CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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THE CENTER, SUPPORTED BY THE ROBERT WOOD JOHNSON FOUNDATION AS PART OF ITS HEALTH TRACKING INITIATIVE, IS AFFILIATED WITH MATHEMATICA POLICY RESEARCH, INC.

Managed Care Woes: Industry Trends and Conflicts

Although managed care plans have had success in controlling costs, they now face challenges on many fronts, including tighter profit margins, pressure for broader provider networks, increasing clout of hospitals and physicians and more demand for consumer protection regulation. Underlying these trends is a fundamental conflict between health plans and consumers, who are demanding—and, in many cases, getting—greater control over their health care delivery and services. This Issue Brief reports on a roundtable convened by the Center for Studying Health System Change to discuss these trends and conflicts and how they may play out over the next number of years.

MANAGED CARE CHALLENGES

These are trying times for the managed care industry. Despite continued enrollment growth, the profitability of most managed care plans has declined significantly since 1994. In 1995, the profit margin for the average publicly traded managed care plan was only 3 percent; in 1996, it shrank to 0.3 percent. Industry figures for 1997 will probably be even worse, predicted Ron Winslow, health care reporter for *The Wall Street Journal*. These problems are not confined to the for-profit sector, and earlier this year not-for-profit giant Kaiser Permanente announced a $270 million loss for fiscal 1997, despite a 19 percent membership increase.

Revenue pressures are fueling these industry losses, observed Paul B. Ginsburg, president of the Center for Studying Health System Change, who said that aggressive actions by price-sensitive employers have been the primary factor in holding health care revenues down. In the 12 communities that are part of the Center's ongoing Community Tracking Study, for example, researchers found that employers are more than willing to switch plans for lower premiums (see the sidebar on page 3 for additional findings). At the same time, many plans have appeared willing to sacrifice premium increases in exchange for entering new markets and growing their enrollments.

Meanwhile, consumer demand for greater choice of providers have spurred many health plans to broaden their networks and offer out-of-network options. "What we've seen is rapid growth in enrollment in point-of-service and PPO products and also rapid expansion of health plan networks," said Janet M. Corrigan, executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Essentially, she believes, plans are responding to—and to some extent, accommodating—consumers' resistance to change. "Managed care introduces change to people's lives, and they are uncomfortable with that," Corrigan said. Consumers don't want established relationships with their doctors to be disturbed, she noted. In addition, when they need specialized care, consumers want to be able to go to hospitals and other providers of their own choosing, either because of the reputation of those providers or because of their own familiarity with those providers.

Although the implications of increased provider choice are not completely clear, Corrigan observed, "it's safe to say that it's more difficult for a health plan to manage its delivery system and its providers when there is an extensive amount of out-of-network use and when these networks grow larger." Kaiser Permanente, for example, cited out-of-network

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PANELISTS

Peter Boland
Boland Healthcare, Inc.

Janet Corrigan
President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

Paul Ginsburg
Center for Studying Health System Change

Karen Ignagni
American Association of Health Plans

Ron Winslow
The Wall Street Journal

MODERATOR

Roger Taylor
Center for Studying Health System Change

costs of $180 million during 1997 as a contributing factor to its recent losses.

Opinions varied on future trends for network size and out-of-network use. Karen Ignagni, president and chief executive officer of the American Association of Health Plans, predicted that local market conditions will determine how plans design their networks and coverage options. Roger Taylor, senior advisor to the Center and roundtable moderator, observed a fundamental dichotomy in trends. On the one hand, there is a national move to hold health plans more accountable for their care and services. To do that, he said, plans need to manage care more tightly, which requires narrower provider networks with increased accountability to plans at the local delivery level. At the same time, he noted, consumers, employers and policymakers are pressuring health plans for greater provider flexibility through broader networks and out-of-network coverage.

Another challenge to managed care plans is continued consolidation among hospitals and physician practices and development of new types of provider-sponsored networks and delivery systems. Although consolidation has been touted by some as a precursor to better, more integrated care delivery, Winslow believes it really amounts to a negotiating strategy by providers, "who are actually gaining clout against managed care companies." Providers, said Winslow, sense weakness in the industry and are trying to take advantage of it. As a result, he predicted, managed care plans will find it increasingly difficult to wrest more discounts from providers.

Meanwhile, health plans have faced many efforts at the state and national level to legislate or regulate various aspects of managed care, many of which are characterized as consumer protection (see the sidebar on page 4). These initiatives include:

- narrowly focused bills, such as those mandating a minimum length-of-stay for childbirth or mastectomy;
- broader efforts to promote standardization around infrastructure components such as reporting and data collection; and
- other proposals that seek to build safeguards for consumers, such as external appeal systems.

> **We've confused provider and consumer protection, and standard-setting and micromanagement.**
>
> *—Karen Ignagni, American Association of Health Plans*

Ignagni expressed concern that proposals to increase managed care regulation are disjointed, lacking in perspective and sometimes at cross-purposes. What is needed, she said, is an objective assessment of what the industry is doing well and where it is falling short. "We've confused provider and consumer protection; we've confused standard-setting and micromanagement; and I think we're at risk of confusing control and innovation," she said. "Those are serious issues that have to be worked through."

REDEFINING CARE DELIVERY

These trends are playing out as some health plans try to take managed care to a new level through techniques such as disease management and care coordination, Ignagni noted. However, Ginsburg observed, as plans broaden their networks, it becomes more difficult for them to enlist the participation of providers (many of whom have contractual relationships with several plans) in such programs. As a result, some plans are emphasizing capitation and risk-sharing and leaving it up to the provider groups to implement their own care management techniques.

Capitation of medical groups may become the driving force behind redefining care delivery, according to Peter Boland, president of Boland Healthcare. There are significant conflicts in local markets, however, over who should control capitated dollars. "Physician organizations in particular are seeking to be paid on a capitated basis because they believe they can reclaim their autonomy and profit from innovations in care delivery," Ginsburg observed. "But plans are very skeptical about the ability of some of these organizations to actually pull it off." To succeed under capitation and be

truly accountable for their services, provider organizations need to extensively re-engineer the way care is delivered, Taylor added.

Consumer demand for enhanced provider choice may present serious obstacles to plans' efforts to redesign and better manage care, panelists agreed. Many consumers are offered little or no choice of health plans by their employers, but they do have a great deal of choice at the provider level because of the broad, inclusive provider networks or out-of-network options offered by many plans. These features, which are extremely popular with consumers and employers, limit plans' ability to manage care and hold providers accountable for their services.

For health plans, the keys to successfully managing quality and cost will be "good management, adequate investment in infrastructure and good, solid relationships with providers," Corrigan noted. Yet the push for provider choice challenges all of these fundamentals.

INVESTING IN INFORMATION SYSTEMS

Panelists expressed particular concern about the lack of health plan investment in information systems, which they considered critical to plans' holding providers accountable for their services, monitoring and improving the quality of care, and coordinating care across settings. According to Corrigan, a recent survey found that nearly 60 percent of companies in the health care industry spent less than 4 percent of their total operating budget on information technology. In comparison, another survey found that the banking industry spent about 5 percent of revenue and the financial industry spent 7.5 percent of revenue on such technology.

Panelists agreed that big managed care plans are in the best position to purchase and install modern information systems because they have the capital necessary for investment. But the loosening of relationships between plans and providers could diminish plans' ability—and motivation—to create electronic linkups with providers. In addition, it is unlikely that a physician affiliated with multiple plans will willingly integrate electronically with a slew of different information systems. Boland predicted that the smart plans in the next 12 to 24 months will recognize that "they have to invest in new medical management systems and give them to their affiliated medical groups, which have the capacity to save money and produce better outcomes but don't have the capital to invest."

Another possible scenario is that providers will purchase data or lease the systems of information technology vendors, which have the platforms, capital and expertise that providers lack. Vendors, therefore, have a potentially important role in the modernization of the health care industry's information infrastructure.

WHO'S IN CONTROL?

At some level, it appears that efforts by health plans to re-engineer care to improve effectiveness and efficiency may be directly at odds with what consumers want—greater control over health care decision making. Basically, consumers have reservations about managed care. "The issue of choice for consumers is really a proxy for control," Winslow asserted. "Consumers want to feel that, with their physicians, they are in control of their health care. With the way the system has gone in the '90s, they feel that control has been wrested from them, and that's the issue this battle is being fought over."

This puts health plans in a difficult position. Managed care often comes under fire for managing costs, not care. But how effectively can plans manage care if they must share control over key health care decisions with consumers, such as when to see a specialist or have surgery?

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> *—Ron Winslow,*
> The Wall Street Journal

Center Survey Findings about Managed Care

Preliminary findings from the Center's Community Tracking Study related to managed care show that:

- *Forty percent of Americans with health insurance are in some form of gatekeeping arrangement in which their primary care physician controls their access to specialists.*
- *Most Americans trust that their doctor will refer them to specialists when necessary, but a sizable proportion—16 percent—are concerned that their doctor may not.*
- *Most doctors say they can make clinical decisions in the best interests of their patients without compromising their income, but 25 percent do not think this is true and see potential conflicts.*
- *Nearly 60 percent of Americans are willing to accept a limited choice of doctors and hospitals to save costs; 40 percent are not.*
- *Overall, Americans are satisfied with the health care they receive: 61 percent are very satisfied, 28 percent are somewhat satisfied. Only 5 percent are somewhat dissatisfied, 5 percent very dissatisfied and 1 percent are neutral on the issue.*

Backlash Fueled by Many Groups

Sweeping changes in the health care industry are fueling a consumer backlash against managed care, said Janet Corrigan of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

"Before managed care, people could select almost any provider in their community. Now there are restrictions and less choice for some people," she observed." These are not welcome changes for consumers, who have found willing allies among providers, advocacy groups and some lawmakers.

Providing consumers with objective, credible information when they face important health care decisions is one possible solution to this quandary. In the absence of good information about the health care decisions they face—and because they are uneasy with the dramatic changes sweeping the industry—consumers are turning to other avenues to exercise control. They are making their views known through the marketplace and the political system to suppress managed care and take back control over health care decision making.

> **Managed care is regulated by Wall Street, not public policy.**
>
> *—Peter Boland, Boland Healthcare, Inc.*

WHAT ABOUT THE FUTURE?

Despite these challenges, panelists were generally optimistic that managed care will be able to retool to meet current market and legislative challenges. Ignagni expressed confidence in the diversity of approaches that health plans are using in local markets and in the plans' ability to improve care coordination and management. Ginsburg noted that capitation of providers may fuel successful interventions in care management. And Corrigan predicted that consumers will become much more adept at assimilating and using different types of information about health care quality, which will drive value purchasing. However, this may take 10 or 15 years, she noted, because the industry has to make significant progress in the scope of information it produces for consumers.

Ignagni also spoke about the need for a dialogue between the industry and the American public on the reality of limited health care resources and the need to make choices. "How can you meet consumer expectations in an environment where there are no limitations on cost?" she asked. At the same time, she said she believes employers will continue to play a major role in shaping health care policy. Boland noted that Wall Street wields significant influence over the industry. Managed care is "regulated by Wall Street, not public policy," he said. "Part of our debate is how to balance out Wall Street approaches and pressures with broader public policy."

Corrigan cautioned that the quest to reduce health care costs and boost profitability has taken a toll on many physicians and other health care professionals, who feel frustrated by their diminished autonomy under managed care. Providers, she said, "feel out of the loop in the transition that is taking place." They have very strong sentiments that the health care system has become too driven by Wall Street, which could adversely affect quality of care." To be successful in the long term, she said, plans must build bridges with providers and engage them in efforts to redesign and improve care. ■

HCFA AS A VALUE PURCHASER

The emergence of the Health Care Financing Administration (HCFA) as a more assertive and discriminating purchaser of managed care will have a significant impact on the employer-led value purchasing movement, and on efforts to promote market-based policy that provides safeguards for consumers, panelists agreed.

"What we have seen is an awakening or a signaling on the part of HCFA that it is very tuned into being more aggressive in terms of its demands for quality and satisfaction data," commented Janet Corrigan, executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Mandating the reporting of the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) and the development of the Consumer Assessment of Health Plans Survey (CAHPS) for Medicare are good examples of HCFA's new strategy and "bold steps forward," she said. "But if we're going to have a comprehensive strategy for the information demands that are placed on health plans, providers and others, we've got to develop a better functioning public-private partnership."

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