

MANAGED CARE COMES OF AGE

As markets mature, managed care plans will increasingly be forced to actually manage care as a vehicle for generating earnings growth.

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The Hallmark of Adolescence is defining one's identity by contrast, by rebelling against parental expectations and values. It is also an awkward, angst-ridden time -- a time of searching and testing. Despite its 60-year history, managed care as a business is still in its adolescence. After a lengthy period in the shadows of "fee-for-service" and indemnity insurance, managed care plans have emerged in the mid-Nineties as the dominant force in American healthcare financing. Given what we already know about maturing industries, we can be sure that managed care will evolve as it solidifies its position as the organizing template of American healthcare payment. This article looks at how the burden of market leadership will change the managed care movement.

Shifting risk and responsibility

However health reform ultimately plays out, those who pay for care (government and employers) are shifting significant responsibility for managing future costs onto private health plans. Health plans will, in turn, shift both cost and responsibility for future healthcare expenditures onto providers through fixed-price or capitated contracts, as well as onto patients and subscribers through increased cost-sharing.

For both employers and the government, this shift represents a change in benefits philosophy from an open-ended "service benefit" approach to health coverage, to a "defined contribution" approach embodied in managed care entities such as health maintenance organizations (HMOs). Less obviously, these changes also represent the end of a "casualty" model of health insurance, where illness is viewed as an act of God, and the emergence of an "active agency" model, in which our behavior mediates health risk and illness. The real debate in government and society revolves around the pace at which these shifts will occur.

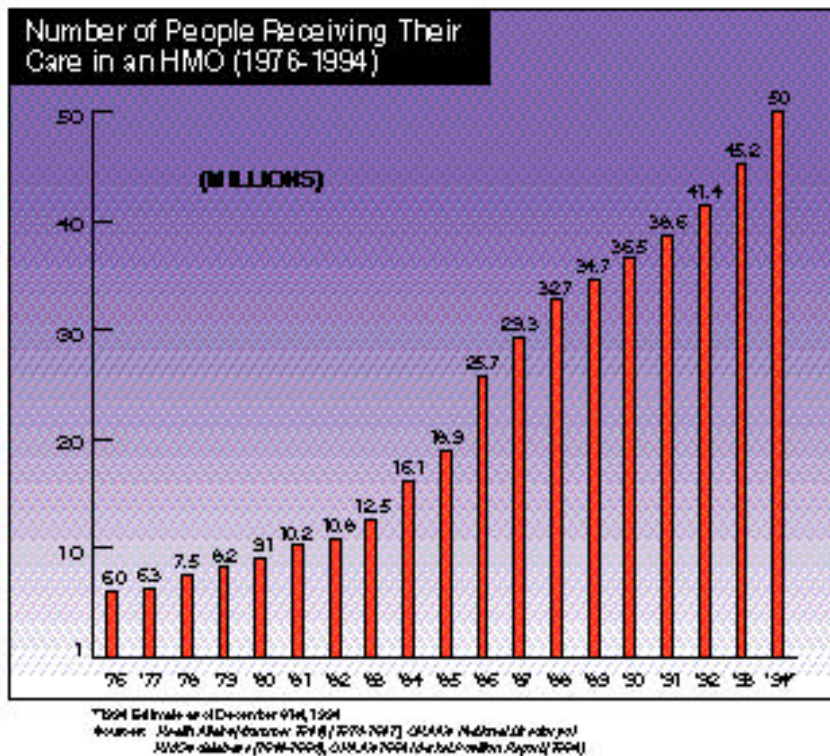
These changes in healthcare financing principles and practices are, ironically, the product of our health system's successes. The American economy leads the world in scientific and technical innovation in medicine. As a result, Americans support much of the costly early stage of the worldwide learning curve in applying medical innovation to improving human life. American economic plenty has permitted an expansive healthcare financing system with a "bias toward action." The resultant health cost expansion has outstripped the society's ability to fund the costs.

Shaking the pillars

For almost 20 years, policymakers and corporate benefits managers have sought the right mix of incentives and benefits to encourage a more conservative use, of medical resources. The result has been a progressive shifting of economic risk to the health system, a result not only of federal policy changes but of growing acceptance by employers and families of HMOs as 'single source' providers of care.

Fifteen years ago, less than one in 20 Americans were enrolled in HMOs (more than one-third of them in one entity, the Kaiser Permanente Medical Care plans). Health maintenance organizations were a regional, not national, phenomenon—strong in the West and upper Midwest, and virtually nonexistent in the South and most of the East. In many communities, HMOs grew out of consumer movements, such as the Group Health Cooperative of Puget Sound, or labor union benefit trust activism such as the Henry Ford Health Alliance Plan in Detroit.

During the Seventies, the federal government threw its weight behind encouraging HMO development, setting the stage for the historic expansion during the Eighties. Since 1980, HMO enrollment has more than quintupled, from less than 10 million to more than 50 million Americans



(see Figure 1).

The growth in managed care is good news for the American economy, because only inside the HMO can one find the economic discipline produced by a fixed resource limit for caring for a defined population. The rest of the healthcare financing system has been both open-ended and event-driven. The economic bias of the conventional health insurance system and federal health financing programs has been explosively inflationary.

But the growth of managed care does not feel like "good news" to the healthcare system's major players -- physicians, hospitals, and insurers -- all of whom are struggling to redefine their economic destiny in an era of "at-risk" payment. This growth has shaken the twin pillars of American medicine -- private medical practice and the acute -- care hospital to their respective foundations. Under the old financing ground rules, hospitals and doctors bore virtually no risk for future healthcare use. At the same time, the growth of managed care has challenged health insurers to fundamentally redefine their business and their relationship to their corporate customers.

"Out of position"

The growth in managed care has caught all the major actors in the American healthcare system "out of position." Physicians realize that as individual professionals, they will no longer be contracting with individual patients for care. Rather, physicians will contract through groups for groups of potential enrolled lives.

Physicians practicing alone or in very small groups have come to realize that their future incomes could be determined by individual decisions they make to join, or not to join, someone else's provider network-hardly a power position. Primary-care physicians have come to realize that though they are the indispensable core element of managed care systems, they often lack the organizational vehicle or resources to leverage their potential influence on healthcare provision.

Hospitals recognize that they are the principal cost-reduction target of most health plans, and that someone will be upstream of them in the healthcare payment system, not only attempting to minimize their use, but to pay bottom dollar for the care that is required.

Hospitals have responded not only by merging and by absorbing primary-care physicians through practice acquisition, but by entering the financing of care through direct contracting with employers and through hospital-sponsored health plan development. In a threatening economic environment, hospitals are "out of position" to manage the shifting of economic risk.

Many health insurers suffered catastrophic underwriting losses in the 1986-87 "bottoming" of the health insurance underwriting cycle, and benefited from the 1993-94 pause in health cost increases without taking significant management action to affect their cost trends. Health plans realize that simply functioning as a passive conduit for future health cost increases is a path to economic ruin. They also realize that the external utilization controls many of them imposed during the Eighties, such as utilization review, may not be sufficiently robust to protect them and their corporate clients from a new burst of cost inflation or a surge in cost shifting produced by Medicare and Medicaid funding constraints.

A number of traditional health insurers, such as Blue Cross or commercial carriers like Aetna and CIGNA, have realized that as health maintenance organizations have created "point of service" networks for subscribers that provide free choice of physicians and hospitals, traditional health insurance has become increasingly superfluous for their large corporate customers.

How much to become involved in actual healthcare delivery is a central strategic question facing insurers. With the dawning realization that consumer choice of physicians and hospitals is price sensitive, insurers seem poised to increase their influence over healthcare delivery, yet they lack the management tradition, expertise, and information base to leverage that influence.

The repositioning of the various actors in American healthcare has blurred the traditional "bright line" between medical practice, the hospital, and health insurer, and created many new entities that integrate financing and delivery of care.

Growing pains

The drive to integrate represents a recognition that each sector of the health system—physicians, hospitals, and insurers—has fundamental structural problems in managing the health costs of defined populations of subscribers within fixed payment contracts.

Physicians face the problem of collaborating in sharing economic risk. Under the old payment ground rules, physicians not only didn't have to work closely together, they didn't even have to like one another. Each physician ran his or her own shop and referrals and clinical decisions were highly individual and informal decisions. Sharing economic risk requires far closer physician collaboration than most members of the current Generation of physicians have experienced.

As if this weren't enough, managed care also redistributes wealth and power in medical communities away from the specialists, such as Surgeons, radiologists, cardiologists who have traditionally dominated, toward primary-care physicians such as general internists and family practitioners. Managed care economics are profoundly divisive and threatening to medical communities. Even large, seemingly well-positioned multi-specialty physician groups have encountered great strains and conflict in managing capitated payment.

Hospital management and boards have traditionally exerted limited influence over clinical cost decisions. These decisions have been the province of a medical staff the hospital typically neither employed nor meaningfully controlled. Even in institutions with employed physicians, such as teaching hospitals, executives typically have had limited impact on physician clinical decisions. In the past, hospitals benefited from vigorous patronage by physicians, who bore no economic risk for the hospital's commitment of capital or operating dollars to support their practices.

As a result, hospital governance is often so weak that it can barely meet the minimal test of removing a dangerous impaired physician from the hospital staff. The task of managing how physicians use the hospital is considerably more demanding and difficult, since it will reduce physician income and restrict freedom as well as shrinking the hospital's traditional franchise, placing the hospital at risk. For the health costs of large populations of enrolled citizens puts great strain on very weak governance structures. These structural weaknesses not only do not disappear when hospitals merge or hire their own physicians, but often actually intensify to the point of institutional paralysis.

Health insurers who lack hardwired physician and hospital networks that include contractual arrangements limiting how providers are paid (replacing the “do more, make more” ground rules of traditional provider payment), cannot make meaningful long-term cost management guarantees to their corporate customers. In the absence of such contracts, insurers are still locked into paying on an after-the-fact, per-incident-of-service basis for care.

Insurers spent hundreds of millions of dollars during the past ten years putting these networks in place, as well as developing the information technology to track payments and service use. However, the duplicative networks of utilization monitoring (the proverbial rooms full of nurses in Tucson who approve clinical services for payment) are a huge cost and public relations burden to health insurers.

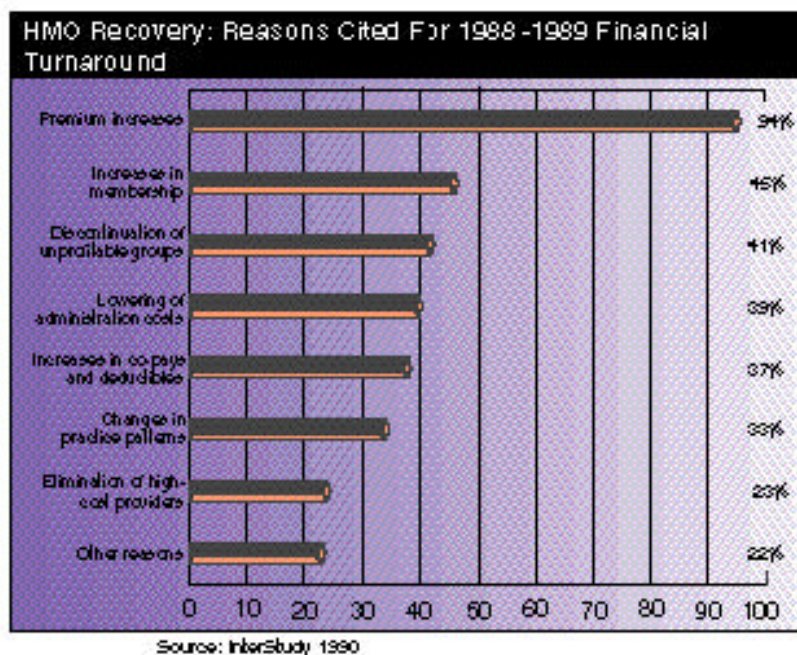
These costs become unnecessary if the insurer can contract with physician groups on an at-risk, per capita basis. Capitation renders service-by-service approval of care unnecessary, because additional services reduce physician incomes, giving physicians powerful incentives to police their own clinical behavior. Insurers are thus burdened with unsustainably high fixed costs

as well as a “command and control” mindset sharply at odds with a collaborative risk-sharing environment.

Image and reality

Managed care providers, as well as traditional health insurers, took a public relations beating during the 1993-94 health reform debate. Advocates of health reform hammered health insurers for abusing the public trust by denying access to insurance for those in need, for excessive profits and executive compensations, and for bureaucratic interference with doctor patient relationships. While these attacks were obviously designed to justify a marked expansion in federal regulation of health insurance, the behavior of managed care firms in the late Eighties raised legitimate questions about their operations.

In 1990, the policy research film InterStudy reviewed the strategies managed care firms pursued regain profitability in the wake of the underwriting debacle of 1986-87. “Managing care” did not play a significant role in the turnaround. Only one-third of managed care firms actually pursued a strategy of modifying clinical practice (see Figure 2). By contrast, increasing rates, discontinuing coverage for selected groups, growing enrollment, and tightened “underwriting” (aggressively pricing premiums to match group risk) were the dominant strategies. These strategies were indistinguishable from those pursued by traditional “indemnity” insurers.



We believe that several of these strategies will be less available with increasing congressional and public aversion to health insurance practices. Health insurers, both traditional and managed care-based, will find their ability to underwrite aggressively or to selectively exclude groups or individuals from coverage sharply restricted by changes in federal and state policy. And in many parts of the country, the ability to grow enrollment will diminish as managed care saturates traditional employer-based markets and spreads into the Medicare and Medicaid populations. As markets mature, managed care plans will be forced increasingly to actually manage care as a vehicle for generating earnings growth.

A coming of age

As the market matures, managed care enterprises will be driven to fundamentally redefine their business. Managed care firms will follow a predictable path of redefinition of their business as growth plateaus and traditional strategies for generating earnings no longer yield measurable gain.

As managed care evolves, HMOs will be forced increasingly to demonstrate not only qualitative improvement in the care rendered to patients, but actual improvements in their health. Managed care firms will be forced to adopt these strategies as relatively easy methods for generating savings.

As more elderly and high-risk individuals enroll in health plans and underwriting is restricted by health reform, it will take actual differences in health plan performance to generate savings for the customer and earnings for the managed care firm.

The evolution of managed care consists of three stages: (I) event-driven cost avoidance, (II) value improvement, and (III) health improvement. (The progressive redefinition of managed care is displayed in Figure 3.)

Stage I: Event-driven cost avoidance

The historic strategy for generating earnings in managed care relied on two approaches: securing discounted fees and charges from providers, and avoiding hospitalization of subscribers after they have become sick. This latter strategy we term event-driven cost avoidance. The traditional cost-reduction strategy for managed care plans has been to reduce hospitalization of their subscribers below the level of the community at large, through utilization review and substitution of ambulatory for inpatient services.

At the beginning of the Eighties, hospitalization rates for managed care plans were often one-third or less than the rates in the community as a whole. This often translated into a significant cost advantage relative to "unmanaged" health insurance plans. Managed care plans were assisted in achieving profitability by enrolling the healthiest part of the U.S. population -- blue and white-collar workers and their families -- and by not enrolling significant numbers of the poor or elderly, who consume much larger quantities of healthcare. Enrollment of Medicare and Medicaid populations in managed care plans grew very slowly during the Eighties, despite rhetoric from the Reagan and Bush administrations about supporting managed care. By 1990, only 8 percent of the more than 60 million Medicare and Medicaid recipients were enrolled in prepaid health plans.

Managed care plans were able to retain most of the savings from discounts and reduced hospitalization because they "shadow priced" their premiums under the spacious cost umbrella of traditional indemnity or Blue Cross health insurers, who were simply writing checks after the fact for services provided their subscribers. In sum, managed care was not a very demanding business.

Managed care firms were perhaps most constrained by market resistance-unwillingness of physicians to contract with them, consumer concerns about restricted access to their physicians, or employer unwillingness to sever ties with traditional insurers rather than by the fundamentals of their business.

While consumer and employer acceptance has rapidly grown, the relatively undemanding nature of managed care as a business has markedly toughened-particularly in the parts of the United States where managed care has become the dominant form of health insurance. Managed care hospitalization rates rose by more than 10 percent during the early Nineties as more elderly and high-risk enrollees were added to plans, while overall community hospitalization rates fell by as much as 50 percent in some communities.

Now, it is not unusual to find HMO hospitalization rates that are not one-third, but two-thirds or three-quarters of those in the surrounding communities. "Arbitraging" hospital use no longer provides a meaningful cost advantage for managed care plans in those markets. Provider discounting has become widespread, eliminating the other major source of the premium differential that managed care firms enjoyed.

And as traditional indemnity carriers or Blue Cross plans have mounted aggressive efforts to convert their subscribers to managed care, the spacious cost umbrella has also disappeared. In many communities during 1994 and 1995, health insurance rates have actually been failing.

Managed care providers are now competing against one another in many markets, rather than against indemnity carriers. The result has been a flattening or disappearance of price differentials among health plans, as well as an increasing breadth of provider networks. The result in highly competitive markets is that price and access no longer differentiate health plans from one another. The traditional strategy of event-driven cost avoidance and discounting no longer assures long-term profitability. In those markets, managed care "best practice" has already shifted toward primary-care-oriented medicine driven by empirically derived standards of care, and away from specialist/hospital-driven care.

Some HMOs have pursued an alternative short-term strategy: driving the purchase price of hospital and physician services below the provider's marginal cost, in order to harvest the maximum cost advantage from a panicked provider community. This strategy has been successful for some of the aggressive, investor-owned HMOs like U.S. Healthcare and WellPoint, but it has a limited window before provider consolidation and economic losses force a realignment of negotiated prices. It also risks disintegration of broad network coverage, because disgruntled providers may refuse to continue serving health plans they perceive as exploiting them. Nonetheless, for providers, the playing out of this below-cost procurement strategy heralds a sustained period of real suffering, as excess capacity is shaken out of the hospital and specialty physician sectors.

Stage II: Value improvement

As sources of easy cost savings play out and premiums for managed care and networks increasingly converge, managed care firms and many of their contracting provider groups have been forced to take a much more detailed and aggressive look at how to maximize the value of their product. To achieve meaningful value improvement, the managed care enterprise must realign the behaviors of all components of their delivery system and create new incentives to conserve clinical resources in treating patients.

To achieve competitive price and service advantage, managed care firms must work with hospitals and physicians to restructure their delivery Systems, as well as create a knowledge-based framework for improving results at the level of actual clinical decision-making.

Value improvement has both tactical and strategic dimensions. Long-term competitive advantage will be measured by corporate purchasers and the government not only in reduced per capita cost of care but in measurable improvements in clinical outcomes (such as reduced infection rates, post-surgical complications, and re-admissions). In the short term, however, managed care firms can make a significant cost difference by redesigning clinical processes.

Prescription drug use is a good example. Often, in unmanaged care, patients will see multiple physicians for different conditions. Each physician may prescribe drugs for the condition he or she sees, without knowing that other physicians are prescribing drugs that interact with them. This practice, known as "polypharmacy," is not only expensive but dangerous, and it can lead to physician-caused complications that inflict needless suffering and increase the cost of care.

In an Unmanaged setting, physicians have no incentive to examine prescribing patterns or explore generic drug Substitution, which can yield further savings. Managed care firms save money and avoid complications for patients and employers by standardizing prescribing practices across participating physicians and developing drug formularies to maximize opportunities to save money on prescribed drugs.

Accurate clinical information available at the point of service is an essential precondition of value improvement. Information systems architecture must provide multi-site access to a much finer-grained picture of how resources are used in treating patients-in the physician's office and clinic as well as the hospital. Often this information is gathered, but not made available to clinical teams to monitor and control costs. Creating this information framework is a long-term tactical challenge, as well as a major economic investment for the managed care system.

To use this information effectively however, clinical teams must collaborate on a multidisciplinary basis to change how care is provided. Traditional hospital structures and the culture of medical practice have inhibited this collaboration. Inside the hospital, traditional authority has been "top down" in vertical "silos" built around the multitude of professions that work there.

As healthcare has decentralized the physician's office and remote sites (surgi-centers, clinical laboratories) have fiercely resisted "integration" into a hospital-based decision framework. Patients experience these discontinuities as multiple repetitive requests for insurance information, multiple visits for the same condition, and duplicative testing. Traditional forms of physician remuneration -- in which payment for each piece of the clinical encounter flows to different physicians, have contributed to this disjointed process.

Actual clinical-care processes are horizontal across disciplines and sites -- that is, organized around the patient's needs through an episode of care, rather than around professions and departments. The culture of medical practice is increasingly collaborative and collegial, not hierarchical. It is the improvement of these processes -- how patients experience the health system while using it -- and dismantling organizational barriers to information flow that hold the key to long-term success in value improvement.

The fact that clinical practitioners are intensely curious, empirical individuals makes it easier to collaborate around process and clinical outcome improvement. "Top down" discipline is

often superfluous if clinicians can engage in active, data-based dialogue about the best and most cost-effective clinical practices.

The most progressive managed care plans and integrated healthcare systems are working simultaneously on the various pieces of what we have termed "value improvement." These individual strategies (such as TQM/CQI, clinical pathway development, outcomes measurement, and information systems development) have yet to be integrated in a way that produces measurable cost or quality differences among health plans. Unless the strategies can be tightly linked to profitability and improved consumer satisfaction, they will not yield market advantage or produce market share gain. It may take as much as a decade for managed care firms to actually achieve control over the value of their product through value improvement.

Stage III. Health improvement

One is driven by this logic to ask how health plans and systems will differentiate themselves once value improvement has become the norm. As managed care firms succeed in stripping out layers of cost from reduced hospitalization, delivery system consolidation, and clinical process improvement, they will have to find new strategies for creating value.

We believe that, unavoidably, health plans will see the level of health risk and actual illness of their enrolled populations rise as more of the poor, elderly, and those presently uninsured enroll. The traditional strategies of excluding high-risk individuals or groups through underwriting will be foreclosed not only by health reform but by the practical realities of saturated enrollments.

By the time managed care plans enroll 70 or 80 percent of a metropolitan population, health plans with large market shares will find their subscribers' health risks effectively mirror those of the larger community. If a plan has 25 or 30 percent market share in an area where managed care plans enroll the vast majority of a community's citizens, the health plan will discover that it is really in the public health business.

Health plans will begin employing population-based medical tools such as epidemiology to focus their attention on the high-risk individuals in their pools, and direct their clinical resources toward managing that risk.

New technological developments will enable identification of clinical risk long before it flowers into disease. Marked expansion of genetic testing for the preconditions of disease and much more sophisticated blood testing will be available to help managed care plans and health systems identify those at highest risk.

It is highly unlikely that insurers will be permitted to use genetic testing to individually rate high-risk subscribers or to exclude them from coverage (or for that matter, even to compel individuals to be tested or treated if they do not wish to be). However, as more therapies for genetically based diseases such as diabetes, cystic fibrosis, and cancer emerge from pharmaceutical and biotech firms, individuals will be increasingly motivated to determine their risk and to collaborate with their health plan in avoiding or delaying illness.

These new approaches-such as gene therapy, new immunizations for chronic as well as infectious disease, and immune therapy using new bioengineered substances-are likely to be very expensive, compelling health plans to make difficult judgments about who will receive them.

These judgments will require not only good information about outcomes and cost-benefit ratios, but clinical and, ultimately, community consensus on the criteria for such interventions.

But many of today's medical expenditures are for conditions that are manageable with existing technologies or no technology at all. Assuring that high-risk pregnant women get effective prenatal care does not require rocket science. Neither does assuring that high-risk diabetics get assistance in reducing their weight and controlling their blood sugar, or that those with high blood pressure receive medication and assistance in stopping smoking.

Changing behavior will also require changing values and incentives. What the current health system has conspicuously failed to do is provide incentives to providers or subscribers to identify and manage disease risk before it flowers into illness. This is due in part to a payment system that has rewarded costly intervention and penalized preventive care. But it is also due to a passive, "bottom of the cliff" posture on the part of clinical practitioners, and, the belief on the part of citizens that disease is an act of God or nature, not something in which they are complicit.

Both of these cultural factors must change to enable managed care plans and systems to actually improve the health of their subscribers. The public health experience is that improving the health of high-risk individuals is a "hard sell" and requires a kind of "in your face" medicine, which sharply contrasts with the gentility of traditional medical practice. Clinicians who are at risk for the cost of avoidable illness will have new incentives to persuade their patients to change their behavior.

Active agents for health

Health plans' cost-sharing arrangements embody a matrix of incentives to individuals and families to behave in certain ways. Implicating individuals and families as active agents in managing their health risks will require rethinking the incentives embodied in health insurance. Traditionally, health plans, insurers, and public health programs have "socialized" virtually all the cost of patently risky behavior.

Yet why should the individual who has a motorcycle accident without wearing a helmet, and requires costly hospitalization, have the same economic exposure to the cost (nominal hospital co-payment with a low cap on MA outlays) as the individual who wears the helmet? Under new insurance contracts, individuals and families might be asked to pay a significant fraction of the costs of accidents or injuries in which helmets or seatbelts were not used.

Providing positive incentives to subscribers to avoid or manage their risk will also be essential. Rewarding individuals who avoid illness (through rebates on their premiums) or providing bonuses to encourage specific behavior (immunization, compliance with prenatal care, weight reduction) is beyond the traditional boundaries of health insurance. Tax laws could be changed to exempt these bonuses from taxation.

Managed care plans will be forced to address these issues as more high-risk persons enroll in their plans, and as public health systems, which have traditionally enjoyed a monopoly on the high-risk people in their communities, are forced to re-organize into managed care enterprises to retain their funding. Those plans that find the right matrix of incentives will be rewarded with both the improved health of their subscribers and improved financial performance.

On the cutting edge

Some progressive health plans with large metropolitan enrollments are already laying the groundwork for stage III. The Group Health Cooperative of Puget Sound has recently launched a health risk appraisal initiative for its large subscriber pool, using computerized epidemiological screening to identify the high-risk individuals in their plan. Risk identification leads to active disease management aimed at containing the risks associated with selected subscribers.

HealthPartners, the large, Minneapolis HMO, has taken the further step of setting ambitious health status improvement goals (e.g., a 25 percent reduction in heart attacks and a 30 percent drop in maternal/fetal complications) for their subscribers by incorporating preventive care into the mainstream of their service.

We believe that initiatives like HealthPartners' are not public relations maneuvers but represent efforts to differentiate the health plan from competing offerings. As price differences between health plan premiums evaporate and networks become increasingly identical, the unassailable position of competitive advantage for a plan will be to demonstrate health status gains for their subscribers relative to other plans. Health status differences must not be attributable to clever efforts to avoid enrolling the sick, but to actually managing the health risk in their subscriber pool.

Health plan goals and strategies must change as the health plan market matures. Individuals and firms will increasingly select plans based not on cost differences but on differences in value. Proximate value measures like consumer satisfaction and clinical process measures (reduced infection rates, surgical complication rates, avoidable re-admissions) will give way to health status measures (disease-free years provided, functional capacity restored, functional life-span extended) as health plans and systems refocus on working with their subscribers to improve their actual health.

This transition will be impossible for managed care plans that have a "command and control" relationship with their provider networks. Deepened collaboration among plans, physicians, and hospitals will be an essential precondition of effective "value improvement." And as health plans move toward health status improvement as their principal goal, they will find their business converging with public health systems and competing health plans, as well as schools and other community agencies. Increasingly, health plans will be compelled to collaborate to meet the needs of their subscribers and the broader community.

This evolution will require not only cultural change, but fundamental change in clinical practice and organization. The ultimate justification for reliance on managed care as the basis for health coverage (as opposed to a government-controlled national health insurance system) will be tangible health status gains for our people. Focusing on the community's health will not only be good business for health plans and employers, but sound health policy as well.

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