important are method of provider payment, method of physician selection, the level of benefit coverage, and structure of the network? Do savings arise through price reductions or changes in use patterns? How important is cost shifting from the employer to the enrollee? What happens to the quality of care and enrollee satisfaction?

What happens to overall administrative costs, as insurers move from passive claims processors to active use managers? Insurers’ administrative costs are already high relative to those in other countries and are particularly high for the small-group insurance market. Managed care could increase costs substantially, due to the enormous up-front costs incurred by some insurers, higher insurer network management costs, and increased provider administrative costs, the latter in response to greater insurer management. On the other hand, insurers’ micromanagement costs may eventually drop with careful selection of physicians, while providers’ administrative costs may decrease markedly if providers switch from dealing with dozens of different carriers to dealing with a handful of large networks.

From a societywide, “macro” perspective, if managed care does contain costs relative to conventional insurance, does managed care help contain overall health care costs, or are costs simply shifted to households, to employers with conventional insurance, or to government payers? Will managed care programs really succeed in reallocating a constrained number of dollars to a highly selected provider pool while forcing other providers to suffer real income losses? If not, the extra administrative costs will merely increase health expenditures.

Managed care outcomes will both affect and be affected by future health care financing arrangements, which raises other policy-related questions. What impact will managed care developments have on solving
the problem of thirty-four million uninsured and additional millions of underinsured persons, without major new government financing legislation or regulation? What impact would competitive managed care solutions have if incorporated within the framework of universal coverage proposals based on a play-or-pay or an Enthoven/Kronick scheme? How would managed care perform if more fundamental changes in the health care financing system took place, such as the creation of a single source of health care financing with overall health care budgets or expenditure targets? According to the competitive private-sector rhetoric behind multiple managed care plans, such a system would allow a more aggressive containment of provider incomes than would be the case under government/provider negotiations.

Obviously, these questions go far beyond the scope of the paper by Hoy, Curtis, and Rice. Most cannot be answered now, and some may never be answered. However, the essay suggests that the health insurance industry is in the process of a major transformation. As long as the primary business of carriers was speedy and efficient claims processing, there was little rationale for the multitude of carriers. The shift toward managed care means the development of truly different products, while it probably also foreshadows increasing concentration of power. Not only the structure, but also the existence, of the private health insurance industry is tied to these developments. Eventually, the major policy issue may be whether there is a rationale for even a relatively small number of carriers in each market area. Managed care with concentrated market power likely will be the way the insurance industry attempts to demonstrate a viable alternative to government monopsony.
NOTES

3. Enrollees in a PPO plan pay lower deductibles and/or copayments when they use PPO network providers than when they use out-of-network providers. A point-of-service plan is often either a PPO with a primary care physician service “gatekeeper” or an HMO with an out-of-network option. Again, enrollees face lower out-of-pocket expenses when they use point-of-service providers rather than nonnetwork providers.
4. SMG Marketing Group, Preferred Provider Organizations.
5. For example, much of the early PPO growth was automatic rollovers into “hold-harmless” situations, where insurance/enrollee proportions of service costs went from 80/20 in conventional insurance to 90/10 in network and 80/20 out of network.
11. It is important to note that some of the limitations are inherent in the use of a survey rather than in-depth interviews, some arise from the constraints imposed by a brief article rather than an extensive monograph, and some arise from carriers’ concerns about maintaining the confidentiality of their business strategies. When investments are in the hundreds of millions of dollars, such concerns cannot be dismissed as being unrealistic.
13. Unfortunately, the data provided in “Change and Growth in Managed Care” simply indicate whether a carrier rents at least one network or not, rather than how important renting is to different carriers.
14. While “home-grown” HMOs are often grandfathered into a multiple-option plan, new enrollment in these HMOs is often not permitted.
15. Providing “one-stop shopping” by adding HMOs is not limited to commercial carriers or the Blue Cross/Blue Shield plans. The reverse phenomenon is also occurring; HMOs, such as United Health Care, are attempting to provide “one-stop shopping” by offering PPOs and even conventional insurance. Also, some HMOs, such as Group Health in Minneapolis, are entering joint ventures with insurers.