

Managed care in the United States*

F. Douglas Scutchfield, Joel Lee and Dana Patton

Summary

Medical care in the United States continues to consume an increasing amount of the Gross Domestic Product. To control the rising costs of health care many industries have turned to a controlled form of financing and delivery of health care – often referred to as managed care. Many types of managed care exist, including preferred provider organizations (PPO), exclusive provider organization (EPO), and health maintenance organizations (HMO).

HMOs involve prepaid premiums, limited panels of providers and assumption of financial risk on the part of the providers. A variety of HMOs are currently operating in the United States. Managed care involves taking risks by those who administer it. Some methods of controlling patient and physician behaviour by taking risks are capitation, risk pools and withholds. With capitation the physician is paid a 'per member per month' fee regardless of whether the patient uses the service. Risk pools are concerned with who shares the risk; for example, the primary physician shares the financial risk with specialists. Withholds involve a fee-for-service with a portion withheld which may be returned to the provider if he/she is parsimonious.

A concern expressed about HMOs is the possibility of restricted services. Moreover, hospital expenses make up a large portion of the total health care dollar. In 1995 the average length of stay for a Medicare patient was 6.1 days as opposed to 3.9 days for the non-Medicare patient. Indeed, HMOs were the leaders in the development of same-day surgery and out-patient treatment.

Increasingly, in the United States, public and social insurance plans are turning to managed care as a method to control health care expenditure. Some government insurance plans, such as Medicare and Medicaid, also increasingly offer managed health options. The trend, for now, in the United States increases enrollment in managed care plans. Although this is occurring at a rapid pace, managed care will probably not be the final solution to provision of medical care in the United States.

Keywords: managed care, medical care organization, financing medical care, health services delivery

The cost of medical care in the United States has been and remains a major problem for the nation. Medical care consumes an increasing proportion of the total Gross Domestic Product, a proportion that has consistently increased annually. Approximately 70.3 per cent of individuals in the United States have health insurance that is employer-based.¹ The premium is paid primarily by the employer, with some participation in the premium expenses being borne by the employee. The premium

is, in turn, tax deductible for the company, and the employee. In spite of that, as premiums increased, companies began to look for ways to control their premium cost. This became an even greater concern as companies began to self-insure, bypassing insurance companies as intermediaries, in their relationship with medical providers. This meant that they frequently acquired expertise within their own company for medical underwriting and understanding health care insurance and health care delivery.

To control costs or at least to make them more predictable, these industries have turned to a form of health financing and delivery generally called managed care. Managed care is defined by Iglehart as: 'A system that integrates the financing and delivery of appropriate medical care by means of the following features: contracts with selected physicians and hospitals that furnish a comprehensive set of health care services to enrolled members, usually for a predetermined monthly premium; utilization and quality controls that contracting providers agree to accept; financial incentives for patients to use the provider and facilities associated with the plan; and the assumption of some financial risk by doctors, thus fundamentally altering their role from serving as agent for the patient's welfare to balancing the patient's needs against the need for cost control.'² A variety of methods for financing health care costs and delivery of medical care exist under this rubric. The simplest is managed fee-for-service. In these arrangements providers are paid in the traditional fee-for-service method, or retrospective cost reimbursement for hospitals.

However, there are methods imposed to control use of health care services. These methods include second opinion surgery, in which the insurance plan requires an additional surgical consultation before a surgical procedure. Another method is prior authorization, in which the physician must obtain authority

Center for Health Services Research, Policy and Management, University of Kentucky Medical Center, 121 Washington Street, CAHP Rm 111, Lexington, KY 40536-0003, USA

F. Douglas Scutchfield, Peter M. Bosomworth Professor of Health Services Research and Policy Director

Joel Lee, Professor

Dana Patton, Research Associate

Address correspondence to Dr. F. D. Scutchfield.

*This paper was commissioned by the Editors.

for a diagnostic procedure to be covered, and, depending on the patient's diagnosis, assigning a specified number of hospital days that will be covered. This method of managed care has been facetiously called rationing by harassment.

Another type of managed care is the preferred provider organization (PPO) and its variants. In this form of managed care, the insurance company contracts with a select group of providers to reimburse them on a discounted fee-for-service basis. For providers to be willing to accept the discount, they want the list of participants limited, assuring them of increased patient volume and prompt payment. In turn, patients are limited to providers on the list, in exchange for care without out-of-pocket expenses for the full amount of the discounted bill. If the patient decides to use a provider outside the contracted panel the insurance company pays a limited amount to that provider, with the patient responsible for the balance. In 1995, 1001 PPO plans were operating in the United States, with 79.6 million enrollees.³

A variant of the PPO is the exclusive provider organization (EPO). In this arrangement the insurance company will not pay anything to a non-contracted provider. This clearly provides additional incentive for the patient to use a contracted provider. It also provides an incentive for the provider to more deeply discount his or her rate. In some plans, renewal of provider contracts is conditioned upon 'ratcheting down' expectations of cost or performance. In 1995, 310 EPO plans were operating in the United States, with 4.6 million enrollees.⁴

Unlike PPOs, EPOs or fee-for-service with utilization controls, true managed care is provided in Health Maintenance Organizations (HMOs). As a result of consolidation, the number of operating HMOs in the United States has recently declined; however, enrollment has grown from 26.6 million in 1986 to 67.6 million in 1995.⁵ HMO penetration has reached 25.7 per cent in 1995, the highest level ever.⁶

HMOs involve a prepaid premium, a limited panel of providers and the assumption of financial risk by providers of care. That is, if resource use is lower than the amount paid in premiums, the remaining funds go to the provider to reward their parsimony. If, however, resource utilization exceeds the prepaid amount, then the provider is at risk for covering that overage. As a practical matter, most health plans and providers have what is called 'stop loss insurance', a reinsurance pool which limits the potential losses of the plan and/or the provider.

There are a variety of HMO models that are currently operating in the United States. These include the following types. The Group Model is an HMO where the plan has an exclusive contract with one group of physicians, and the group in turn has an exclusive contract with the plan. Kaiser Permanente is the classic example. The Kaiser Foundation Health Plan contracts with only one physician provider, the Permanente Medical Group, which sees only patients of Kaiser Foundation Health Plan.

In a Staff Model HMO, the physicians are all employees of the plan. The classic example is Puget Sound Cooperative in the

Northwest United States. These HMOs are frequently not-for-profit organizations that have a consumer board that governs their activities. Usually staff model physicians are employees paid a salary and, frequently, a bonus based upon performance.

The Independent Practice Association (IPA) or foundation provides the opportunity for individual practitioners to contract with HMOs in a non-exclusive relationship. That is, a practitioner can contract with as many plans as they wish and the plan can contract with as many physicians as it wishes. The physician may also see patients that are fee-for-service as well as prepaid patients. In some cases, individual practitioners will contract with an IPA group that negotiates contracts, as a group, for all the individual practitioners in that group.

The network model combines features of the group and IPA models. The plan contracts with large groups, and with individuals or IPA groups. Again, these contracts are not mutually exclusive and allow groups or individuals to contract with several plans and vice versa. In 1996, enrollment by plan type was 24.0 per cent in Group HMOs, 6.4 per cent in Staff HMOs, 13.2 per cent in Network HMOs, and 56.3 per cent in IPAs.⁷

A variant is the Point of Service (POS) or open-ended option. In this arrangement, the patient or their employer pays a higher premium. The patient has a choice and may also visit a provider outside the plan, but would pay a larger copay or deductible for that visit. Point of Service plans are particularly attractive to individuals who do not have experience with managed care and want the assurance that they can select any physician or hospital. Satisfied participants frequently move from the POS to other managed care options. In 1995, an estimated 13.5 million enrollees had access to POS plans.⁸ In addition, over one-half of all HMOs offer a variety of stand-alone specialty programmes in areas including dental, vision, psychiatric and prescription drug services.

The primary concern of managed care organizations is the management of utilization. Clearly, an advantage is using fewer resources in a managed care setting. This is frequently accomplished by using additional utilization controls. Many managed care plans use the notion of the primary care provider as a 'gatekeeper', where the primary care physician (PCP) controls the use of other health care providers and services. The patient cannot, for example, see a specialist without the approval of the primary care physician, a circumstance that is definitely not the case with fee-for-service patients.

There are other economic mechanisms for controlling patient and physician behaviour. The usual mechanisms are capitation of physicians, risk pools and/or the creation of withholds. In capitation the physician is paid a monthly fee for each patient, the so-called 'per member per month', or PMPM. This money is paid by the managed care organization, regardless of whether the patient uses the physicians' services. Again, this is essentially a payment for assuming risk; if the patient had extensive use of the physician's service, the physician is responsible for that service for the same PMPM.

The notion of risk pools revolves around who shares capitation or, in other words, who the physicians and other providers share risk with. If the PCP is the only person sharing a capitation payment, that is the lowest level of risk, but also the lowest level of potential benefit to the physician for controlling utilization. If the PCP also shares risk with specialists, that is a higher level of risk, but it is a larger risk pool, so if utilization is low the potential for additional income is higher. The largest risk is if the PCP, specialists and the hospital are all in the risk pool, but again, if utilization is controlled income is substantially higher.

Another method of risk sharing is a withhold. In this circumstance, the physician receives a fee-for-service payment, with a portion of the bill withheld and deposited in an escrow account. On a periodic basis the withhold account is examined to see if there are surpluses and, if so, a prorata share of the withhold account is distributed to the provider.

One concern expressed about HMOs is the tendency to restrict needed services and to decrease quality, so as to accrue additional resources for the physician. To deal with that question, a great deal of effort has been expended on how to assure quality in the provision of managed care. This has resulted in a number of activities. First is the creation of a voluntary accrediting body for managed care organizations, the National Committee on Quality Assurance (NCQA). As a part of its process, NCQA has also incorporated a quality of care activity with the managed care organization (MCO) industry. In contrast to professional self-accreditation for settings such as hospitals, NCQA was established by payers of health care. NCQA itself developed the Health Employers Data and Information Set (HEDIS). This is a series of measures of the quality of the health plan under examination, a sort of report card to allow for examination of various MCOs. HEDIS measures such things as plan financial solvency, patient and provider satisfaction and a series of outcome measures, which address objective evaluation of quality. Table 1 lists the eight current HEDIS 3.0 Reporting and Testing Set Measures. HEDIS 3.0 is result oriented. Health plans seeking NCQA accreditation will be expected to measure how well their patients are able to function in their daily lives, address health promotion and disease prevention, as well as acute medical care, and survey patient satisfaction.

Table 1 HEDIS 3.0 measures

I.	Effectiveness of care
II.	Access to or availability of care
III.	Satisfaction with the experience of care
IV.	Health plan stability
V.	Use of services
VI.	Cost of care
VII.	Informed health care choices
VIII.	Health plan descriptive information

Research examining the character of managed care organizations versus the experience of fee-for-service care demonstrates some generalizations that can be made regarding managed care, particularly HMOs. In general, when one talks about the data, the direction is from fee-for-service, then IPA HMOs, and then group and staff model HMOs.

Given the fact that essentially 40 per cent of the health care dollar is expended for hospital care, the obvious source of cost savings is in hospital care.⁹ In fact, HMOs lower the admission rates to hospitals. They also have significantly lower average lengths of stay and thus they use fewer patient bed-days than fee-for-service care. In 1995, hospital in-patient days declined to 258.4 per 1000 HMO members, with an average length of stay of 6.1 days for Medicare members and 3.9 days for non-Medicare members.¹⁰ They make up for this decrease in bed-days by increasing the number of ambulatory visits among Medicare members, and usually they have more ambulatory visits per member than fee-for-service plans. The 1995 data indicate an average of 2.8 ambulatory care visits per Medicare member, 1.4 ambulatory visits per non-Medicare member, and 6.4 ambulatory visits per Medicare members enrolled in group plans.¹¹ In fact, HMOs were at the vanguard of ambulatory, same-day surgery and the development of out-patient surgical centres.

There is evidence that patients in HMOs have fewer elective surgical, laboratory, and radiology procedures performed than fee-for-service patients. They are more likely to use less expensive options in diagnostic and therapeutic services than in the fee-for-service system. There have been a number of evaluations of the quality of care provided and there appears to be little difference in the quality of care provided in these systems. Patients in HMOs appear to be more satisfied with the financial arrangements than those in fee-for-service. This would seem reasonable, as copays and deductibles are less in an HMO than in most fee-for-service health plans. Also, the billing and collection procedures are much more straightforward in an HMO. Patients are less satisfied, in general, with the care they receive in HMOs as opposed to fee-for-service care.

There are a number of current trends in the managed care industry. The first is that an increasing number of MCOs that were ordinarily not-for-profit agencies are converting to for-profit. This is primarily so they can have access to increased capital to expand their base (or covered lives) as the market penetration of managed care increases. Another trend is for MCOs to merge and to acquire other MCOs. The extent of mergers and acquisitions in the managed care industry has been remarkable in recent years as markets consolidate. This is particularly the case in so-called mature managed care markets, where the vast majority of individuals are in MCOs and there is very little indemnity market left. In these markets, a limited number of MCOs insure the majority of the people.

There has been an effort to regulate MCOs by law. In general, MCOs are subject to the insurance regulations of the state in which they do business. The insurance commissioners are generally concerned about such issues as plan solvency and

less concerned about quality of care in the plans. In response to this, plans have made several business decisions against which there has been a public outcry resulting in legislation. Two examples are so-called 'gag clauses', which prohibit a physician from giving the patient all the information they need for informed decisions concerning high-cost or experimental therapies, such as bone marrow transplants. The second example is the 'drive through delivery' where patients have been discharged from the hospital with less than a one day stay. In the first case, policy statements have been established by organizations including the American Medical Association, and legislation is under consideration or has been enacted in several states. In the latter case, the federal government passed legislation to address the issue and mandate a 48 hour minimum stay. Discussion continues to address the appropriateness of legislation versus quality activities such as NCQA.

Increasingly, the public insurance and social insurance plans in the United States are turning to managed care as a mechanism to manage government's cost for the provision of health care. Medicare, the health insurance system for the elderly, has available the opportunity for their beneficiaries to enroll in managed care plans. In mature markets, Medicare patients are being actively recruited by MCOs, with additional enticements such as prescription benefits, which are not available through Medicare to fee-for-service enrollees. Similarly, Medicaid, the federal or state health insurance plan for low-income beneficiaries, is moving to enroll their beneficiaries in MCOs, again if not to save money then at least to modulate the increase in costs.

Finally, there is a trend for employers to band together to negotiate premium rates with MCOs. The Pacific Group on Health, for example, comprises many relatively large corporations in the San Francisco Bay area. This group has been very successful in using its market power to negotiate favorable rates with MCOs licensed to do business in that area.

It is important to recognize that managed care is probably a signpost and not a destination. When managed care reaches its full market share, the United States is likely to be moving on to other mechanisms for the finance and delivery of medical care

services. There are a variety of scenarios for the next step in medical services; however, it is too early to predict the likely character of post managed care medical care. What does appear to be true is the inexorable march to enroll patients in managed care in at least the short run, and increasing momentum as the Medicaid and Medicare programs participate. It is important to recognize there is still the potential to increase enrollment in several areas in the United States, for example the deep South, where there is still limited market penetration.

References

- 1 US Census Bureau Health Insurance Historical Table 1 1987–1995. World Wide Web. <http://www.census.gov/ftp/pub/hhes/hlthins/historic/hihist1.html>
- 2 Iglehart J. Managed care. *N Engl J Med* 1992; **327**: 742–747.
- 3 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 49.
- 4 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 52.
- 5 Marion Managed Care Digest. *HMO Edition 1988*. Kansas City, MO: Marion Laboratories, Inc.: 5.
- 6 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 5.
- 7 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 6.
- 8 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 14–15.
- 9 Williams S, Torrens P. *Introduction to Health Services*, 4th edn. Albany, NY: Delmar, 1993: 301.
- 10 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 24–25.
- 11 Managed Care Digest Series. *HMO/PPO Digest 1996*. Kansas City, MO: Hoechst Marion Roussel, Inc.: 25.

Accepted on 15 April 1997