

## **Managed Care Mythology: Supply-Side Dreams Die Hard**

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*As managed care gains increasing influence over the American health financing system, economic pressures and emerging market realities have created a fertile climate for wishful thinking on the part of hospital executives and physicians. Rather than accept the inevitability of reducing excess capacity and incomes, providers cling to self-serving myths about managed care's strategic direction. Here are five of these myths along with their contrasting market realities.*

### ***Myth 1. Integrated delivery systems will dominate the managed care marketplace.***

There is a remarkable unanimity of opinion, particularly among multi-hospital system executives, that future regional healthcare markets will be controlled by a handful of integrated delivery systems that offer a broad-spectrum, closed-panel menu of physician, hospital, and community-based health services for a fixed price. Indeed, this was the Ellwood/Enthoven vision of the end state of managed competition: multiple closed-panel integrated health enterprises competing for enrollment.

This belief has led to an unprecedented volume of mergers, consolidations, and physician practice acquisitions as systems position themselves to emulate the classic, closed-panel entities like Kaiser or the Group Health Cooperatives.

The reality is that employers and consumers are asking the healthcare system for something very different: a seemingly incongruous mixture of broad choice and economic discipline. Employers and consumers are profoundly reluctant to disrupt long-standing relationships with physicians and hospitals that have met their needs in the past.

The over-supply of hospital beds and specialty services, and the resultant provider panic at the bargaining table, has enabled IPA and network style plans-and even PPOs in many cases-to offer the amenities of fee-for-service medicine at HMO prices. As a result, the growth in health plan enrollment has bypassed the closed-panel plans.

Consumers and health plans simply do not gain economic or qualitative advantage by selecting provider- packaged services from a closed panel. Many traditional group- and staff-model health plans find themselves in the anomalous position of being three down to their broader-based competitors: They are (1) more costly, (2) less convenient, and (3) offer poorer service. As a result, enrollment in closed-panel plans peaked in 1989, and has since fallen significantly (see graph).

The pressure toward broad, inclusive networks has been so intense as to force the historically closed systems like Kaiser and Group Health to build point-of-service network relationships with the private practicing cohort of the physician community (against which they have competed for three generations!). These "partnerships" have

Stimulated bitter dissension among the traditional group- and staff-model physicians, who viewed participating in the managed care movement as a "just cause."

The imperative to attack the physician cost and productivity problem has led traditionally closed-panel plans to make dramatic departures from their historical strategies. FHP and CIGNA, both mixed-model health plans, recently spun off their staff-model physician clinic systems in the West (and, in FHP's case, their owned hospitals as well), citing unacceptably high fixed costs and poor productivity. For the traditional "prepaid group practice" plans like Kaiser and Group Health, improving physician productivity and responsiveness has become the central management challenge.

On the hospital side, the marginal cost of an inpatient day has fallen to the point where having "captive" hospitals within a health plan no longer makes economic sense. Kaiser has decided to close its Bess Kaiser Hospital in Portland, Oregon rather than replace it, and to contract with rival systems, the Sisters of Providence and the Legacy Health System, to hospitalize its north Portland patients, Kaiser has also decided to close, rather than replace, several of its San Francisco area hospitals and to contract with community hospitals for inpatient care.

For many years, the conventional wisdom in the managed care world has been that closed-panel group- or staff-model health plans were the "end state" in the evolution of health systems. The economic realities of the Nineties have led to a different conclusion: Closed-panel "integrated" plans may be dinosaurs incapable of competing in an increasingly cost- and access-conscious healthcare marketplace. The decline in market share and profitability of closed-panel plans is not temporary; rather, it reflects fundamental defects in the strategy.

An important implication of this market reality is that most of the tremendous expenditure of funds or energy by providers in creating new closed-panel entities-through mergers, practice acquisitions, and physician-hospital organization development-seems likely to be wasted. Those systems burdened with high acquisition costs or increased debt will find themselves struggling to operate profitably in a tightening healthcare market.

Major re-engineering of clinical and management systems will be required to salvage the positions of the long-established "integrated" organizations. Evaluating the economics of the "make or buy" tradeoff for each component of a system's product will be a management imperative for the vertically integrated system. Selective "disintegration" through outsourcing and creation of internal competition between provider panels within broad networks will be the ultimate management response to the disabilities of asset- and employment-based systems.

***Myth 2. Health plans fear direct contracting by providers as a competitive threat to their business.***

Providers believe that employers are to bypass health insurers and contract directly with providers. Hospitals and physicians look hungrily at the difference between premiums and medical expense as either pure profit or waste, and believe that by cutting out the middleman, they could pay themselves more generously than current market rates and reduce irritating oversight of their activities. In this comforting vision, health plans simply melt away, and provider systems and business groups contract directly with one another on an at-risk basis.

The reality is less comforting: Most employers continue to view health plans as effective counterweights to provider economic interests and as market consolidators and simplifiers. It is difficult for employers who blamed hospitals and doctors for the massive run-up in their health costs during the Eighties to believe that providers have had a "religious" experience and are now wholeheartedly in the cost-containment business.

The lack of provider credibility in this arena has had visible market consequences: the nearly universal lack of success of physician-hospital organizations in direct contracting with employers (or even with health plans, for that matter). As long as event-driven (e.g., per admission or per procedure) payment for health services remains the principal payment methodology (see Myth 4), provider incentives remain linked to generating more volume and cost, and employers will continue to view health plans as bulwarks against future health cost inflation.

While some health plans may explore "administrative services only" relationships with a few well-organized provider systems, the likelihood is that employers will continue to rely upon health plans to organize and discipline the medical market. Direct contracting may succeed in a few places, but for most providers, it will remain only a tantalizing mirage that distracts them from the less glamorous but necessary task of putting their own houses in order, and learning how to be profitable, high-quality vendors of health services.

***Myth 3. Managed care is a highly profitable, low-risk business.***

Many providers characterize insurers as simply packagers of providers' services, laying virtually all the risk of future cost increases off onto providers through capitation, and then pocketing the huge differences between premium and cost. While this may describe some health plan strategies, many health plans decline to share risk with providers, relying instead on their bargaining power and external utilization controls to contain cost (please see Myth 4).

Health plan executives also have long memories; they remember that underwriting medical risk is a brutally cyclical business. During the last "bottoming" of the underwriting cycle in 1986-87, health insurers-HMOs included-lost billions of dollars. Despite record profits during the early Nineties, the next three years will see narrowing or vanishing profits in health insurance, and serious cash-flow problems for overextended

plans. Providers need to remember that bearing risk has a downside, and that it is possible to drown in a river that is on the average only a foot deep.

Historically, HMO operating margins have averaged around 5 percent across the underwriting cycle (though there remains great dispersion around this average depending on plan underwriting and enrollment strategies).

The rest of the difference between premium and medical expense consists of working capital, the cost of reinsurance, broker commissions, customer service/claims management, and marketing. The latter functions are not only a bloody nuisance and poorly automated, but areas where providers have been, if anything, even more inept than most insurers. How many hospitals can yet generate an intelligible bill, or "interface" with customers on medical claims without infuriating them?

Yet, the lure of "owning the premium" has attracted an increasing number of provider groups, even Columbia/ HCA, to enter the health insurance business. It would be difficult to think of a worse time to enter the health insurance market than today: when health insurance is on the down-curve of the underwriting cycle.

Health insurers cannot raise rates even to cover modest cost inflation for most of their group insurance customers. In many health insurance markets, rampant price cutting is the order of the day. And most health plan managers understand that the systems they have in place will not adequately protect them against the next, inevitable upsurge in medical expense. Finally, health plans are politically vulnerable if they run very low medical loss ratios for a sustained period, because the loss ratio is an alluring regulatory target.

Middlemen exist in markets for a reason: to matrix with a highly fragmented customer base and to cushion the variability in product expense. Neither the fragmentation nor the variability seems likely to disappear in the foreseeable future.

***Myth 4. Capitation will be the dominant or exclusive form of provider payment in the future.***

This is a major current topic for debate in the managed care community. The nature and amount of risk sharing in health plan contracting varies significantly from region to region around the country. For much of the South and East, managed care payment is still event-driven (for example, fee-for-service with withholds for physicians and per them or per case for hospitals).

Many health plans see little reason ever to share risk and premium with hospitals or hospital systems, since physicians control hospital use decisions. There is profound philosophical division among health plan managers over whether and how to share risk even with physicians. Some plan managers anticipate moving to a protocol-driven framework for managing cost, while continuing to pay physicians on a fee basis. Other

plan managers, particularly those with long-term successful relationships with IPAs or medical groups, are more willing to share risk with physicians.

Now, however, with increasing numbers of high-risk patients from the Medicaid and Medicare programs entering health plans, there are the beginnings of a backlash against capitating the primary-care physician (see Myth 5), instead keeping the risk at the group level. Increasing questions are raised about how much control primary-care physicians can or should exert over specialty use decisions.

Capitating specialists appears to provide health plans more leverage for controlling procedure volume and hospitalization rates, particularly in broad-based plans that can rely on competition between panels of specialists for primary-care referrals or patient-directed choice. By carving out capitated niches along specialty lines, however, health plans run the risk of unacceptable fragmentation of patient experience. The whole patient seems likely to be far greater than the sum of the carved out parts, and coordination and communication problems may ultimately doom this approach.

The reality is that no one has yet devised a method for paying physicians that will optimize clinical effectiveness. Capitating the individual physician and capitating the hospital will probably not be the mechanisms of choice for paying providers in the future. In the final analysis, risk will probably devolve from health plans to broad-based physician entities, and then be suballocated to physician/nonphysician teams based on acuity of illness or patient demography. Hospitals will have to learn to make money and deliver effective care on a per them or per case basis.

***Myth 5: Primary-care physicians will function as incented gatekeepers for the health system.***

Many health plans presently require their subscribers to select a primary-care physician who will function as a "gatekeeper" for their use of health services. The health plan then creates incentives for the primary-care physician to minimize healthcare use, particularly hospitalization and consultation with medical and surgical subspecialists.

The current view is that having your own network of primary-care physicians to function as gatekeepers for enrolled populations is the key variable in determining the success of the health plan.

Yet consider the following situations and ask yourself how helpful the gatekeeper model is likely to be in producing a good outcome:

- A 32-year-old female who has recently experienced debilitating episodes of fatigue and depression. She eats only irregularly and has lost weight. She lacks the energy to maintain her professional career, take care of her two young children, and keep her marriage together.

- An 18-year-old male who is comatose in a hospital ICU as the result of a motorcycle accident.
- A 45-year-old male at the pinnacle of his professional career who has a father with Alzheimer's disease in a nursing home, is divorced, and maintains joint custody of his two teenage children. He is stressed out, unhappy with his job, and unable to manage financially the transition to a new job or career. He is drinking too much, is overweight, and at a recent physical exam was found to have hypertension, an irregular heartbeat, and an abnormal stress test.
- A 24-year-old female who has debilitating rheumatoid arthritis, frequent attacks of asthma, and appears to be diabetic.
- A 74-year-old female who has chronic depression, low blood pressure leading to fainting spells, periodic recurring Upper respiratory infections, and osteoporosis. During the past six months, she has been hospitalized for pneumonia, a hip fracture, and a possible stroke. She calls her primary-care physician's office at least twice a day seeking help or advice on her problems, both medical and non-medical.

Conceivably, several of these situations could be handled by a competent general internist, but the economic pressure to minimize specialty consultation would probably result in suboptimal care for the patients with multiple symptoms. Results would probably be better in several of these instances if the appropriate subspecialist assumed the role of "attending physician." In other instances, the need for a less expensive point of contact between the patient or family than a physician is obvious.

It is ironic that America has spent many billions of dollars creating the knowledge framework of subspecialty competence, and now is spending billions more to prevent physicians from using their knowledge. What is missing is an appropriate and agreed-upon division of labor between primary care and specialty care for given medical problems.

Arriving at a consensus on this issue has been complicated by the politization of relations between these important and interdependent branches of medicine. Huge income inequality between primary-care and specialty physicians has lent a "class warfare" quality to physician relationships, which health plans have exploited.

The central issue in managing care should be making sure that the fit between patient problems and clinical resources is both optimal and dynamic, and that communication among physicians and others with differing clinical competencies and knowledge is improved. Polarizing relationships between primary-care physicians and specialists via gatekeeper systems will not achieve either goal.

This issue will become more important as more poor and elderly patients enter the managed care risk pool. Effective care for the multi-functionally impaired, chronically ill elderly should be team-based. The team leader may not even be a physician, but a

professional care manager. With the Medicaid population, one-third of whom are now enrolled in managed care plans, there is a similar need for a seamless blending of medical and social/human services.

Finally, in life-threatening crises, the primary-care gatekeeper is simply an administrative headache for the critical-care team charged with saving the patient's life.

As managed care plans better understand the constellation of health risks in their pools, they will develop a more sophisticated method of matching clinical needs to appropriate health resources than a single, predetermined primary-care physician.

Even for the largely well or worried well populations, a system that relies solely upon a physician as the principal contact point may not be either the cost-effective or patient-friendly solution. Multiple patient pathways and staffing approaches will be required depending on the acuity of patient needs. Dr. Sidney Garfield, the visionary founder of the Kaiser Health Plans, anticipated such a multi-path approach in a remarkable article that appeared in *Scientific American* in 1970 (see figure).

Health plans that base their clinical architecture on a primary-care gatekeeper, or for that matter on an all-physician clinical system, may find that the rigidity of this approach will cost them both dollars and lost subscribers.

In this problem may lie the seeds of comparative advantage for physician systems with strong enough governance to manage the increased use of nonphysician caregivers and care managers. This will be a very difficult transition for network-style health plans and hospital systems with large numbers of private practicing physicians. The fragmentation of private medical practice will provide a window of market opportunity for health plans or care systems that can re-engineer the patient's pathway through the system, and create systems that manage clinical risk before illness strikes.

Careful examination of the reality behind each of these five myths casts doubt on the vision of a future medical marketplace as a zero-sum contest between closed-panel enterprises. The emerging market appears to be a more complex melding of collaborating and competing enterprises and exciting, more responsive models of care. Provider organizations will learn painfully that understanding and leveraging their core competencies is a more reliable strategy over the long term than seeking to aggrandize control over patients.

We continue to believe that physician-directed enterprises capable of hearing and managing risk have a very bright future. Acquiring these competencies and developing strategic partnerships among hospitals, health plans, -and accountable physician entities will be essential as managed care continues to grow.