

danger signs ahead...



The trajectory of change for the health care system foretells danger signs ahead. It is a course that may lead to poorer outcomes for consumers, with prospects of higher costs, more barriers to care and missed opportunities to improve quality. Six years ago, many leaders were enthusiastic about integrated delivery systems that promised substantial cost savings and a more seamless experience for patients whose care would be coordinated and managed according to the most effective medical practices. Now, a powerful backlash against managed care—some of it well founded—has led to consumer desire for broad provider choice. This, in turn, is leading to a dismantling of many of the structures that were the source of optimism.

The key change that has reverberated throughout the health system is the retreat of managed care over the last several years. For reasons that include lack of plan choice on the part of consumers, physician unhappiness with loss of autonomy and low fees, clumsy execution on the part of health plans and media attention to these problems, a virulent backlash has developed against managed care:

- >> Fearful that their medical care will be compromised, consumers see broad choices among physicians and hospitals as their key protection.
- >> Employers that pressed employees to enroll in managed care plans have responded to the backlash by demanding that health plans make key changes.
- >> Plans have responded by including wider provider networks, products that offer direct access to specialists and benefits for out-of-network use, external appeals processes and fewer authorization requirements.
- >> Governments have directed similar changes through policies that regulate health maintenance organizations (HMOs).

Managed care's retreat is having profound ripple effects throughout the health system, and this is only the beginning. It will likely lead to higher costs, more cost sharing for consumers, new barriers to access, greater numbers of uninsured and a weaker platform from which to improve quality. But what is most troubling is the lack of a vision for the next wave of innovation in health care financing and delivery. Most of the energy of leaders today is going into dismantling structures to adjust to the retreat of managed care.

Higher Costs in 2001

After remaining under 4 percent from 1995 through 1998, health insurance premium increases exceeded 8 percent in 2000 and are expected to be higher in 2001.¹ A major determinant of health care cost trends over the last decade has been the interplay between health costs and the economy's performance. Employers started their push to move employees into managed care plans when health benefit costs were rising rapidly and loomed large compared with profits. A key sweetener for employees was the fact that the typical managed care benefit structure offered broader benefits (e.g., preventive services) and required much less cost sharing than traditional coverage. Indeed, out-of-pocket spending on medical services for those with insurance declined during the 1990s.² Of particular note, pharmaceuticals became more affordable to consumers because of lower cost sharing; in 1999, drugs accounted for 44 percent of the increase in costs underlying private insurance.³

This was a double-edged sword for consumers. Along with less financial responsibility for health care came more management of care. But when consumers encountered barriers to care, or heard through friends or the media about restrictions faced by others, they complained to their employers and lawmakers. With health care premium trends decreasing, profits increasing and labor markets unusually tight, employers responded to these complaints. They offered less restrictive plans with wide networks, direct access to specialists and fewer restrictions. Many of these changes are leading to higher costs now.

Another factor driving costs higher is increased provider leverage. More choice has substantially weakened health plan

bargaining power with providers. Hospitals and some specialty physicians have received substantial rate increases from plans as a result of consumer and employer demands that plans offer a broad choice of providers. Indeed, showdowns between health plans and hospitals over contract terms have occurred in many communities, often with substantial media attention.⁴ Employer pressure on health plans to minimize instability of provider networks has further weakened plans' bargaining position and has led to higher rates.

More Cost Sharing

The retreat from managed care is likely to lead to much more extensive cost-sharing responsibilities for consumers. With premiums rising, corporate profits down and labor markets loosening, employers are beginning to consider options to keep their benefit outlays from growing rapidly. The backlash against managed care suggests that patients will have to pay more at the point of service. A harbinger is the recent action by the California Public Employees' Retirement System (CalPERS) to increase cost sharing in its HMO plans as a way to pare down a negotiated 13 percent premium increase to 6 percent.

Greater cost sharing is likely to take place for two reasons.

- >> First, with the shift to looser restrictions in managed care moving ahead at full steam, it is unlikely that employers will take a 180-degree turn back to tight restrictions.
- >> Second, with many restrictions dismantled, the typical managed care benefit structure is increasingly seen as providing inadequate financial incentives to control costs.

The need for incentives is noted most dramatically in pharmaceuticals, where the scope for discretion by both physicians and patients is relatively large. It is not surprising that many employers adopted a three-tiered copayment strategy for drugs before taking other steps to increase cost sharing.

Initially, increased cost sharing will come largely from higher deductibles, coinsurance and copayments. However, the field is ripe for innovation. Following the lead taken for prescription drugs, innovation will emphasize giving consumers choice at the point of service between degrees of restriction and related cost sharing. With drugs, the consumer faces a choice with each prescription whether to adhere to the

Stuart Altman
Brandeis University

“Managed care has been defanged, and the leverage providers have gained will not be easily reversed. This should send a chill down the backs of employers, public purchasers and consumers because we can expect our premiums to surge.”

formulary and avoid the additional copayment. To reduce costs further, the three-tiered copayment for pharmaceuticals is likely to evolve to three-tiered coinsurance (based on percentage amounts of the prescription cost).

This approach is starting to be applied to provider networks. Some plans offer two networks with different copayments or coinsurance required (along with the highest coinsurance for providers not in either network). This approach dovetails with the ability of providers with the strongest brand names to demand higher payment rates from health plans. Although the classification of providers into high- and low-cost networks will be based initially on payment rates negotiated with health plans, one can envision a future in which profiling of practice patterns plays a role as well.

As cost sharing in general and tiering in particular become more significant, the gap in access to care based on income level is likely to capture the attention of policy makers. Today's horror stories about needed services being blocked by managed care bureaucrats could well be replaced by examples of people doing without important care because the cost sharing was beyond what they could afford. Policy attention might

then turn to making sure that regulation does not interfere with products that require minimal cost sharing and depend instead on tight management to keep costs controlled. Indeed, a few years of experience with high cost sharing is likely to rekindle interest in the tightly managed products that are so out of favor in today's market.

New Barriers to Access

Disruptions to the health system caused by the retreat from managed care are also posing barriers to access to care. For the first time in decades, hospital capacity problems have emerged in a number of communities. Most visible are problems in emergency departments, where ambulance diversions are occurring with increasing frequency, resulting in patients being rerouted to other hospitals and delays in care.⁵ Some of the reasons for crowding include regulations limiting managed care restrictions on emergency room use, stepped-up enforcement of the Emergency Medical Treatment and Labor Act and acute shortages of nurses and other skilled personnel.

Overall hospital capacity has played a role as well. From 1994 to 1999, the number of emergency departments declined by

Karen Ignagni
*American Association
of Health Plans*

“Policy makers should know that we can’t have it both ways: we can’t by law or regulation take away basic tools of managed care or encumber plans, employers and doctors with more liability, and then still expect the system to deliver on its promise.”

8 percent. Patients who need intensive care when beds are not available often must remain in the emergency department to get the care they need. Over the same period, inpatient beds declined by 15 percent, as intense pressure to cut costs—coming from both low payment rates in managed care contracts and reductions in the growth of Medicare payment rates under the 1997 Balanced Budget Act—led to closure of capacity deemed not essential. With hospitals vigorously adding facilities to provide the most prestigious and profitable services, investing in emergency facilities, which tend to lose money, may be losing out in the competition for scarce capital resources.

A different type of barrier to access seen over the past two years is network instability. In many communities, important providers have declined to renew contracts with health plans, largely because of disagreements over payment rates. For example, in Orange County, Calif., St. Joseph Health System terminated the largest of its managed care contracts, with PacifiCare, affecting 100,000 consumers.

Such terminations can be highly disruptive to consumers, who often face a choice of changing providers—perhaps during a course of treatment—or paying substantially more out of pocket.^{6,7} Closures of physician organizations, such as medical groups owned by failed physician practice management companies, also contribute to network instability.

Increase in the Uninsured

As we enter a period in which the economy may not be as robust and insurance premiums are increasing more rapidly again—in part due to the retreat from managed care—the proportion of people who are uninsured is likely to increase. The literature suggests a substantial sensitivity of health insurance coverage to premiums.⁸

Federal policy might offset this trend somewhat. Over the past year, diverse interest groups have reached out to each other to work on legislation to reduce the number of uninsured.⁹ Many envision a compromise consisting of expansions of public programs providing coverage for

James Bentley
*American Hospital
Association*

“Many hospitals are experiencing emergency room capacity problems and staff shortages and expect things to get worse before they get better. Looser managed care has resulted in patient logjams, and with premiums rising hospitals are likely to treat growing numbers of uninsured who have no place else to go.”



the poor and tax credits for individuals with somewhat higher incomes to purchase private insurance. Initially, enactment of proposed federal legislation to expand public programs and offer tax credits to purchase coverage would outweigh the erosion of coverage from higher premiums. However, it is clear that rising health care costs will outstrip the gains over time, making the goal of universal coverage more difficult to reach.

Another dynamic affecting insurance coverage is state and local policy for the low-income uninsured. In recent site visits to 12 nationally representative communities, HSC noticed increased support at the state and local level for funding safety net providers, such as public hospitals and community health centers. A number of states, for example, have devoted large portions of tobacco settlement money to the safety net.

Although some analysts have raised the conceptual choice between policies promoting expansion of coverage and those providing more services for the uninsured, HSC has found that communities pursuing efforts in this area are doing more on both counts. President Bush has put forward initiatives related to both care and coverage. Discussions may lead to a consensus that some low-income individuals can best be

assisted by enabling them to obtain health insurance coverage while others cannot be brought into the health insurance system and are best supported through funding safety net providers.

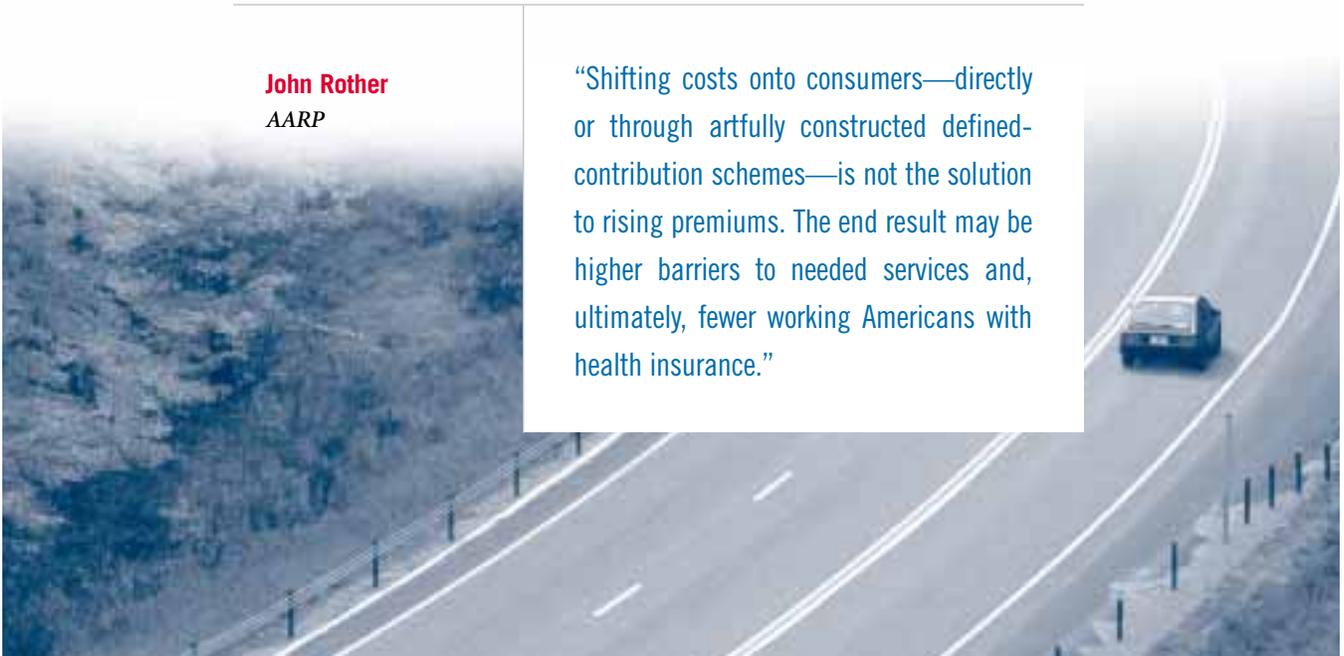
Concerns About Quality of Care

Integrated delivery had offered the hope of accountability for the quality of care provided to an enrolled population. The movement away from integrated delivery systems and capitated payment of provider organizations— aspects of the retreat from managed care—is removing a potential platform for providers to improve quality. Integrated delivery systems were seen as improving quality through the use of evidence-based medicine applied to the needs of a defined population.

Although longstanding integrated delivery systems, such as Kaiser Permanente, are pursuing this vision vigorously, the expectation of creating many more such systems has diminished. Some of this occurred because of the difficulty of getting large organizations with different cultures to work together effectively, but the retreat from managed care may have been a more significant blow.

John Rother
AARP

“Shifting costs onto consumers—directly or through artfully constructed defined-contribution schemes—is not the solution to rising premiums. The end result may be higher barriers to needed services and, ultimately, fewer working Americans with health insurance.”



The desire for broad provider choice has meant that the archetypical integrated delivery insurance product—an HMO with the provider network comprising a single hospital system and physicians associated with it—is not an attractive one. HMOs today tend to offer enrollees access to most hospital systems in the area. Furthermore, in many communities, interest in HMO products has declined.

In addition, global capitation—hospitals and physicians together assuming all financial risk for health services—has not developed as expected. Both providers and health plans have pulled away from this arrangement over the past two years. In many cases, this retrenchment has been the result of unfavorable experience—providers losing money or plans having to support providers in financial difficulty. But the lack of growth in the market share of HMO products is an important factor as well. Preferred provider organizations (PPOs) do not lend themselves to capitated payment, and providers

report important difficulties in accepting risk in point-of-service (POS) products.

The absence of capitated payment undermines the business case for providers to engage in quality improvement activities. For example, when hospitals are paid on a per diem basis, programs to reduce length of stay detract from the bottom line. When disease management programs have significant educational components or require investment in information systems by physician practices paid under fee-for-service arrangements, the practices receive lower payment for physician services but are not paid for the services that are a substitute for seeing the doctor. The potential exists for disease management and other such programs to fall out of favor, leaving patients facing fractured, uncoordinated and, potentially, poor-quality care. According to the recent Institute of Medicine report, *Crossing the Quality Chasm*,¹⁰ the lack of functioning systems and related incentives is at the heart of quality problems plaguing health care in this country.

Janet Corrigan
Institute of Medicine

“Quality of care is a concern across all sectors, in large part because there is no system but rather an aggregation of many parts with little coordination among them. It is unclear what kinds of organizations will integrate care in the future, but they should include science-based practice, well-designed care processes and programs to improve population health.”

No Vision Ahead

Many people perceive the retreat from managed care to be a positive development and welcome less interference with delivery of care. But the retreat has set in motion a number of negative trends for consumers:

- >> Cost trends will be higher and consumers will face more cost sharing.
- >> New barriers to access are appearing, such as capacity shortages in emergency departments and disruptions in physician-patient relationships because of network instability.
- >> Higher costs will lead to more people going without coverage, although public policy to expand coverage may postpone this development.
- >> The integrated delivery platform to improve quality has been stymied

by consumer demands for broad provider choice.

The situation in 2001 resembles that in the early 1990s, especially in terms of costs. But some differences do not bode well for the health system or consumers. One such difference is that the easy gains from managed care have already been exhausted. The potential for a rapid slowing of cost trends does not exist, especially given the higher degree of provider leverage. Another critical difference is the absence of a vision for an improved health system. In the early 1990s, many people shared a vision that managed care and integrated delivery would improve care. I cannot identify any comparable vision today.



Paul B. Ginsburg

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