Managed Care: The Dominant Paradigm in US Healthcare

by Julie J. Welch, RRA

What does "managed care" really represent -- and what effect has managed care had on the healthcare market? The author describes how managed care came to be a critical market force, offers a snapshot of its proliferation, and examines its effects on the traditional payment system.

It's a byword for the healthcare environment of the '90s. But what does "managed care" really represent in the marketplace?

Managed Care: A Payment System or a Delivery Mechanism?

It is not always apparent whether managed care is a system of payment, a mechanism for delivery, or a hybrid. Ultimately, however, managed care is both a payment system and a delivery mechanism. In its broadest sense, managed care can be defined as any attempt to influence the access, delivery, or financing of healthcare. Some consider it simply to be the application of business principles to healthcare. In current everyday use, the term "managed care" often refers to managed care organizations such as health maintenance organizations (HMOs).[1] Various types of HMOs include the group model, the staff model, the independent practice association, and the network or mixed model (see sidebar). There are many types of managed care plans, but in general all of them attempt to integrate a packaging concept affecting the delivery and financing of care and to apply new constraints on encounters between physicians and patients.

In this article, we will examine statistics that illustrate the massive shift of America's healthcare delivery system to managed care and present a snapshot of today's managed care market. The shift to managed care is the single most important force for change in the healthcare industry today, and it will probably remain so for at least another decade. The article will also examine the effect of managed care on fee-for-service compensation and the cost-containment outcomes of the Prospective Payment System.

Where the Patients Are -- The Managed Care Market

Managed care is often viewed as something new or as a byproduct of the healthcare reform movement of the early 1990s. However, the concept has existed for a much longer time. Healthcare has always been managed to some degree; it has never been without at least some constraints.

Why, then, has managed care become so popular during the last two decades? There have been many contributing factors; chief among them is the phenomenal growth in the cost of healthcare. The US now spends roughly 14 percent of its gross domestic product on healthcare -- about twice that of other developed nations. Patients are becoming more aware of treatment options and are demanding medical research and new technology. The process of weighing the current growth rate of healthcare expenditures against the resources needed elsewhere has made cost effectiveness and cost containment enduring challenges. These concerns, combined with a number of other important issues, led to the healthcare reform movement. But attempts at passing national legislation have failed, and managed care has emerged as the driver of healthcare reform.[2]

Once shunned by mainstream American medicine, managed care by all accounts now is the mainstream -- and it is forcing a restructuring of the American healthcare system. Enrollment in managed care systems has soared from 6 million in 1976 to more than 50 million today, with predictions that the number will reach 100 million in just five years. Today, about 3.5 million Medicare patients are enrolled in a Medicare HMO. Depending on the level of managed care market penetration, the regional enrollment varies from more than 40 percent in Portland, OR, to less than 5 percent in New York and New Jersey. "Seventy-

five percent of practicing physicians had at least one managed care contract in 1993," Bischof and Nash write. "They have accepted the trade-off of lower fees for a guaranteed flow of patients and have seen an erosion of professional autonomy."[3]

Managed care plans are thriving. While traditional or indemnity insurance continues to shrink, from 73 percent of the private health insurance market in 1988 to 33 percent by 1993, managed care plans are booming. HMO enrollment increased from 29 million in 1987 to more than 45 million in 1993. Preferred provider organization (PPO) enrollment increased from 12 million in 1987 to 77 million in 1993. Indicators show that forces in the healthcare market will lead to continuation of the rapid growth of managed care.[4]

Today, HMOs and PPOs provide for the healthcare needs of about 75 percent of those with employee-sponsored healthcare coverage nationwide. HMOs and PPOs also have made healthcare more accessible and affordable for millions of Americans. After rising nearly 15 percent annually from 1988 to 1992, healthcare premiums increased just 0.5 percent from 1995 to 1996. From 1988 to 1992, total Medicaid spending increased an average of 22 percent annually; from 1995 to 1996, it rose just 3.2 percent.[5]

Even traditional indemnity insurance has become increasingly managed. In 1987, 41 percent of indemnity plans had some form of utilization review. By 1990, 95 percent had some form of review. Using a liberal definition of "managed care," almost all third-party payers today are managing care in some fashion.[6]

Table 1—HMO Enrollment as a Percentage of Population

Area	1994	1995	Percentage change
Houston	15%	28%	86.7%
New York	17	28	64.7
Boston	36	55	52.8
Dallas	18	27	50.0
Seattle	24	34	41.7
Atlanta	22	30	36.4
Washington, DC	36	44	22.2
Riverside, CA	37	45	21.6
Los Angeles	38	42	10.5
Philadelphia	40	43	7.5
San Diego	41	44	7.3
Detroit	24	25	4.2
San Francisco	55	56	1.8
Minneapolis	43	43	0
Chicago	17	17	0

(source: Medical Data International, Irvine, CA)

Between 1994 and 1995, HMO enrollment as a percentage of the population increased for the 15 largest metro areas in the US -- from an average of 30.9 percent to 37.3 percent, according to research by Medical Data International, of Irvine, CA. National managed care firms accounted for 81 percent of HMO enrollment at the beginning of 1996, while independent plans and Blue Cross and Blue Shield plans accounted for most of the remaining 19 percent.

Managed Care and the Fee-for-Service Market

Traditionally, healthcare providers in the US have sold their services for a fee. Market demand was generated by patients, and price was inelastic. Patients bought whatever healthcare they thought they needed and providers sent the bill to the insurers, who then passed it on to payers.

The situation is different now. In the late 1980s, employers began to refuse to pay ever-rising premiums for employee health insurance. As a result, millions of members of employer-sponsored health plans were shifted from fee-for-service plans to HMOs and other managed care arrangements. Now, negotiating highly competitive contracts that set a cap on their own costs, employers effectively shift the risk back to the HMOs, which then transfer it back to the providers.

One segment of the industry that has been particularly affected by the shift has been physician groups, according to the Medical Group Management Association (MGMA). A recent MGMA survey shows that the portion of physician group revenue coming from fee-for-service patients keeps dropping. Multispecialty practices have been hit hardest, according to the analysis of 1065 medical practices. For each dollar of fee-for-service care they billed for in 1995, multispecialty groups collected only 73.1 cents -- the lowest mean percentage in the survey's history.

Most of the 26.9 cents per dollar that weren't collected -- 23.2 cents -- was eaten up by adjustments in the practices' contracts. The groups make a financial trade-off by agreeing to charge less than the rates they would normally bill for single fee-for-service procedures. But those contracts with Medicare, Medicaid, insurers, PPOs, and HMOs bring in a steady stream of patients.[7]

Table 2—HMO Penetration Rate (Percentage) of Profile by State, 1997			
California	46%	Illinois	17%
Oregon	45	Vermont	15
Rhode Island	34	Virginia	14
Massachusetts	34	Nebraska	12
Utah	32	Georgia	11
Colorado	31	Texas	11
New York	30	Louisiana	10
New Hampshire	30	Indiana	10
Minnesota	28	Tennessee	10
Kentucky	27	Oklahoma	9
Florida	25	Alabama	8
Maryland	25	Iowa	8
Pennsylvania	25	West Virginia	6
Delaware	24	Kansas	6
Connecticut	24	South Carolina	6
Wisconsin	24	North Carolina	5
Arizona	23	Arkansas	5
New Jersey	22	Maine	3
Michigan	22	Montana	3
Hawaii	21	South Dakota	3
Missouri	20	Idaho	2
Nevada	19	Mississippi	2
Ohio	9	Wyoming	1
Washington	18	North Dakota	1
New Mexico	17	Alaska	0
(source: Medical Data International, Irvine, CA)			

Another Way to Contain Costs:The Prospective Payment System

The Prospective Payment System (PPS) refers to a method of reimbursement that entails setting a rate or set of rates for a specified amount of service before the service is provided. The system could be based on a variety of units, such as visit, episode, enrollee, or even by outcome. Research has shown that the implementation of the Medicare Prospective Payment System and the shift by private insurers from open-panel, fee-for-service plans to HMO and PPO selective contracting plans has restrained the growth of hospital costs. The cost containment observed in these studies could have been the result of reductions in the number of services provided by hospitals or in reductions in the unit costs of these services. These reductions could have been made across the board in all departments, or hospitals may have targeted specific revenue centers to bear the deepest cuts.[8]

Studies of hospital competition before the implementation of PPS policies indicate that greater competition led to higher costs. Cost- and charge-based reimbursement allowed hospitals to compete purely on the basis of quality and amenities and thereby increase expenses. Studies have proven that hospitals have responded to incentives such as the PPS to cut costs. The strategies employed to cut costs, however, have yet to be thoroughly explored. Each system -- managed care, fee-for-service, and prospective payment -- has incentives. Managed care serves patients at a lower cost with a decreased utilization of resources. Fee-for-service gives physicians more professional autonomy with no incentive to decrease costs, and competition actually leads to higher costs. The Prospective Payment System been successful in controlling expenditures and controlling costs.

The reign of fee-for-service is over. Managed care is the dominant paradigm in US healthcare. Although HMO market penetration varies substantially nationwide, the outcome is no longer in doubt. Those regions of the country that have little or no managed care today know that its arrival is inevitable.

Notes

1-4, 6. Bischof, Ralph O., and David B. Nash. "Managed Care Past, Present, and Future." *Managed Care and Office Practice* 80, no. 2 (1996): 225-243.

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Some Commonly Used Managed Care Terminology

- **Exclusive provider organization (EPO):** A closed-panel preferred provider plan in which enrollees receive no benefits if they use care outside the EPO
- **Fee-for-service:** A payment system derived from a list of fees on which an insurance company or the government bases payment to physicians and other providers
- **Health maintenance organization (HMO):** An organization that provides financing and a specified amount of comprehensive health services to a defined and voluntarily enrolled population for a prepaid amount of money for

membership. The following are the most common types of HMOs:

  - *Group model* -- One or more physician group practices that are not employees of the HMO, and therefore, operate as independent contractors or corporations
  - *Staff model* -- Physicians and health practitioners employed by the HMO
  - *Independent practice association (IPA)* -- Solo practitioners who are paid a fee or fixed amount per patient to treat the IPA's patients
  - *Network or mixed model* -- A combination of any of the above

- **Integrated delivery system (IDS):** An integrated financing and delivery system that uses a panel of providers selected on the basis of quality and cost management criteria to furnish members with comprehensive health services. IDSs are also known as integrated medical systems or integrated health systems

- **Managed care:** A type of healthcare delivery system that manages, reviews, and controls its processes and costs by controlling access to providers, requiring preauthorization for hospitalization, and providing cost control incentives to its providers

- **Managed care organization:** The umbrella phrase used to describe all the different types of HMOs

- **Management service organization:** A legal entity that manages the administrative and financial components of managed care organizations

- **Medical staff organization:** A group of physicians or specialists that form a legal entity to provide services

- **Medical services organization:** An entity formed by a provider, that offers ancillary services, such as billing or marketing

- **Physician-hospital organization:** A contractual relationship between physicians and hospitals whereby a single entity provides services to the insurance company's members

- **Preferred provider organization (PPO):** A PPO typically contracts on behalf of employer groups or other plans with hospital and physician providers at reduced rates. The hospitals and physicians who become part of the preferred provider network are either called preferred or participating providers. Generally, there is a financial incentive to the patient to utilize a preferred provider. Providers offer discounts to PPOs in anticipation of achieving additional patient volumes or to minimize the chances that their patient volume will not go to another provider

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