

The Future of Managed Care: Experiments in Reinvention



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EXECUTIVE SUMMARY



Is Managed Care Dead?

Some highly respected health professionals, economists, and pundits say flatly that managed care is dead—that it has failed and will go the way of the dinosaur. Certainly headlines have widely heralded its demise. But is managed care really dead? Will it exist in 2005? If so, what form it will take? If not what will replace it?

As the Institute for the Future (ITF) set out to investigate the future of managed care, it became clear that the first question to answer was, “What is managed care?” We found many experts who thought of managed care—not as a way to finance and deliver health care—but rather as the health-maintenance-organization (HMO) industry itself. For them, the HMO form defined managed care. Others thought of managed care as any type of health insurance with provider payment incentives to change care-delivery patterns and control the costs of care. Insurance programs, using “preferred provider” or “exclusive provider” arrangements, were included in managed care under this definition. Experts who linked managed care exclusively to HMOs saw managed care as dead, or at least dying. When asked whether the future would hold a diminished demand for a mechanism to coordinate the delivery, and control the costs of health care, however, the experts unanimously said no.

For this report, we define managed care by its functions:

Managed care is any system of financing and delivering health care that attempts to coordinate the use of health services by its enrolled population in order to contain costs, improve the quality of health care, or both.

The central question is not, “Is managed care dead?” but rather, “How will the health-care industry control costs and deliver care in the years to come?”

Why Forecast the Future of Managed Care?

Managed care immutably altered health care in the United States. During the 1990s, managed care became the dominant health-care insurance and delivery system, covering more than 60 percent of publicly and privately insured lives. In its HMO form, managed care fundamentally changed the role of the physician from that of a free agent to that of team player. It transformed employer-purchasers from benevolent sponsors to key decision makers and tough negotiators. It changed the patient–physician relationship by enforcing restrictions on costs and services and by instituting mechanisms to oversee the quality of care.

The original promise of managed care was first and foremost to deliver comprehensive, coordinated health care. In fact, managed-care plans were originally the *high-priced* alternative to indemnity plans. Many would argue that managed care introduced better standards of practice and greater accountability. Licensing of physicians and hospitals had become established in the United States during the early 1900s. Later, a quality review and accreditation infrastructure grew up to provide information to health-care purchasers—it included the National Committee for Quality Assurance (NCQA), which accredits HMOs, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

which accredits hospitals. Nonetheless, there was little interest in health plans' performance until the late 1980s, when large employers like Xerox demanded performance assessments from the HMOs they retained. No widely used or publicly available mechanism to measure the quality of clinical care was established until 1993, when the Health Employer Data and Information Set (HEDIS) was adopted nationally. Quality measurement does not yet encompass newer forms of managed care, namely the preferred provider organization (PPO).

Managed care was instrumental in controlling national health-care expenditures during the mid 1990s. The rate of growth for those expenditures fell from 11 percent per year in 1990 to a low of 4.86 percent per year in 1997. As more people in the United States moved from indemnity plans to managed-care plans, as managed-care organizations suppressed prices to gain market share, and as the economy grew, the growth rate for health-care premiums fell substantially too, reaching a low of 0.8 percent per year in 1996.

Managed care *did* deliver lower-priced health care while providing a wider array of services than did indemnity plans.¹ Yet the successes of managed care did not make it popular. Instead, a backlash erupted:

- Consumers demanded choice in reaction to restrictions on access to specialty services and to new, expensive technologies, procedures, and pharmaceuticals
- Physicians uniformly professed antagonism to managed care plans' low payment rates and bemoaned their loss of professional autonomy in making decisions about patient care
- The media repeatedly covered individual cases that suggested barriers to access had resulted in a lower quality of health care
- Consumer advocates and providers of care lobbied aggressively and effectively to convince state and federal legislators to regulate managed-care organizations. This activism resulted in new laws mandating specific benefits and levels of service, along with new grievance procedures permitting consumers to appeal health plans' rulings involving access to services

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- Provider organizations experienced financial collapse, which increased the pressure for increases in reimbursements. This situation particularly affected providers in the western United States, where many had accepted capitation risks and where several declared bankruptcy and left the market.

Despite the sentiment against managed care, the virtues of controlling costs and coordinating care continue to be important to health-care providers, plans, and purchasers—patients and regulatory bodies alike. To date, managed care has proved to be our best hope of controlling the costs and quality of health care. Its evolution will be a central issue in American health care for many years.

What Will Drive Change in Managed Care?

 Our research has identified five forces that will drive change in the ways that managed care administers care and controls costs during the next five years:

- Relentlessly *rising health-care premiums and costs* that compel purchasers to push for cost containment
- Dissemination of new *information technology (IT)* that allows for improved clinical and administrative oversight
- The *New Consumers* of health care, who demand choice, information, and control over their health care
- *Increased regulation* of the managed-care plans and of access to patients' medical data
- *Innovation* in business models to coordinate the financing and delivery of health care

This report suggests where these forces of change are likely to drive managed care by 2005.

The Forecast: Managed Care— Experiments in Reinvention

The next five years will be a period of amassing new tools, new information, and new capabilities to manage care and control costs in the health-care industry. Managed care will be alive and evolving in 2005. The pressure to coordinate the delivery of care and improve the quality of care while still controlling costs will persist, as purchasers exert pressure on insurers to lower premiums, and providers struggle to maintain profits. However, managed care will still be less expensive than its indemnity counterparts. Internet-enabled technologies will offer robust data on costs and clinical practice to managed-care organizations and providers alike. Managed-care organizations and providers in turn will use those data to control costs and improve care delivery, even as they respond to consumers' demand for choice. While the HMO will not disappear, enrollment in less restrictive forms of managed care, such as the PPO, will surpass HMO enrollment. New managed-care products may emerge.

- ***National health-care expenditures will reach 15.6 percent of the Gross Domestic Product by 2005.*** The drive for market share, the parsimonious provider-reimbursement rates, and the lower premiums that drove the slower growth rate of the mid 1990s have run their course. Premiums will rise through 2003, and by 2005 annual growth in health-care expenditures will reach 6.5 percent. The health-care industry will grapple with the relentless inflationary forces of an aging population, the rising cost of prescription drugs, and advancing medical technology over the next five years, but will not come close to imposing the restrictions on costs that were seen in the 1990s.
- ***Plans will develop new ways to control costs.*** Plans will develop three-tiered payment schemes, channel patients to preferred providers, focus on disease-management strategies, and redesign means to reimburse providers.

Managed care
will be alive and
evolving in 2005.

Data about the quality of medical care will gain importance in managing care.

- ***Health-care purchasers will move to reformulate benefits.*** After several years of paying the rapidly rising costs of health care, purchasers will begin to share the costs with consumers and will redouble efforts to manage the behavior of both health-care plans and the consumer.
- ***Consumers will pay more for health care.*** The rate of growth in annual out-of-pocket expenditures will continue to increase and then will level off by 2005. At the same time, consumers will be given more information about health-care choices and will be rewarded for choosing the more cost-efficient providers.
- ***Plans and providers will use information-driven tools to control costs and manage care.*** As the more heavy-handed management tools collapse and as Internet-enabled clinical and administrative information systems emerge, health-care plans, providers, and purchasers will use IT to help health-care providers control costs better and improve the quality of care that patients receive. IT will assist in monitoring patients with chronic conditions, in avoiding medication errors, and in improving the diagnosis and treatment of illness, often supplanting the current, restrictive methods of care management.
- ***The structure of the delivery system will not change much.*** Providers will continue to consolidate in order to improve their bargaining position with health plans and to build capital for investment in their infrastructure. Investments will target new information technologies that help track and control costs and guide clinical practice.
- ***There will be a growing push for value in managed care.*** Both plans and purchasers will seek to increase the value—the price–performance relationship—of health-care services. They will provide consumers with performance data on players in the health-care system and encourage them to choose cost-effective providers. They will experiment with purchasing for value and rewarding providers accordingly. Data about the quality of medical care will gain importance in managing care.

Managed Care Beyond 2005: Power Plays for 2010

We conceived three *power plays* to explore the potential status of managed care in 2010. With each, we imagined how the managed-care market would operate under a different dominant player:

- Big Insurance Dominates
- Government Leads
- Consumers Meet E-Health-Care Markets

These are different from the IFTF's customary scenarios because they are not necessarily mutually exclusive. Each could exist within a region or across the nation. We offer these *power plays* to help prompt insights into strategies for success, no matter which sector dominates the managed-care market in the United States.

Endnote

¹ Harris, GE, Ripperger, MJ, and Horn, HGS. From the Field: Managed Care At a Crossroads, *Health Affairs* (January/February) 2000; 19,1.

Chapter 1

WHAT IS MANAGED CARE?



Twenty years ago, “managed care” was nearly synonymous with the term health maintenance organization (HMO). Today that has changed. In the 1990s, rising health-care costs gave rise to renewed interest in managed care because it held the promise of controlling costs and better managing how care is delivered. The forms that managed care took began to vary as traditional insurers competed with established HMOs. Managed care’s functions, however, have remained constant: coordinating care while controlling costs.

For this report, we define managed care by its functions:

Managed care is any system of financing and delivering health care that attempts to coordinate the use of health services by its enrolled population in order to contain costs, improve the quality of health care, or both.

This report focuses on how managed care may perform those functions in 2005.

HMO:
Health Maintenance Organization.

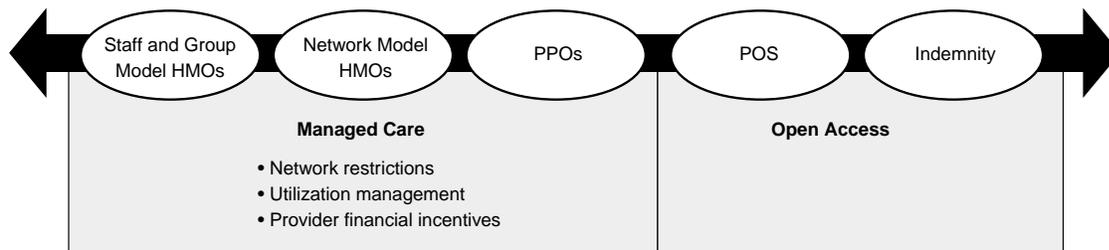
PPO:
Preferred Provider Organization.

POS:
Point of Service Plan.

In the United States today, the health-care system uses a variety of organizational and reimbursement structures to manage care and control costs. We categorize the continuum from staff- and group-model HMOs, through network-model HMOs, to preferred provider organizations (PPOs) as *managed care* (see Figure 1-1). Whereas HMOs constitute heavily managed care characterized by network restrictions, utilization management, and financial incentives, PPOs are “managed care lite,” with discounted fee for service and looser restrictions on providers and consumers alike. As of 2000, 80.9 million people were enrolled in HMOs and 84.5 million were enrolled in PPOs, accounting for 71.4 percent of the insured population in the United States, including commercially insured and Medicare and Medicaid beneficiaries.¹ For the first time PPOs have overtaken HMOs in market share, holding 41 percent, versus HMOs’ 29 percent, of the employment-based insurance market.²

As we see a shift from heavy to “lite” managed care, these questions arise: What drives this shift? What are the implications for managing care and controlling costs? What effect will purchasers’ response to rising premiums have on managed care? How will providers react to renewed efforts to control costs while offering consumers the choice embodied in managed care lite? As old techniques of controlling costs and managing care meet with resistance, what will replace them? Will Internet-enabled technologies be the tools of choice? Will managed care ultimately achieve the goals of managing care while controlling costs, and if so, how?

Figure 1-1.
Spectrum of Managed Care



Source: Institute for the Future, Joan Trauner, Ph.D.

The Institute for the Future (IFF) set out to address these questions and forecast the future of managed care to the year 2005. What we discovered is a health-care delivery and payment mechanism in crisis. While new tools for managing care and controlling costs are at hand, the health-care industry is struggling to acquire, test, and integrate them, and to bring them to scale.

2005: Forecast

We forecast that the next five years will be a period of experimentation preceding a reinvention of managed care. During the next five years, leaders of managed care will position themselves to adopt new methods to coordinate care while controlling costs. Those who do not change will flounder. The future of health care in the United States will be influenced by technologic advances that alter the way consumers perceive health care, the way players in the health-care marketplace do business, and the regulations that affect health care. The outcome by 2010 will be governed by market dynamics under the influence of different sectors of the health-care economy. The face of health care 2010 will depend ultimately on which participants in the health-care marketplace dominate.

Endnotes

¹ Managed Care Online, Managed Care National Statistics, www.mcareol.com.

² Kaiser Family Foundation and the Health Research and Educational Trust. *Employer Health Benefits 2000 Annual Survey*. September, 2000.

Chapter 2:

MANAGED CARE IS OUT OF BALANCE



After successfully restraining premiums and health-care inflation in the early to mid-1990s, managed care has ceased to deliver promised savings and many question its ability to deliver quality care. Both health-care costs and premiums are rising at ever increasing rates (see the sidebar “Premium Increases and Health Care Expenditure Growth” and Figure 2–1, pages 14 and 15). Consumers and providers alike are expressing concern about the quality of care.^{1,2} In a struggle for survival, health-care institutions—together with physicians seeking to regain control over clinical decision making—are resisting both low reimbursement rates and restrictive practice management. Consumers want ready access to providers and choices among doctors and treatments.³ As providers and consumers have made their case about damage wrought by the restrictions of traditional managed care, health plans, the courts, and regulators have responded. The established managed-care techniques for controlling costs, for administration and utilization review, and for restricting patients to set physician networks and denying service have fallen prey to lawsuits, regulation, and bad press. At the same time, health care faces immutable cost drivers. Managed care may not be at a breaking point, but the current situation is unsustainable.

Premium Increases and Health-Care Expenditure Growth

We want to draw a clear distinction between the upward trend in health-insurance premiums and the growth in underlying health-care spending. Growth in premiums is not a good proxy for growth in health-care spending, at least in the short term. Insurers base their premiums on historical claim information and projections of future costs. Increases in premiums may also be influenced by competition in the local market, by payment and risk-sharing arrangements with providers, and by the willingness of purchasers to absorb premium increases

Problems with the historic information or flaws in the projections of future costs may mean that premiums are too high in some years or too low in others. Health plans may keep increases down in years when the growth in health-care costs is low in order to expand market share, but they may lose money in the process. They

may then seek heftier premiums in order to regain profitability. In other words, we have described the *insurance underwriting cycle*, which is often disparaged but characterizes the cyclical pattern of premiums rates quite well.

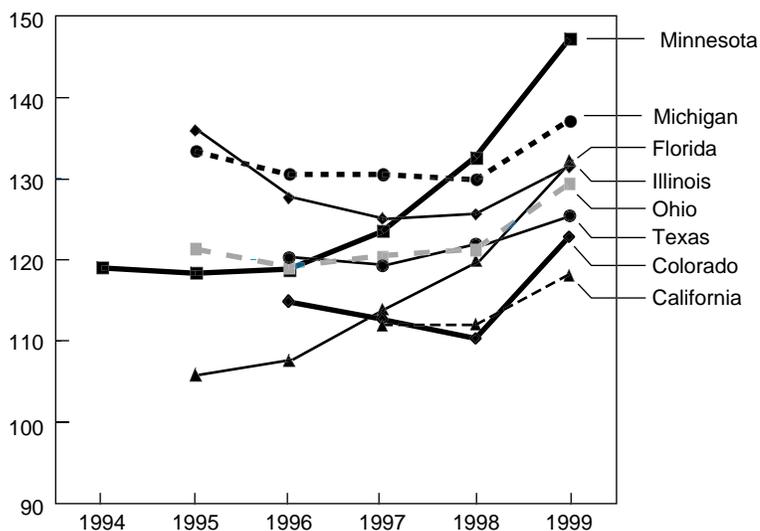
Figure 2-1 compares eight states with regard to the growth of commercial HMO premium revenues through 1999. In most of the states, premium revenues were flat in the three years from 1996 to 1998, meaning that employers were enjoying low annual increases and even some decreases. Health plans—and there were many new ones during those years—were holding down premiums to gain or maintain market share, even though it meant losing money.

By 1999, however, premium revenues had turned upward in all of the states. Premiums in two states, Minnesota and Florida, turned upward sooner. In Minnesota, a heavy concentration of HMO enrollment in a few plans means that there is

little competitive pressure to hold increases down. In Florida, some large HMOs had used Medicare profits to subsidize commercial business in order to comply with a 50-50 rule for Medicare and commercial enrollment. When that rule ended, they phased out the cross-subsidies and boosted commercial premiums.

The gap between health-care costs and premiums for health benefits has a significant impact on both plan sponsors and providers of care. If premiums fail to keep pace with underlying costs, plans and providers stand to lose money. The insurance underwriting cycle ensures that the market will move to recoup losses.

Figure 2-1.
HMO Commercial Premium Revenue, Per Member Per Month, 1994-1999



Source: Allan Baumgarten, *Minnesota Managed Care Review*

Managed care plans did deliver what they promised to health-care purchasers: the growth of premiums slowed. . . . (But) managed care did little to cut the underlying costs of delivering health care.

Making Up for Lost Time: Prices Soared

Between 1994 and 1998, health plans scrambled to respond to purchasers' demands for cost containment and to gain market share by dramatically suppressing the growth of premiums. To do this, they used a familiar set of management tools to control costs.

- *Capitation and shared risk arrangements* place providers at risk for some or all components of care at a predetermined fixed price
- *Utilization review and restriction of services* use a centralized process of either prospectively or retrospectively reviewing and approving payment for medical procedures
- *Bargaining down payment rates* to providers simply attempts to set an advantageous rate for payers

With these tools, managed care plans did, in fact, deliver what they promised to health-care purchasers: the growth of premiums slowed. While inflation of medical costs dropped to 4.6 percent in 1996, the growth of premiums plummeted to 0.8 percent per year—one quarter of the overall inflation rate (see Figure 2–2). What managed care did was keep premiums artificially low by restricting access to care, cutting staff, and reducing professional fees. But plans and providers failed to attack the underlying problems, including poor information systems, weak administrative support to identify and track costs, and lack of discipline among providers. Thus managed care did little to cut the underlying costs of delivering health care. Public and private purchasers were much happier with lower premiums, but physicians, health systems, and consumers were not.

Managed-Care Premiums Were Unsustainable

Plans and providers paid for the dampened price growth. HMOs experienced four years of net losses from 1995 to 1999.⁴ Parsimonious reimbursement wreaked financial havoc on providers. In California, where managed care realized the greatest penetration and the lowest premiums, the California Medical Association found that 113 out of 300 medical groups failed or quit between 1996 and 1999.⁵ The industry saw a pre-

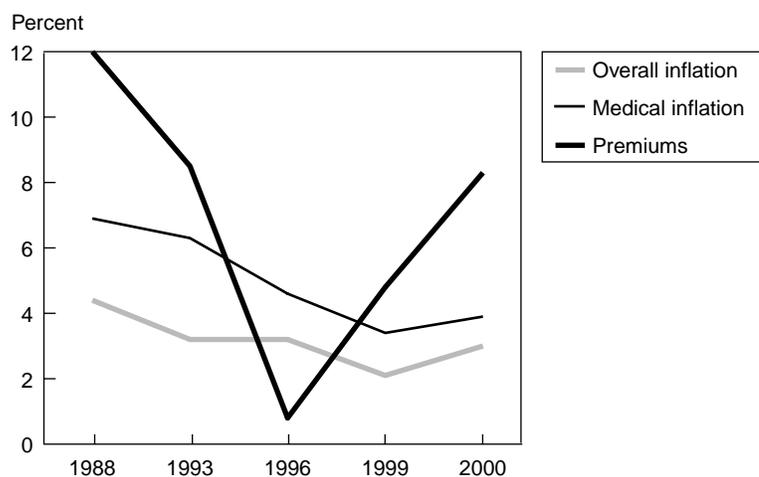
cipitous rise and fall of physicians' practice-management companies that could neither manage nor squeeze profits out of medical groups.⁶

The financial markets began to reappraise health care. The value of privately owned hospitals fell by 33 percent between January 1999 and January 2000.⁷ In the first six months of the year 2000, Moody's Investor Service downgraded the debt ratings of 28 not-for-profit hospitals.⁸ As medical costs continued to rise, albeit more slowly, hospital systems, providers, and plans could not sustain the discounted prices.

Evidence that established managed-care techniques are crumbling is abundant.

- The financial demise of many Independent Practice Associations (IPAs) and medical groups in heavily capitated areas indicates that these groups have struggled to find the management capabilities and the infrastructure to manage effectively under capitation.^{9, 10} These entities failed because reimbursement did not keep pace with the rising costs of health care.

Figure 2-2.
Inflation Rates Diverge



Source: Kaiser Family Foundation; Health Research and Educational Trust

Health plans in the public managed-care market rebelled, pulling out of the Medicare market...

- Highly publicized cases have caused plans like United Healthcare and Aetna to back away from utilization review. In addition, new restrictions on utilization review and new laws enabling consumers to sue HMOs for denial of service are chilling enthusiasm for this form of medical management.
- Health plans in the public managed-care market rebelled, pulling out of the Medicare market in response to the low reimbursement rates introduced by the Balanced Budget Amendment of 1997. (See the sidebar “Will Medicare Managed Care Exist in 2005?” for a look at the likely future Medicare-managed care relationship.)
- Providers are much less likely to accept low payments in order to be included in a managed-care network. Both hospitals and physicians have become much more militant in their demands for what they see as adequate payment, and providers have become more sophisticated about the factors leading to costs. Many provider organizations are now of a size to control a significant regional market share, and the “brute force” approach to negotiation by payers is less likely to be successful. Mergers and acquisitions among providers have been seen as means of increasing negotiating leverage in many parts of the country, particularly in the West and Northeast.

Will Medicare Managed Care Exist in 2005?

Over the next two years, we will continue to see a decline in the number of managed-care organizations choosing to participate in Medicare. However, due to the omnipresent need to contain costs, managed-care plans will not be able to abandon the Medicare market completely. Regional variations will continue to be a crucial factor in the Medicare market. Competitive market forces will cause managed-care plans already established in urban and large suburban markets to consolidate and offer coverage to a growing number of Medicare beneficiaries. Beneficiaries in rural markets will have little or no choice about participating in managed care because the plans will not be able to serve those areas profitably. Improved indemnity programs that incorporate key managed-care concepts, such as disease manage-

ment, coordinated health care, and outcomes review will prevail in less populated regions.

Policy makers will create incentives to entice managed-care organizations to participate in Medicare in an effort to contain overall Medicare costs. The traditional indemnity model cannot provide the level of choice and services that consumers in the increasingly large Medicare population will demand in the future. The Congress will seek mechanisms to encourage managed-care organizations to offer seamless, coordinated benefit plans to Medicare beneficiaries. To encourage managed-care plans to do so, Congress and Medicare will have to address concerns about inadequate payment to both the providers and plans under Medicare contracts.

Will Medicare Managed Care Exist in 2005? (cont.)

Managed Care Option Likely

The elderly population's need for comprehensive health care and the aging Baby Boom generation's familiarity with managed care will drive the government to make efforts to maintain a managed-care option for Medicare beneficiaries. Consumer demand is likely to ensure that a managed-care option will include a prescription-drug benefit, but a strong pharmaceutical lobby will succeed in averting strict governmental price controls on its products. Beneficiaries' choices among coverage options probably will not increase substantially in the next couple of years, since managed-care organizations will continue to leave the Medicare market while payment methodologies are being reevaluated in Congress. By 2005, however, beneficiaries *will* have new choices, facilitated by the success of a few demonstration projects that foster competition among health plans for inclusion among the Medicare managed-care options.

Drivers

- The costs of health care continue to escalate and Medicare revenues remain insufficient.
- Anticipation—by Baby Boomers and the government—of the unprecedented number of New Consumers that the aging of the Baby Boomers will bring to the Medicare rolls puts the federal government under increasing pressure to ensure maintenance of the Medicare managed-care program while controlling costs.
- The solvency of Medicare managed-care programs continues to be threatened by issues regarding inadequacies in providers' reimbursement rates.
- Regional variations in market conditions allow managed care to thrive in densely populated areas, but it falters in rural areas.

Barriers

- Partisan politics in Congress interferes with the incorporation of managed care into overall Medicare reform.
- The eventual inclusion of outpatient prescription-drug coverage under the traditional Medicare program makes managed-care coverage less attractive, since many beneficiaries choose managed-care plans primarily for the drug coverage.
- Antipathy toward managed care among consumers and providers spills over to foster antagonism to Medicare managed care.
- Managed-care organizations continue to argue that Medicare reimbursement rates are so low that they can't afford to offer coverage to the Medicare population.
- A vocal constituency argues that managed care should play no role in delivering health care to seniors because its presence marks the edge of the slippery slope to privatizing the popular public program.

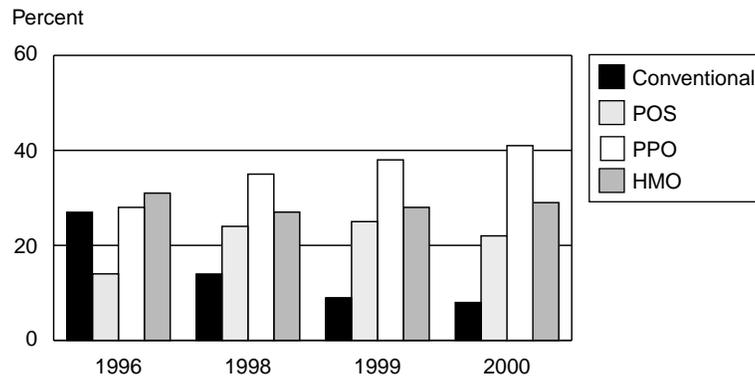
Wildcards

- The government imposes a universal system of health coverage, including long-term care, for the entire population.
- Continuing budget surpluses lessen the pressure for cost containment so that the current Medicare program can be sustained without gains in Medicare managed-care enrollment.
- Managed-care organizations overcome the business risk challenges of serving rural markets and offer a choice of plan options to Medicare beneficiaries in those regions.

Enter the Empowered Consumer

To make matters worse, managed care faced the increasingly demanding “New Consumer” of health care. With disposable income, computers, and at least a year of college education, these New Consumers want choices, access, control, and information.¹¹ Managed care’s efforts to reduce utilization and costs by limiting access ran afoul of the New Consumer’s demand for choice. The Kaiser Family Foundation found that 70 percent of respondents to their survey who were in “loose” managed-care plans gave their plan a grade of A or a B, but only 53 percent in “strict” plans assigned their plan those high grades. Respondents in the strict plans were more likely to report problems (62 percent versus 49 percent of those in loosely managed care).¹²

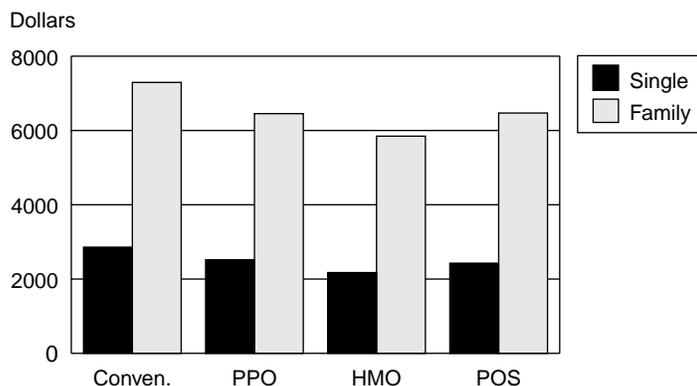
Figure 2-3.
Enrollment in PPOs grows



Source: Kaiser Family Foundation; Health Research and Educational Trust

In search of choice, consumers are moving toward less restrictive managed-care plans. Between January 1999 and January 2000, overall enrollment in the most restrictive form of managed care, the HMO, declined slightly for the first time.¹³ At the same time, PPO enrollment grew substantially among consumers with employment-based insurance. From 1996 to 2000, PPO enrollment grew from 28 percent to 41 percent of insured workers (see Figure 2–3). PPOs have essentially halted the growth in point-of-service (POS) plans and have drawn enrollees from conventional insurance. What they offer the New Consumer is choice and access, while offering employers competitive prices (see Figure 2–4).

Figure 2–4.
PPOs Compete with HMOs on Average Premiums for 2000



Source: Kaiser Family Foundation; Health Research and Educational Trust

Bad Press Amplified Discontent with Managed Care

There is no doubt that consumers have been unhappy with the restrictions of managed care, and the media have heightened the widespread sense of antipathy. By publicizing selected cases in which denial of care led to bad results, the media kept managed care caught up in a din of bad press. Although public opinion polls consistently yield negative opinions of managed care overall, they also show that people report relatively high levels of satisfaction with their own plans.^{14,15} The Kaiser Family Foundation and Harvard School of Public Health found that the media were the third most influential factor shaping public opinion of managed care, trailing personal experience (37 percent) and reports from friends and family (35 percent). Although the media did not manufacture discontent with managed care, they did amplify it.

Regulators Responded to Anti-Managed Care Sentiment

As clinicians and consumers bridled at managed care's restrictions on access to care and on providers' decision-making prerogatives, regulators responded. Building on sweeping federal legislation, including the HMO Act of 1973, the Employee Retirement Income Security Act (ERISA) of 1974, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Balanced Budget Amendment of 1997, regulators passed laws to protect patients' rights to access and treatment and to ensure that medical decision making is squarely in the hands of qualified clinicians. The effect has been to make managed-care organizations more wary of denying care.¹⁶

Patients' Rights to Treatment and Access

While debate continues about patients' rights at the federal level, states have moved to ensure access to treatment and physicians. Thirty-nine states passed acts for patients' protection between 1994 and 1998,¹⁷ 35 states passed laws requiring independent review in the event of a denial

of care, and 37 had laws on the books requiring that women have direct access to obstetric and gynecologic services. By 1999, 21 states had passed laws requiring that managed care plans accept “any willing provider” who agrees to their contracting terms. Like the federal government, states also moved to mandate clinical services. For example, as of 1998, 48 states and the federal government required 48-hour maternity stays after a normal delivery.^{18, 19}

Putting Clinical Decisions in the Hands of Clinicians

Suspicion that financial incentives in managed care ran counter to patients’ best interests led states to pass laws supporting clinicians in making clinical decisions. Forty-eight states passed laws banning gag clauses that prevent doctors from discussing treatment options outside of plan coverage. Twenty-seven states passed laws to prohibit financial incentives to provide the least expensive treatment. The federal Omnibus Reconciliation Acts of 1990 required that provider incentives be subject to Health Care Financing Administration (HCFA) rules.²⁰ Many states passed laws requiring that medical directors of managed-care organizations be licensed physicians and/or physicians licensed specifically in the state in which they work.

Managed Care Must Adapt to Survive

Faced with the colliding pressures of relentlessly rising prices, frustration and insolvency of providers, consumers’ demands, and regulatory intervention, managed care’s customary tools are hard to apply to coordinate care while controlling costs. Yet just as the old tools of managed care increasingly are rejected, public and private purchasers are feeling a renewed pressure to improve the quality of health care while controlling its costs. It is this confluence of influences that will drive managed care to adapt if it is to survive.

Just as the old tools of managed care increasingly are rejected, public and private purchasers are feeling a renewed pressure to improve the quality of health care while controlling its costs.

Endnotes

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Chapter 3

DRIVERS OF REINVENTION IN MANAGED CARE



Five dominant forces will drive managed care to change how it coordinates care and controls costs in the future. They are:

- Relentlessly *rising health-care premiums and costs* that compel purchasers to push for cost containment
- Dissemination of new *information technology (IT)* that allows for improved clinical and administrative oversight
- The *New Consumers* of health care, who demand choice, information, and control over their health care
- *Increased regulation* of managed-care plans and of access to patients' medical data
- *Innovation* in business models to coordinate the financing and delivery of health care

Taken together, these drivers of change will force managed care to invent new tools to manage care and control costs—or fail.

Rising Health-Care Premiums and Costs Drive a Push for Cost Containment

Despite its initial success at cutting health-care costs, managed care has lost its fiscal way. The easily won savings have been realized. An aging population, advancements in medical technology, and the rising cost of pharmaceuticals are intractable forces driving health-care expenditures up (see Figure 3-1).

An Aging Population Will Use More Health-Care Resources

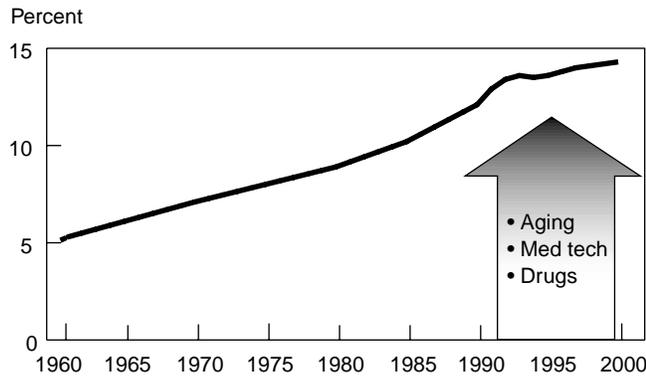
By 2010, the Baby Boom that began in 1945 will transform into an elder boom, as the youngest Baby Boomers turn 65 years of age (see Figure 3-2).

As the population ages, more people will have chronic illness and their use of medical resources will increase. People older than 65 years of age are more likely than those who are younger to take three or more prescription drugs routinely at any one time. They are also more likely to have spent \$1,000 or more of their own money on prescription drugs during the past year.¹ Prescriptions are just one age-related component of health-care expenditures. The aging of the population has the potential to amplify the already staggering share of health-care expenses incurred at or near the end of life as well.

Medical Technologies Proliferate

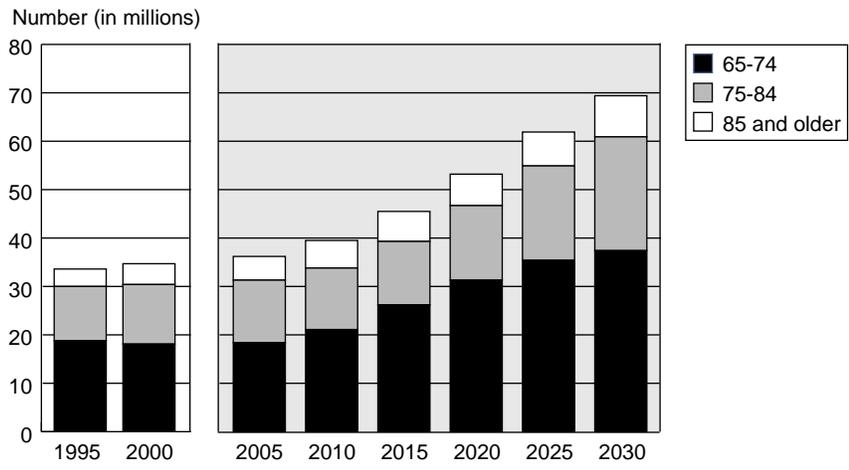
Managed care can rid the system of inefficiencies and reduce health-care costs, but it does not slow the adoption of new medical technology.² Advancements in medical technology can transform the diagnosis and treatment of disease. Nonetheless, there is strong consensus that medical technology is an important factor driving the long-term growth of inflation-adjusted health-care costs. According to one study, 91 percent of health economists believe that a major share of rising health-care costs can be attributed to increasing development, diffusion, and use of new medical technologies, including prescription drugs.³ Research also suggests that technology diffusion is a more significant cost driver than any other factor, including the aging of the population, the spread of health insurance, the growth in defensive medicine caused by malpractice liti-

*Figure 3-1.
Expenditure Increases Persist*



Source: Institute for the Future; Health Care Financing Administration.

*Figure 3-2.
The Population of People Over 65 Years Old Will Surge*



Source: Institute for the Future; U.S. Census Bureau.

In many cases, courts favor any medical service that could potentially benefit the patient, *regardless of how small the probability or the magnitude of the benefit.*

gation, and increasing administrative costs.⁴ Moreover, the chair of former Secretary Donna Shalala's Department of Health and Human Services committee to study the future of Medicare, Dale Yamamoto, has warned that, "We have a generation of people coming into the Medicare program who have lived a pretty good life. They will demand more technology."⁵ Unfortunately, the promise of supplanting old modalities with new, more cost-effective technologies is not yet a reality.

New But Unproven Technologies

A particular challenge for managed-care plans is controlling the use of medical technologies for which there is strong demand among patients but controversy about the indications for use. For example, plans paid dearly for denying high-dose chemotherapy followed by bone-marrow transplantation to patients with metastatic breast cancer—sustaining multimillion-dollar judgments in court. Yet scientific evidence never supported this treatment. When bone-marrow transplantation was finally put to the test, the results were worse than those obtained with standard chemotherapy. Chernew and colleagues⁶ found that the introduction of minimally invasive surgical techniques often leads to an increase in the volume of procedures performed, particularly when indications for their use are controversial and so, to some extent, subjective. They concluded that, if the increase in volume is large enough, the new techniques might cause aggregate health-care expenditures to rise, despite per-case savings.

Courts have supported consumers' demands for technology. Efforts by public and private insurers to deny claims on the basis of formal technology assessments have often been overturned by the courts.⁷ In many cases, courts favor any medical service that could potentially benefit the patient, *regardless of how small the probability or the magnitude of the benefit.* Considering that it is difficult to predict with certainty that a health service will have no possible benefit, the courts have made decisions in individual cases that may not reflect society's long-term interests in regard to reducing spending on health care. In the short term, this judicial trend hinders the ability of managed care not only to control costs but also to ensure the quality of care.

Technologic advancements ultimately may bring the quality and co-

ordination of health care to new levels of excellence, but they will not come without cost. Factoring together technologic advancements with consumers' demands for technology and a longer life span produces a multiplier effect on costs: the more people who live longer, the more people there are using new medical technology to improve and prolong their lives. Higher costs appear to be inevitable.

Pharmaceuticals: the More They Make, the More We Take

New, more, and expensive drugs are driving dramatic spending increases. While the price of prescription drugs rose just 6.1 percent in the year 1999, some health plans saw double-digit increases in expenditures on prescription drugs.⁸ Prescription drugs constituted 7.9 percent of national health-care expenditures in 1998, marking a 46 percent increase over 1990 levels. While growth in other medical costs slowed substantially, growth in prescription drug spending has increased from a low annual rate of 8.7 percent in 1993 to a high of 15.4 percent in 1998.⁹

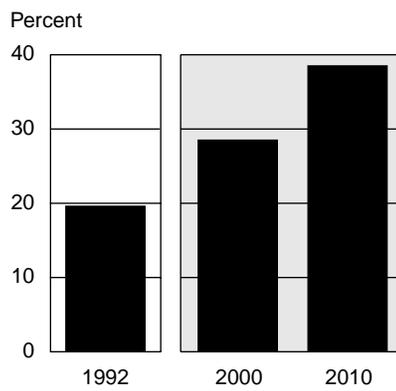
What is driving increases in prescription-drug expenditures? Although drug prices *have* increased, that does not fully account for the dramatic increases in prescription-drug expenditures, nor do the prices of drugs alone drive the policy initiatives and benefits adjustments that are emerging. The combination of increased prices *and* volume, along with a shift to newer, more expensive drugs accounts for increased drug spending.

Volume is up. People all across the United States are using medications to treat conditions earlier in life, and there are new drugs for an increasing number of conditions. In particular, the direct-to-consumer promotional strategies of big pharmaceutical companies have exacerbated Americans' de facto self-prescribing behavior. Beyond the phenomenon of Viagra, there is an ever-growing array of lifestyle drugs. For Highmark Blue Cross Blue Shield in western Pennsylvania, lifestyle drugs were projected to claim 25 percent of the drug budget in 2001.¹⁰

The potent combination of prescription drug prices and a greater volume of use is particularly evident among Medicare recipients.¹¹ The average number of prescriptions per elderly person grew from 19.6 in 1992 to 28.5 in 2000, an increase of 45 percent. By 2010, the average number of prescriptions per elderly person is projected to grow to 38.5—an increase

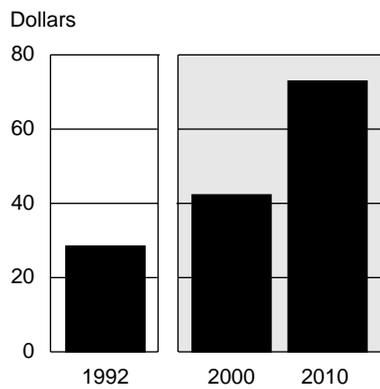
New, more,
and expensive
drugs are driving
dramatic spending
increases.

Figure 3–3.
Average Number of Prescriptions Per Senior Citizen, 1992 to 2010



Source: Families USA.¹²

Figure 3–4.
Average Cost Per Prescription for Senior Citizens



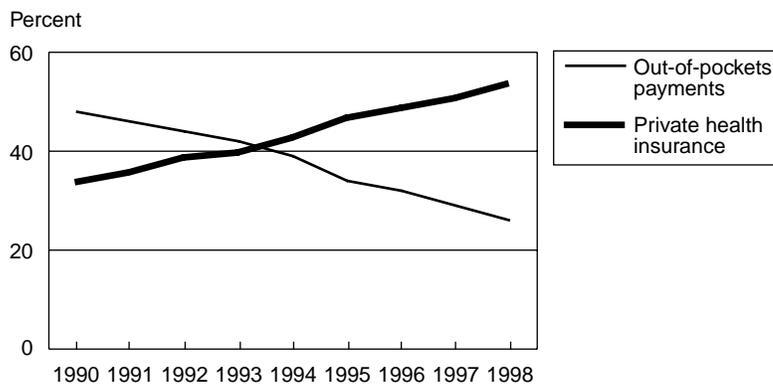
Source: Families USA.¹²

of 10 additional prescriptions, or 35 percent, per senior citizen since 2000 (see Figure 3–3). In the same time period, the average cost per prescription is projected to increase from \$28.50 to \$72.94 (see Figure 3–4).

Private health insurance is footing the bill for these costs. While private health insurance companies' share of national prescription-drug expenditures increased by 20 percent between 1990 and 1998, the consumer's out-of-pocket share of expenditures fell by nearly as much (see Figure 3–5). Public programs' share grew from 17.2 percent in 1990 to 20 percent in 1997, primarily because of the growth of Medicaid and other state and local programs.

Managed care cannot ignore galloping expenditures for prescription drugs. They constitute 16 percent of all expenditures by private health insurance companies and have consistently grown more rapidly than other components of national health-care spending. The pharmacy line item is a red flag to purchasers, plans, and consumers alike.

Figure 3–5.
Private Insurance's Share of Drug Costs Climb



Source: Employee Benefits Research Institute.

If managed-care organizations use IT wisely, it could propel their reinvention.

Information Technologies Offer New Tools for Managed Care

Health-care organizations, in comparison with other industries, have chronically underinvested in information technologies. Internet-enabled IT is proving to lower the costs of adopting IT for many organizations, however, and Internet-enabled IT is helping managed-care organizations to manage administrative costs. If managed-care organizations use IT wisely, it could propel their reinvention.

Currently available applications permit managed-care organizations to easily and efficiently reach their customers: employers, providers, brokers, and consumers. The managed-care organizations that adopted Internet-enabled technologies the earliest have used them to enhance financial, market, and operational performance.

Information Technology: Beyond the Holy Grail

Health care has long looked to IT as its Holy Grail, the artifact that will make it possible at last to improve quality while reducing costs. However, this expectation has proved to be less a vision than a mirage, as the health-care industry has been hindered by legacy systems and a lack of standards for systems integration. Moreover, perceived priorities and cost constraints in health care have relegated IT to a low-level line item in budgets for several decades.

A case in point is electronic medical records, an innovation introduced at the Harvard Community Health Plan and the Regenstreif Medical Center in the early 1970s. Thirty years later, these two organizations continue to be in a minority of health-care IT innovators—the organizations that have met the IT challenge to become highly wired.

There is an e-commerce gap between the most completely wired and least-wired health-care organizations.¹² The most-wired organizations submit more claims to health plans online, automate a greater proportion of the supply chain, and provide more clinical information to their patients.

For example, the most-wired hospitals submit about 16 percent of their health-plan claims online. But, according to a survey by the magazine *Hospitals and Health Networks*, the “less-wired” hospitals submit a little more than 3 percent of claims online (see Table 3–1). This is a huge gap, considering that electronic claims and remittances have an immediate and obvious return on investment as a result of the reduction in manual

labor required to process paper claims.

The health-care players who adopted Internet-based IT early on have found the Internet to be a powerful force for change and cost efficiency. The potential benefits are many:

- *Internet-driven IT can help prevent errors.* The Institute of Medicine (IOM) recently highlighted the frequency with which serious medical errors occur.¹³ Well-designed electronic systems can confirm that the correct patient is being treated and ensure that the right dose of a medication is administered—and, in so doing, can prevent errors and complications. One such application is the ePocrates clinical database, accessible by physicians through a personal digital assistant (PDA), which in clinical trials has reduced medication errors and their complications. According to the IOM, more than three in ten of the 3 billion prescriptions written by doctors each year have to be rechecked because of confusion about a doctor's handwriting or insurance rules.
- *IT can improve clinical decisions.* Several studies have shown that—while it is difficult to change physicians' behavior—information systems can influence decisions at the point of care. IT-generated reminders that clinicians receive when they are doing tasks, such as ordering a test or writing a prescription, can significantly improve the quality of care. In the long term, it can reduce the cost consequences of complications resulting from errors. Publications in the area of evidence-based medicine

Table 3-1.
The 10 Most-Wired Health Plans By Wired Function

	Member Services	Public Services	Disease Manage- ment	Employee Services	Employer Services	Agent/ Broker
10 Most Wired	7.8	4.8	3.7	10.1	4.4	3.4
Less Wired	3.7	3.4	1.8	4.5	1.7	1.5
All Respondents	2.6	3.1	1.1	2.9	0.9	1.1
Total Possible Functions	14	10	11	16	7	15

Source: Hospital and Health Networks' Most Wired Health Plans survey, April, 2000.

Vigorous application of a simple and effective information intervention could save thousands of lives annually.

include many reports of clinical trials that support the effectiveness of physicians' using information systems that provide reminders. One such trial showed that preventive care could be greatly improved by using information systems to prompt physicians and that, "vigorous application of a simple and effective information intervention could save thousands of lives annually."¹⁴

- *Caring for patients through the Internet.* Patients with special needs can be referred to disease-management programs or case-management programs and can be monitored closely through Internet technology, thereby reducing high-cost acute episodes, such as emergency-room (ER) admissions for patients with asthma. Health Hero Network is an innovative service that affords a cost-effective, interactive communications link between health-care providers and patients at home. It provides patients with daily in-home monitoring, coaching, and education, and it reinforces self-management skills. In a clinical trial with PacifiCare Behavioral Health, a six-month outcomes analysis of the plan's disease-management program for congestive heart failure (which uses Health Hero Network's technology) showed a significant reduction in hospitalizations and ER visits for patients in the program. The analysis showed that inpatient hospitalizations were reduced by 50 percent and ER visits by 73 percent. Costs for hospitalizations and ER visits were reduced by 50 percent, and a total savings in claims of \$5, 271 paid per member per year was realized.

- *Reviewing quality of care and conveying feedback.* In the current paper-laden milieu, it is difficult to assess clinicians' performance. Paper-based systems can be analyzed only through laborious and costly chart audits. The electronic capture of standardized data elements, by contrast, permits a systematic analysis of clinical practice and rapid dissemination of the results. Such rapid feedback can help to modify clinicians' behavior. Data-mining tools can improve health care by providing accurate information on which to base hospital assessments and physicians' peer analyses. Analyzing comparable data for specific diagnoses across providers yields benchmarks or ranges of costs and procedures. When any individual or organization falls outside a designated range, the anomaly can quickly be highlighted. Once identified, effective pro-

cedures can be shared with fellow health-care providers and best practices can be disseminated rapidly, ensuring that patients quickly get the best possible treatment.

Market Forces Accelerate the Adoption of IT in Health Care

Market conditions are aligned to make such robust information systems more likely than ever before to be deployed in health care.

- *Emergence of Application Service Providers (ASPs).* Information technology now permits the remote hosting of software applications on central servers so that the application can be accessed through the Internet. This capability significantly reduces the cost of the application and means that care providers do not need to manage the installation and ongoing maintenance of complex applications. Moreover, contracts with ASPs can include ongoing updates of software, which can otherwise be costly in terms of both money and labor costs. Sometimes, ASPs in health care are willing to provide applications free of charge, as their revenue comes from serving as conveyers of data between trading partners.
- *Acceptance of the Internet among physicians.* According to an October 2000 survey by Medem (an e-health network initiated by the nation's leading medical societies), 70 percent of all physicians' offices now have access to the Internet, of which one-half access the Internet daily and one-half also have a Web site for their practice. One-half also use the Internet to access medical references on bibliographic databases such as Medline. Only 6 percent exchange e-mail with patients, but this type of communication is expected to become more common as the New Consumers demand online access to their physicians and office staff.¹⁵
- *Improved quality of care through improved computer devices.* Moore's Law—that a new generation of microchip emerges every 18 to 24 months and possesses double the processing capacity of its immediate predecessor—continues to be borne out as advances in computer-chip technology provide for faster, smaller, more portable, easier-to-use devices year after year. Entering data manually into computer systems used to be a time-consuming and ergonomically challenging task. Bar coding permits the quick and efficient capture of data elements at the patient's side

By 2004, 20 percent of U.S. physicians will be using hand-held devices for professional transactions.

in both inpatient and outpatient settings. Internet-enabled telemetry enables patients to communicate their vital signs to their clinicians from home in real time through a modem.

- *Skyrocketing of wireless applications.* The capacity of wireless networks is doubling about every nine months. By 2002, most means of access to the Internet will be wireless.¹⁶ As a marketing tactic, many vendors in the wireless market minimize the cost of PDAs to providers by offering free PDAs and software to physicians and charging on a per-use basis. Although fewer than 1 percent of all U.S. physicians use hand-held devices in their medical practice today, the stage is set for physicians to adopt hand-held applications for the health-care market. Wireless applications and marketing tactics are in alignment—but more important is that wireless hand-held devices now fit seamlessly into a physician’s workflow, overcoming the primary obstacle to the adoption of other IT applications targeted to physicians. By 2004, 20 percent of U.S. physicians will be using hand-held devices for professional transactions.¹⁷

The cost of IT hardware and software is dropping, as is the cost of financing IT systems. Meanwhile, more and more clinicians are adopting Internet-enabled information technologies. This convergence of affordability and usefulness will support innovation in managed care.

The New Consumer Demands More

Accustomed to using the Internet for work, online shopping, and stock trading, New Consumers have come to expect an Amazon.com benchmark of convenience from their health plans too. Enrollees in health plans are demanding access to information about health plans on the Internet. They want online administrative services, such as claims processing and precertification, information about enrollment and benefits, referrals, and appointment scheduling. Increasingly consumers are seeking information to help them manage their own health and health care, including information about physicians, consumer-friendly clinical guidelines, and information about treatments.

With some notable exceptions, health plans lag well behind consum-

ers' expectations in Internet use. According to a recent survey, only 25 percent of health plans allow members to change primary-care providers on the Internet, and just over 20 percent allow members to enroll online.¹⁸

Consumers' demands will help make the Internet the medium of choice for communicating with and engaging health-plan enrollees in managed care.

Regulation May Have Cost Consequences

Regulation is limiting managed care's ability to use its customary tools, like utilization review and gatekeeping. The most significant legislation is HIPAA, or the Health Insurance Portability and Accountability Act, which promotes electronic data interchange within health care. However, regulations related to privacy rights and patients' rights also have the potential to drive change in the ways that managed-care organizations coordinate care and control costs.

Paying for Electronic Data Interchange and Beyond

HIPAA is intended to improve the efficiency and effectiveness of the health-care system by standardizing the electronic exchange of administrative and financial data and simplifying administrative processes. Health plans, providers, and clearinghouses that manage health-care data are "covered entities" under the law.

The legislation has the "teeth" to motivate covered entities: the penalties for organizations that do not comply with the regulations are steep. Violations of HIPAA's privacy provisions, for example, can result in fines as high as \$250,000, imprisonment for as long as 10 years, or a combination of both penalties. This regulation, with its steep consequences for noncompliance, is a driving force that is pushing health-care plans to adopt electronic data interchange (EDI), irrespective of whether EDI was among their highest priorities.

Paying for Privacy

In his last weeks in office, President Clinton enacted wide-reaching privacy regulations that could have a strong impact on managed care. The White House estimates that new privacy requirements will increase costs

for the nation's providers and health plans by \$1.2 billion during the first year alone, and \$3.8 billion over the course of five years. Other estimates have put the five-year cost as high as \$22.5 billion.¹⁹ Along with HIPAA regulations, these new regulations will cost managed-care organizations plenty.

Although health-care industry lobbyists moved aggressively to oppose the implementation of privacy regulations, the regulations will be implemented—and their implementation will affect costs, shape methods of managing care, and determine how information is to flow among providers.

Protecting Patients' Rights

The highly publicized federal Patients' Bill of Rights legislation attempts to hold health plans and self-insured purchasers accountable for health-care decisions. If a federal Patients' Bill of Rights that increases the liability of self-insured employers were to pass, these employers might drastically change their role in purchasing health care. Experts believe, however, that the real importance of the Patients' Bill of Rights may be more political than practical. Aggressive lobbying by health plans, employers, and providers makes it highly unlikely that a bill assigning such liability to self-insured employers will pass.

Innovation Spurs Managed Care to New Ways of Doing Business

Innovation outside of established managed-care organizations is fostering innovation within them. Companies marketing health-care information, products, and services on the Internet are capitalizing on the discontent with managed care, focusing on consumers, and driving managed care to change. These e-health-care companies are claiming functions traditionally performed by insurers, independent practice associations (IPAs), consultants, and brokers in both the business-to-business and the business-to-consumer markets. Such companies include Medscape, the purveyor of digital clinical data and medical information; eHealthInsurance, the online portal for individuals, families, and small businesses seeking health insurance; and the employee-benefits-manage-

ment companies eBenX.com and UltraLink.com. Although the downturn in the New Economy threatens such innovators' survival, it does not affect their ability to bring about long-term change in health care. They have already made their mark.

Established managed-care organizations are responding to the threats of these e-businesses. The old dogs of managed care are expanding their presence on the Web and offering new products that respond to consumers' demand for service. Kaiser Permanente allows patients to make and cancel appointments and order prescriptions online. Destiny Health, Inc. (www.destinyhealth.com), is launching a medical savings account product. Highmark Blue Cross Blue Shield is using the Internet to allow enrollees to construct personalized health plans. The New Economy is certainly teaching old dogs new tricks.

Driving Managed Care Toward New Tools

These drivers have moved managed care to action. The ready availability and potential of information technologies, the demands of the New Consumer, regulatory action, and innovation in the e-health sector itself, are driving managed care to develop new methods of care coordination and cost containment during the next five years. These new methods will take advantage of information-driven approaches that track costs, guide clinical practice, and engage the consumer in self-management while meeting consumers' demands for greater choice.

The New
Economy is
certainly teaching
old dogs new
tricks.

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THE FORECAST FOR MANAGED CARE



Experiments in Reinvention

If health-care providers are to provide high-quality care while still controlling costs in the future, smarter approaches to managing care will have to be devised—approaches that are not viewed as detrimental to either health-care consumers or health-care professionals. The emphasis must be on finding positive ways to manage care by eliminating duplication of effort, reducing errors, and reducing ineffectual variability.

Managed care in the 1990s brought about cost cutting, but it produced no fundamental changes in the practice of medicine. As 80 to 85 percent of the costs of health-care delivery lie in the practice of medicine, the changes that took place had no systemic effects on health-care costs. Cost-effective care delivery—care that delivers the best clinical outcomes for the dollar—remains elusive. Rising premiums and dissatisfaction among both consumers and health-care professionals have pushed managed-care organizations to reexamine their methods of serving their original purpose: delivering the right care to the right person at the right time. What is the status of managed care in 2005?

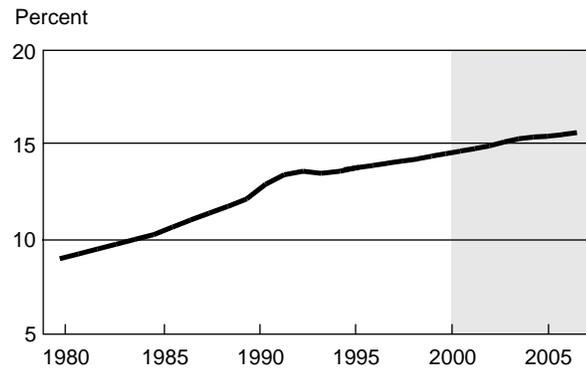
Imagine managed care in a laboratory, running experiments in coordinating care while controlling costs. Managed care, like health care in general, will have begun to invest in IT in 2005, and will be developing new processes to track costs and direct the delivery of care.

Managed care products that offer choices to consumers and help providers deliver better care will thrive. Health-care expenditures will continue to rise. There will be stellar examples of improved health-care management across the country, but the practice of medicine will not be fundamentally transformed. By the end of that period of experimentation, managed care will be poised to reinvent itself. Thus, the story of managed care will be one of experiments in reinvention. (See sidebar “Will State Experiments With Medicare Managed Care Reap Cost Savings?” for the public sector approach.)

All Players in the Health-Care System Will Work to Contain Costs

The IFTF book *Health and Health Care 2010* forecasted that aging, medical technologies, and new drugs would drive health expenditures to 15.6 percent of the Gross Domestic Product by 2005, at a growth rate of approximately 6.5 percent per year (see Figure 4-1). After several years of rising premiums, managed care will find itself in a crucible, combined with four reagents—purchasers pushing to control rising premiums, consumers seeking choice, providers demanding better pay, and the health-care system generally pushing to invest in information technologies.

Figure 4-1.
Expenditures Grow 6.5 Percent Annually



Source: Institute for the Future; Health Care Financing Administration.

Will State Experiments With Medicaid Managed Care Reap Cost Savings?

Medicaid managed care is likely to continue to expand during the coming years. Policymakers generally agree that managed care offers greater potential for cost savings than does indemnity coverage. Because it is still unclear how best to structure the health-care delivery system in order to provide high quality care while controlling skyrocketing costs, the next five years will be a period of much experimentation. The new federal administration is likely to grant more autonomy to the states in the development of their Medicaid program payment and delivery structures, and states are pushing for less federal oversight. The federal government has already waived some of the rules it imposes, granting states flexibility in the coverage options they offer and the structure of their Medicaid programs. States are experimenting. Some states will demonstrate the benefits of their Medicaid managed-care programs, such as increased access to services, more disease prevention, and less waste, and other states will adopt similar programs.

Two federal waiver programs currently enable states to experiment with their Medicaid programs. The “Freedom of Choice” waiver, 1915(b), allows states to mandate that Medicaid beneficiaries enroll in managed care programs, enhance benefits, or create carve-outs for delivering specific services, such as substance-abuse services. The “Research and Demonstration” waiver, 1115, grants states the flexibility to implement and evaluate new ideas for Medicaid programs such as adding services, expanding eligibility, or testing new financing structures. States are taking advantage of these waivers. Twenty states have been approved for waiver 1115 and four more have submitted proposals. Regional variations in managed-care penetration will foster additional experiments to determine which organizational frameworks and payment structures suit each state’s unique needs. Growth in Medicaid capitated provider payments will continue, but will vary significantly from state to state.

Will State Experiments With Medicaid Managed Care Reap Cost Savings? (cont.)

Although many states have been struggling to meet State Children's Health Insurance Program (SCHIP) enrollment goals since the program's inception in 1997, the cost of covering health care for children is generally low and the number SCHIP enrollees is likely to increase. Extensive marketing and outreach campaigns are being developed to boost enrollment of eligible children and the program itself will continue to be refined to make it more attractive and accessible to families of uninsured children. California offers an example of how innovative partnerships have prompted innovation. The California State Department of Health and Human Services, San Diego County, and two private not-for-profit organizations, the California HealthCare Foundation and the Medical Policy Institute, combined forces to create an Internet-based application for Health Families, California's SCHIP program. They call it Health-e-App (see www.chcf.org or www.healtheapp.org). States will also continue to enact legislation to expand eligibility for this program to include whole families and some lower-income workers.

In order to maximize cost savings, states also will attempt to enroll more elderly and disabled Medicaid recipients into managed-care programs. Commercial plans will compete for contracts with the states on the basis of both cost and quality, and states will experiment with payment structures in order to assure their financial solvency. Thus, innovation will be key to the success of Medicaid managed care over the next five years.

Drivers

- Mounting pressure to contain costs causes states to turn to managed care to cover their Medicaid populations.
- Medicaid regulation and the federal administration's support for the autonomy of states permit states to develop Medicaid programs that suit their unique needs.

Barriers

- Expansion of coverage drives states to lower capitation payments in order to control costs, and providers and commercial plans refuse to enter Medicaid contractual arrangements.
- Commercial Medicaid managed-care plans draw paying patients away from safety-net providers, threatening their capacity to serve the uninsured.
- Complications in coordinating benefits for the beneficiaries of both Medicaid and Medicare prevent states from reaping cost savings that would permit enrolling those beneficiaries in managed care.
- Consumers' antipathy toward managed care in the private population results in regulations that prevent states from taking advantage of cost-control mechanisms provided by managed care.

Wildcards

- SCHIP programs overcome their difficulties in enrolling eligible individuals and prove to be extremely successful in reducing the numbers of uninsured. States embrace their widespread application and expand SCHIP programs to include other large groups of uninsured.
- Managed-care organizations pull out of Medicaid programs entirely, forcing states to create their own infrastructures to manage the care of their Medicaid populations or to explore other alternatives of cost savings, such as cutting eligibility or offering less comprehensive benefits.

Plans Will Partner with Purchasers to Contain Costs

Although the well-worn methods that managed-care organizations have used to date to manage provider costs may not disappear, new models of managing costs will come to the fore. Plans will work in concert with purchasers to make consumers become active participants in health-care choices that the consumer will pay for.

Tiered Payment Systems

Consumers will pay differential premiums for services and products available to them. Tiering of prices will depend on the health plan's perception of both need and consumer demand. Currently, most health plans blend the cost of health-care providers and health-care benefits into one price. Consumers are charged the same premium or copayment whether they pick the more expensive or the more economical providers and medications. Three-tiered copayments for pharmaceuticals—that is, the lowest copayment for generics, an intermediate copayment for brand-name formulary medication, and the highest copayment for brand-name nonformulary medication—have been an example to make consumers aware of the cost of their choices. Another approach, used in medical savings accounts, is to implement a higher deductible coverage—such as a \$2,000 deductible—whereby consumers pay for most of their low-cost, ordinary care. Alternatively, health-plan copayments can be adjusted to be higher when a patient picks a less cost-efficient provider. PacifiCare Health Systems in California recently announced that it would use this approach for its Medicare HMO enrollees. Thus, patients are free to make a choice. If they believe that a provider is better and worth the added cost, they can choose to incur that cost.

Channeling Consumers to Preferred Providers

Financial incentives will be used to direct consumers to use a selected panel of providers. Purchasers and consumers now tend to opt for the largest provider networks possible. This situation has sometimes resulted in choices that make managing cost or quality more difficult. If a consumer picks an institution with a record of relatively poor performance, they have a greater chance of a bad outcome and, as a consequence, ultimately, more expensive care. For some complex operations—such

as transplantation, heart surgery, and some forms of cancer surgery—there is good evidence that the institutions performing the greatest numbers of these procedures produce better results, often at the same or less cost than other institutions. Although purchasers have had some reluctance to choose a health plan that places restrictions on network size, this choice may become more acceptable if costs continue to rise. The Leapfrog Group, a coalition of large organizations purchasing health care, has established network restrictions for complex procedures as one of its criteria for choosing health plans.

Redesigning Reimbursement

The current system for paying providers, even those in HMOs, relies heavily on a venerable model of paying fees for individual services, whether for office visits or procedures. This system severely limits innovation and the ability to deliver services in a different fashion. In the coming years, plans will experiment with:

- *Specialty capitation, case rates, and episode-based payment.* Most practices have paid specialists a fee for service and have relied on primary-care “gatekeepers” and utilization management to control their volume of visits and procedures. As those approaches become less acceptable to consumers, other means of paying specialists that don’t provide incentives for more procedures may be adopted. Some groups have moved to paying specialists a capitation payment based on their providing coverage for a fixed number of patients. More recently an approach is to pay a specialist a single fee for providing care for a patient’s episode of illness, adjusted for severity. For example, a health plan would pay a cardiologist a fixed amount to treat a patient with a cardiac disorder for one year, regardless of whether procedures were needed or not. Either of these approaches relies on an ability to risk-adjust the payment, so that treating a more severely ill patient or panel of patients results in greater compensation. These approaches also require good methods for monitoring quality and outcomes because of the inherent potential for undertreatment.
- *Paying for best practices.* It is anticipated that more institutions will focus on providing highly specialized care, becoming especially adept at

It is anticipated that more institutions will focus on providing highly specialized care . . .

An increasing number of computer-savvy patients want to communicate with their doctors and receive health-care services through the Internet.

particular procedures or at the treatment of specific diseases. Institutions have been created that specialize in cardiac surgery, hernia repair, or oncology. These providers may produce excellent results with fewer complications at a lower cost, both because they do the procedure in treating large numbers of patients and because they have honed their approach to make practice highly predictable. These so-called “focus factories” may be the best place for patients to go if they want highly standardized and predictable outcomes. As consumers and purchasers become more aware of the quality *and* cost advantages of this type of provider, it may become more acceptable to direct patients to these centers and to pay preferential fees to those institutions that demonstrate they provide the best care.

- *Paying for electronic visits.* An increasing number of computer-savvy patients want to communicate with their doctors and receive health-care services through the Internet. Physicians have been reluctant because of concerns about privacy, lack of reimbursement, and potential exposure to malpractice litigation. Considering consumers’ demand for these services, solutions to these problems are likely to be found. At least two health plans have announced plans to reimburse physicians for limited services provided through the Internet. This capacity has the potential both to reduce costs and increase consumer satisfaction.
- *Revising payment for chronic illness care.* Evidence from disease-management programs indicates that monitoring and supporting chronically ill patients at home lead to better outcomes and potential cost savings. The ability to provide this type of care will improve as new technology provides devices such as sensors that can transmit data from remote sites and software that can organize it into meaningful information. These approaches potentially can reduce expensive visits with practitioners and time lost from work for travel. Other than through a special contract, such services currently are not reimbursed, making these approaches unavailable to most patients and physicians while promoting more costly alternatives.

Managed Care Will Advance Disease Management

High-risk patients—patients with a serious, chronic illness who are generally at risk of complications or debilitating infirmity—are the most costly patients to treat, and the patients who benefit most from the comprehensive care that managed care can offer. Designed to treat acute, episodic illness, our standard health-care system does not provide well for patients with a chronic disease. It is not designed to monitor patients, nor can it provide the education, behavior modification programs, and continuity of care that are needed to control chronic conditions.

Chronic disease is increasingly common among our aging population. It is estimated that more than 100 million people in the United States have a chronic illness of some kind. Not all of them are high-risk patients, but many chronic diseases—such as asthma, congestive heart failure, coronary disease, and insulin-dependent diabetes—and some rare diseases—such as hemophilia, multiple sclerosis, and sickle cell anemia—have a somber potential to develop complications that cause progressive deterioration and expensive hospitalizations.

Enter disease management. Motivated primarily by a desire to reduce costs, disease-management programs focus on identifying high-risk patients and then working to implement best-practice protocols, often depending heavily on education for patients and behavioral change programs to encourage patients in better self monitoring and adherence to treatment. In these programs, nurses who are care managers are often the principal points of contact for patients. Based on the relatively sparse evidence available, disease-management programs reduce or eliminate the need for hospitalization and ER visits and reduce the costs associated with chronic conditions.

To date, much of the initiative for disease management has come from the vendors of these services and from health plans. Health plans have tended to initiate programs for patients who pose a financial risk, such as patients in their PPOs or patients in a fee-for-service HMO. Other than a few large, integrated care-delivery systems, providers have not become much involved in disease management, in large part because they have

Disease-management programs reduce or eliminate the need for hospitalization and ER visits and reduce the costs associated with chronic conditions.

lacked the resources, the incentives, the information systems, and the organization to mount such an effort.

As provider organizations consolidate and develop both resources and management capabilities, we forecast that they will compete with health plans to take over disease-management programs. Where they have responsibility for much of the financial risk, they will want to maintain control of the programs implemented for their patients. It is also likely that, during the next five years, there will be greater information available about the disease-management programs that work, those that do not, and the cost-benefit ratio of such an approach to care.

Health-Care Purchasers Will Renew Efforts to Contain Costs

While employer-purchasers will retain their role in buying health care and negotiating premiums and benefits,^{1,2} they will also move more decisively than they did during the late 1990s and the early 2000s to contain growth of their health-care expenditures.

Our experts agree that there will be no dramatic move toward radical forms of defined contribution by 2005. Why not? There are several reasons. Tax laws make it cheaper for employers to buy health insurance than for individuals to buy it. Employers do not know how to implement an equitable voucher system. There is no rational, easy-to-use individual market for health insurance. Risk adjustment and adverse selection pose knotty problems for insurance companies. In a recent survey of public and private employers, very few employers were “very likely” to move to defined contribution during the next five years (see Figure 4–2). Instead, our experts say that purchasers will become information brokers, pushing employees to become more informed and more engaged consumers of health care.

Employer-purchasers will not be willing to pay rising insurance premiums and rapidly rising prescription-drug costs for much longer. They will educate employees and reformulate benefits. Should labor markets ease as the economy softens, purchasers have a portfolio of cost-containing tools at the ready. Those tools include:

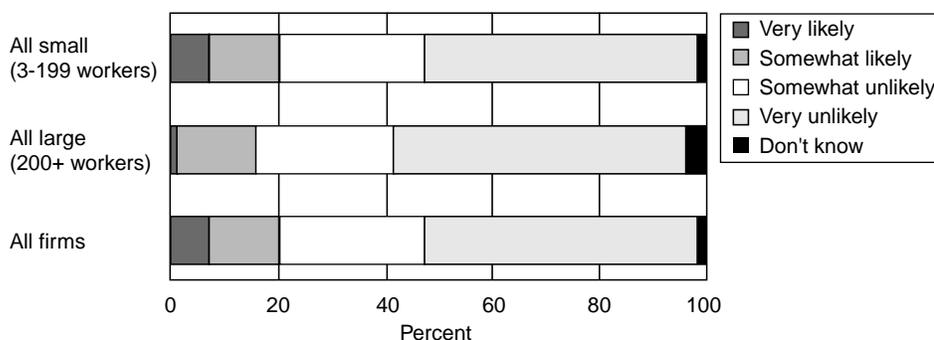
¥ *Shifting costs to employee-consumers.* Employers will reduce premium contributions, reduce benefits, and introduce higher deductibles

or higher consumer copayments for care. This approach reduces employer payments directly, and it also makes consumers seeking care more careful in their choices because they will pay more of the bill.

- *Managing pharmacy expenditures.* Many purchasers will move to three-tiered copays, increase the use of formularies, and educate consumers to use drugs that are less expensive. Some may experiment with new benefits designs, using deductibles rather than copays for prescription drugs.
- *Purchasing value.* For large-scale employers and purchasing coalitions, eliminating plans and providers that are not cost efficient or cost effective can make a big difference in the costs of health care. Purchaser groups, including large automotive companies and the Leapfrog Group, are writing cost-effectiveness requirements into their contracts with plans and providers, and they pay according to performance.
- *Moving to PPOs.* Many believe that PPOs satisfy consumers at a price comparable to that of HMOs. The option of the PPO does not help control costs, but it may help to buy good will from employees and make them more tolerant of footing more of the bill for their health.

With all of these “kinder, gentler” ways of controlling costs, purchasers will provide the options—the consumer and provider will choose.

Figure 4-2.
Employers Are Unlikely to Shift to Defined Contribution.



Source: Kaiser Family Foundation; Health Research and Educational Trust

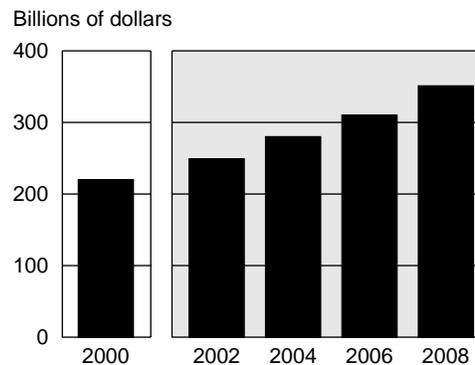
Choices will depend on the ready availability of information about cost and performance. Rather than overtly imposing rules and roadblocks, these cost-control methods will use data to guide consumers' and providers' choices.

Consumers Will Know More and Spend More

Americans are paying more out-of-pocket for health care than ever before. Although the consumer *share* of national health expenditures decreased by almost 30 percent between 1980 and 2000, the absolute dollar amount rose from \$60.3 billion to \$222 billion dollars annually. That trend will continue. The HCFA projects that consumer out-of-pocket spending on all health care will reach \$297 billion per year by the year 2005, an increase of 34 percent over projected expenditures for the year 2000³ (see Figure 4–3).

Although consumers' paying out of pocket for many health-care services does not mark any substantial change from the past 10 years, they will pay even more for routine health-care products and services in years to come. Consumers will contribute more to basic care, including prescription drugs, over-the-counter treatments, basic medical care, mental-health services, dental care, and vision care. They will no doubt pay for complementary and alternative services, such as acupuncture and chiro-

Figure 4–3.
Consumers Will Spend More



Source: Institute for The Future; Health Care Financing Administration, Office of the Actuary.

practic therapy, as well as for expensive alternative therapies. They will also be expected to shoulder a larger share of expenses for elective procedures and for high-cost providers who are not considered cost efficient by their employers and insurers.

As purchasers work to contain costs, consumers will be expected *to know more* as well as pay more. Employers will use information to guide employees to cost-effective plans and providers. Thus consumers will have a growing pool of information to consider about the costs and performance of plans and providers when they make health-care decisions.

We forecast that consumers will become more active and better informed by 2005, as they begin to foot a greater share of the bill for rising health-care costs. But because they will pay, consumers will also have a more robust array of managed-care products, responding to their need for choice, information, and control over their health care. Insurance companies will continue to develop managed-care products that provide consumers—both purchasers and patients—with flexibility and savings over conventional indemnity products.

Despite the expenses they bear, consumers have very little information with which to determine the value or quality of the health care they purchase, relative to its price. The data available by which to assess quality among health-care providers are woefully crude because of the sorry state of information systems in the health-care system at present. There are increasing efforts, however, to collect data useful for consumers. In many instances, this information is available through Internet companies, such as HealthGrades.com and the Florida Association of Christian Counselors and Therapists at FACCT.com, through large-scale employers, or through purchasing coalitions like the Pacific Business Group on Health (PBGH). Independent organizations like *Consumer Reports* are publishing ratings of health plans. Although consumers to date have indicated that these assessments lack the specificity necessary to discriminate between choices, available information is likely to improve gradually. Initially grading most likely will come from consumers' assessments of each provider's performance rather than from rigorous measurement of the technical clinical quality of health care, but as information systems are further deployed, more specific detailed measurement will be possible.

Thus consumers will have a growing pool of information to consider about the costs and performance of plans and providers when they make health-care decisions.

Information Technology Will Guide Care Delivery

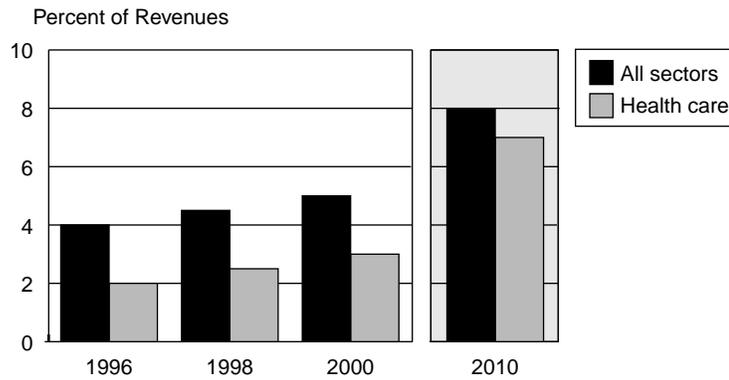
Increasingly, over the next few years, Internet-enabled IT will make data available to plans, purchasers, providers, and patients through an array of devices, ranging from telephones to personal computers to PDAs. This ubiquitous access to medical information will be applied to every aspect of medicine, from patients' records, to pharmacy information, to administrative data, to real-time biological data. It will be used to avoid medication errors and to track the progress of patients who have chronic conditions like diabetes. It has the potential to radically improve medical care, to integrate care across providers and practice settings, and to improve the exchange of information between patients and providers.

We forecast that electronic data interchange will burgeon by 2005. The health-care industry will take substantial strides toward embracing Internet-based IT, creating new clinical and administrative efficiencies that have the potential to contain costs. Plans and providers will seek to realize short-term savings from IT investments by acquiring members and through underwriting and order fulfillment. Other investments, such as computerized physician order-entry (CPOE) systems, have the potential to bring tools for clinical decision making to physicians while they are at the patient's bedside, enabling physicians to prevent costly medical errors and make their clinical practice more cost effective.

HIPAA will drive the industry's initial IT investment, not only because of the requirements for compliance but also because it will catalyze broader use of EDI by the health-care industry. The cost of HIPAA compliance is estimated to range from \$7 billion to \$43 billion, industrywide, over the next four to five years. Considering that new privacy regulations may add \$3.8 billion to the health-care industrywide over the next three years, we forecast that the health-care industry's investment in IT will grow to 5 percent of revenues by 2005 (see Figure 4-4). Managed care will pay its share.

In the short term, investments in IT may drive costs up, but players in the health-care industry who have access to capital and make wise investments—either by purchasing new systems or contracting for information services—will have the information necessary to control costs in the next stage of managed care.

Figure 4-4.
Information Technology Spending Catches Up



Source: Institute for the Future; Price Waterhouse Coopers; Computer Economics.

The Health-Care Delivery System Will Position Itself for Power

We forecast that providers will consolidate to achieve economies of scale, particularly to acquire expensive infrastructural components such as information systems, and to strengthen management. The desire to gain regional market share and bargaining clout in relation to health plans will be the key factor spurring most providers to consolidate.

Provider Consolidation Moves Downstream

Consolidation of providers may take any of several forms:

- *Consolidation of individual physicians and small group practices.* These providers will coalesce into larger, independent groups or hospital foundations—primarily to gain greater collective-bargaining strength and efficiency and to enhance physicians' lifestyles. This form of consolidation has been a general trend nationwide for several decades, and it will continue in regions that have been slow to develop organized physicians' groups.
- *Consolidation of existing group practices and IPAs.* In regions where physicians are already organized into groups, many group practices and IPAs are under serious financial pressure. The pressure of managed-care cost-containment efforts has caused many regional organizations to fail. When the weaker ones close, many of the physicians are absorbed into surviving entities, as was the case after the collapse of Med Partners and FPA Medical Management—both large, national providers' management organizations. The surviving organizations have succeeded financially despite the pressure, and it is likely that they will have greater market share in the future.
- *Hospital closure with consolidation of patients into fewer institutions.* Consolidation can also mean mergers of hospitals to form stronger entities for bargaining power and efficiency of operations. Boston and New York have witnessed the merger of several hospitals to increase their market share and presumably their efficiency. However, mergers do not always meet their goals successfully, as was proved by the merger of the

Stanford University and University of California San Francisco Medical Centers, which dissolved because the merger was poorly implemented and financially disastrous.

The Health-Care Workforce Mix Is Unlikely to Change

Theoretically, substituting personnel who can be paid less should be an effective way for providers to reduce the cost of delivering care. If nurse case managers, physician's assistants, and nurse practitioners were selectively substituted for physicians, costs might be reduced. Many studies show that, in certain domains, nurse practitioners and physician's assistants can provide high-quality care that is at least as satisfying to patients as a doctor's care. Routine primary care, management of stable chronic illness, management of pregnancy and routine labor, and even selected specialty problems can be managed very well by professionals who are not physicians.

Despite the potential that a redeployment of the health-care workforce may have for controlling costs, significant change in this direction is unlikely to occur. Considering that we now train more medical residents than most authorities believe are needed, it is difficult to see how putting allied health care professionals into the mix would not simply add to the workforce rather than substitute for physicians. In the absence of a health-care workforce policy in the United States, there is little hope that planning for a different mix of manpower is likely to occur within the next few years.

Quality Measurement Will Have More Influence on Managing Care

The IOM's report, *To Err is Human*⁴, is only the most recent publication to discuss the frequency with which errors in practice and substandard quality are part of our health-care system. Many believe that, like the industrial sector, the health-care industry can realize significant reductions in cost by improvements in quality that eliminate error and its complications, prevent unnecessary procedures, and ensure that care is provided when it is needed.

Nonetheless, in the health-care industry, a *business case for quality*—with clear evidence that purchasers reward institutions that emphasize

Improving quality relies heavily on agreed-upon standards, an infrastructure of data, staff trained in improving clinical processes, and a culture that supports a commitment to high standards.

quality—has not been made. Few providers have invested resources in improving quality, and those that have might be considered heroic because improved quality has not consistently yielded higher payments or increased market share. The absence of a business case for quality was described well in a monograph recently published by VHA, a nationwide network of community-owned health-care systems and their physicians. It points out the differences between industry in the United States, where quality, strategy, and profitability have been closely linked, and the U.S. health-care system, where quality is a more tactical, sporadic commodity for which institutions are not rewarded.

Is the focus on quality in health care likely to change over the next five years? Improving quality relies heavily on agreed-upon standards, an infrastructure of data, staff trained in improving clinical processes, and a culture that supports a commitment to high standards. Although it is unlikely that the quality of health care will improve quickly, we forecast that several forces will encourage an increasing focus on improvements in quality over the next five years:

- *Greater understanding by the public of the deficits in quality that currently exist in health care.* Reports like the IOM's *To Err Is Human* have alerted consumers and purchasers to the frequency and consequences of errors in medical practice. A recent survey by the Kaiser Family Foundation and the Agency for Healthcare Research and Quality indicates that the public has taken note of information about errors in medicine. Such Internet sites as HealthGrades.com, the PBGH sites, PBGH.org, and healthscope.org, and FACCT.com have all provided information that, although limited at present, will become more robust over time.
- *Development of data regarding quality for PPOs and medical groups.* NCQA and others in the business of evaluating health-care performance are working to develop quality-measurement tools for PPOs. Many are attempting to field tools that will assess performance of medical groups. RAND Corporation is developing "Quality Assessment Tools" that can be used by medical groups and anticipates that they will be available by 2002. Both PPOs and medical groups will be the subjects of quality measurement by 2005, and the results of these measurements will become increasingly available to consumers.

- *Deployment of clinical information systems.* Although the proliferation of tools to foster improved quality of performance is likely to be gradual, they will become increasingly available to practitioners as information systems are installed. Such tools as CPOE systems accessible by hand-held devices, electronic medical records, and clinical databases that physicians can access when making decisions about a patient's care will make quality management more effective and consistent.
- *Studies building a business case for quality.* It seems highly likely that a business case for quality can be built, particularly if the focus is on preventing errors and their complications—the added work needed to remedy the sequelae of medical errors and the loss of an employee's productivity due to inadequately treated illness. The case for high quality has been made in virtually every other industry.
- *Pressure from purchasers of care.* Large-scale purchasers of health care and business coalitions, such as the Leapfrog Group and the PBGH, have experienced the requirements for optimum quality in their own industries, and they are beginning to experiment with “value-based” and “quality-based” purchasing of health care. Again, there are often insufficient data to provide a compelling basis for rewarding one provider over another, but as data begin to accrue, purchasers may be willing to invest meaningful dollars into purchasing quality. Existing monetary rewards for providing high-quality care are minimal, if present at all. A few purchasers hold 1 to 2 percent of premium dollars in reserve and award it based on high-quality performance on specific measures. In general, that percentage is too small to make much difference and little, if any, of the money reaches the provider groups that determine the quality of performance. Increasing the dollars at risk and offering mechanisms for the dollars to reach physicians and hospitals could be important to achieving improvement in managing care. Purchasing coalitions, including the Leapfrog Group and PBGH, have begun to take this approach, but to date most purchasers are not yet convinced that incentives for high quality will produce better results or lower costs.

It is likely that improvements in quality will not have a major impact on cost over the next five years because so many factors have to be in

It seems highly likely that a business case for quality can be built, particularly if the focus is on preventing errors and their complications...

place to make high quality an effective driver. However, we forecast that measurement and management of performance quality will become more prominent as a force driving the shape of managed care.

Will A Kinder and Gentler Managed Care Evolve?

Will these changes in coordinating care and managing costs actually occur? It is difficult to know which of them will gain prominence. It is possible that managed care will simply continue on the track that exists at present, with gatekeepers, heavy-handed utilization management, squeezing reimbursement, and fiercely negotiated capitation. However, the existing degree of dissatisfaction with the current system makes it likely that managed care will modify these “brute force” approaches, relying on information systems and incentives for consumers and providers, and perhaps placing an even greater emphasis on the *cost effectiveness* of health care during the coming years. We forecast that information-driven techniques for coordinating care and controlling costs will begin to dominate managed care by 2005.

Managing Care Delivery: Barriers and Wild Cards

Barriers

What stands in the way of the managed-care industry’s adopting information-driven techniques for controlling costs while coordinating care? Consumers’ demands for choice and control of their health care, providers’ resistance to scrutiny and loss of autonomy, money, the economy, regulation, and technology themselves pose formidable barriers that will hamper managed care’s attempts to lay the groundwork for its own reinvention.

Consumers’ Demands

- Consumers’ fears that they may lose control over their health information due to breeches of privacy and failures in data-security systems may slow the adoption of electronic data-interchange systems.

- Consumers' preference for choice may thwart attempts to channel them to cost-effective providers and plans, thereby limiting purchasers' efforts to use data to control costs and health plans' efforts to guide clinical care.

Providers' Resistance to Scrutiny

- Providers' resistance to scrutiny and their lack of faith in traditional measures of health-care performance, like HEDIS, may prompt them to resist increased pressure from purchasers and plans to provide performance data.
- Providers, being independent and notoriously resistant to change, might balk at consolidation and fail to amass the market share and command of costs and high-quality data necessary to help them negotiate with health plans for favorable payment rates. They may also fail to capitalize on the savings potential of substituting nurses for physicians or allied health-care workers for registered nurses.

Money and the Economy

- The capital demands of investing in information systems may be significant. As money markets have shied away from health care, managed-care organizations and providers alike may find it hard to make the investments in IT required to collect and analyze data and to drive cost containment.
- A softening economy may distract large-scale purchasers and purchasing coalitions from their focus on purchasing high value in health care.
- A tight labor market could make health benefits a key part of an overall benefits package. If such a labor market persists, it would be harder for employers to pass costs on to consumers by using information-driven incentives.

Regulation

- Ironically, privacy regulations may inhibit the use of Internet-enabled systems to manage care across practice settings. Privacy restrictions could inhibit the flow of information among providers and plans.
- The delay in enacting federal privacy regulations could cause a consumer backlash against HIPAA-induced increases in electronic data exchange and slow the use of Internet-based systems to track and control costs of clinical practice.
- Facing a high bill, the health-care industry may lobby effectively to slow the pace of HIPAA implementation and growth in IT spending could slow.
- State and federal regulations could respond to dissatisfaction among consumers and providers with managed care's restrictions on access and services. Legislation—for example, a regulation that would exempt providers from antitrust laws, would make law suits against plans easier, or would require “any willing provider” to be included in a managed care network—would thwart information-driven approaches to controlling costs and add new costs, potentially at a time when purchasers are attempting to bring inflation of health-care costs back under control.

Technology

- Information systems, particularly at the provider-group level, may fall short of what is needed to support sound quality measurement and, perhaps more important, improved clinical decision making. The resulting dearth of timely and useful information about quality of performance—particularly for PPOs and provider groups—and the absence of evidence of cost savings for purchasers may thwart the use of value purchasing as a data-driven, cost-control tool.

Wild Cards

Wild cards are events that have less than a 10 percent likelihood of occurring, but should they occur they would have a significant impact. Which wild cards could derail this forecast for information-driven cost control in managed care?

- The quality movement takes off. Sparked by the actions of the IOM and large-scale purchaser coalitions, an intense focus is placed on improving quality and using health-care quality data as major criteria for purchasing care.
- Purchasers, plans, and providers begin to quantify meaningful savings attributable to improvements in quality. Thus, the business case for quality is unassailable and value purchasing, plus providers' emphasis on quality improvement, become standard health-care business practices.
- Universal health coverage is enacted that excises the costs of avoidable morbidity, redundant technology, and unnecessary prescriptions and procedures. It also mandates implementation of Internet-based approaches, such as electronic medical records, CPOE, and tools to support physicians' decision making. These changes promote best clinical practices. Purchasers are off the hook. The pace at which managed care adopts information-driven cost management picks up dramatically.
- A federal Patients' Bill of Rights passes without protections for self-insured purchasers, causing a large-scale move to defined contribution, in which consumers have a voucher to purchase coverage directly. Thus, the pressure that purchasers put on plans and providers to join the information age is eliminated.
- Concerns about data security force the government to reconsider requiring HIPAA compliance until systems are secure. The delay in HIPAA implementation sets managed care back in its implementation of information technologies.
- Physicians become sufficiently frustrated about managed care and their level of reimbursement that they yield to unionization and collective bargaining, thereby inhibiting the use of information-driven techniques to hold down the costs of care delivery.

An intense focus is placed on improving quality and using health-care quality data as major criteria for purchasing care.

Endnotes

¹ Watson Wyatt Worldwide, *Putting Employees in Charge: A Survey of Employers, Health Care Providers, and Health Plans*. Catalog # W-332; 2000, Bethesda, MD.

² Hewitt Associates. *Employers to Face Double Digit Health Care Cost Increases for Third Consecutive Year*. (October) 2000.

³ HCFA Table 5a: *Personal Health Care Expenditures and Average Annual Percent Change, by Source of Funds: Selected Calendar Years 1970–2008*. Health Care Financing Administration, Office of the Actuary (November) 1998.

⁴ Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System*. Committee on Quality of Health Care in America. Washington, D.C.: Institute of Medicine. National Academy Press 2000.

Chapter 5

MANAGED CARE 2010: PATTERNS OF POWER



Managed care will be in transition during the next five years. We can conceive of three patterns of market power that could emerge by the year 2010:

- Big Insurance Dominates
- Government Leads
- Consumers Meet E-Health-Care Markets

These *power plays* differ from traditional IFTF scenarios because they may coexist. They share a core group of drivers, and each focuses on a particular dominant player in the health-care market rather than on the effects of the two most potent and volatile drivers.

The *power plays* are set in a landscape of these driving market forces: increasing cost, rapid advancement in information technologies, and consumers' continued demand for choice, control of their own care, and information. Yet each power play arises from a different precipitating factor: for *Big Insurance Dominates*, it is the emergence of an oligopoly among plans; for *Government Leads*, it is a downturn in the economy that threatens employer-based health insurance in the commercial market; and for *Consumers Meet E-Health-Care Markets*, it is a dramatic shift of costs and the responsibility for health-care decision making to consumers that forces consumers to the fore.

We conceived these *power plays* as examples of how the relative power of health-care stakeholders could shift to create new market dynamics 10 years from today. They are meant to provide insights about potential market shifts that warrant strategy and forethought.

Health plans that reduce hassles for consumers, possess information systems that track costs, and collect and publish provider performance information will lead the industry.

Big Insurance Dominates

By 2010, consolidation has created a market dominated by a handful of large health plans. Providers are dependent on these plans and focus on delivering care within the frameworks set by the plans. Health plans that reduce hassles for consumers, possess information systems that track costs, and collect and publish provider performance information will lead the industry. The IT infrastructure is critical. Customer service is Internet-driven, providing easy and rapid access to information and services. Plans are responsive to consumers' needs, offering a variety of insurance products. Since the large-scale consolidation of health plans included the acquisition of e-health-care companies, only a few of those companies remain independent.

Coverage

Between 2000 and 2010, smaller, regional plans faced increasingly uncertain market conditions and were driven to merge with larger plans in order to gain market share and capital. The resulting megaplans faced pressure to control costs while simultaneously responding to consumers' and purchasers' demand for quality and accountability. The megaplans responded by investing in information technologies that promised savings through improved care delivery, more efficient administrative functions, and effective dissemination of clinical and administrative information. By 2010, benefit packages have been redesigned to allow more options, but more costs are being shifted to the consumer. Many large health plans have abandoned HMO products entirely, choosing to emphasize PPO-style products.

Providers

By 2010, most physicians are practicing in groups, and the slow attrition among hospitals has leveled off. The providers that function best in this market are those that maintain a robust IT infrastructure that helps them demonstrate high performance in delivering care *and* controlling costs. Legislation has been enacted to ensure that clinical decision making remains in the providers' domain, but widely available performance information means that clinicians are more accountable for their decisions than ever. Most medical groups do not bear financial risk, and so plans

control *their* costs by using IT systems to deliver information on the quality and cost of care to providers, consumers, and purchasers, and by contracting with providers based on performance. Providers are under unprecedented scrutiny.

Technology

Market failures and acquisitions by health plans have forced a shakeout in the e-health-care market. New companies continue to emerge but find themselves in a turbulent marketplace. Those that do survive succeed through mergers or cooperative relationships with plans or providers. Those that maintain independence are most likely to exist in the business-to-business market, targeting back-office functions, high-quality consumer interfaces, disease management, or purchaser needs. Plans use the Internet to help reduce administrative costs, respond to consumers' demands, and improve clinical care.

Medical technology continues to advance in 2010. Health plans fully cover those technologies that promise savings, such as vaccinations and minimally invasive surgeries. Lifestyle procedures (such as cosmetic surgery) and pharmaceuticals are marketed to consumers who can afford them as an out-of-pocket expense.

Purchasers

Government and large employers are still the dominant purchasers of health care. The most progressive purchaser-employers have attempted to control their health-care costs by aggressively directing employees to those plans that offer a high-quality product at a reasonable price. To support this approach, purchasers have taken on the role of information broker, passing detailed information about health-care costs and performance on to their employees. Employers have made it clear how much they are willing to pay for health benefits, and employees are footing the bill for any additional health-care services they require.

Consumers

New Consumers—now the majority of health-care consumers—continue to demand choice, control over their care, and information from their health plans. The Internet and efforts by purchasers now arm them with

information about treatments, coverage options, and providers' performance. Health plans allow for a wide array of choices among providers and benefits packages, but consumers have little choice among insurers.

Regulation

A lax antitrust environment has allowed health-plan mergers and acquisitions to proceed unhampered. The insurance lobby has successfully advanced its agendas at the state and local levels, resisting efforts to regulate benefits or cost-control methods. Medicare managed care has become a competitive program, allowing many commercial plans to compete for beneficiaries. Medicaid managed care thrives in this insurance-dominated market.

Drivers

- Plans and providers consolidate to gain market share and capital
- Big insurance makes substantial investments in IT
- E-health-care companies play a subordinate role as they meet with financial failure or acquisition by health plans in the e-health market
- Lax antitrust regulation allows health-plan mergers

Barriers

- Data standards that would facilitate the free flow of information among plans and providers fail to evolve
- Consumers protect their health information, and privacy regulations constrain the flow of information within the health-care system
- The science of performance measurement in health care fails to provide useful, understandable information about providers
- Purchasers, dissatisfied with the price of plans and their services, work around them and negotiate directly with providers
- Providers cannot deliver the data needed to drive care management, pricing, and accountability

Government Leads

An economic downturn in 2004 triggers a market failure that leads people to lose their health insurance or to drop it. A reduction in employer-based health insurance increases the ranks of the uninsured. The e-health-care market fails as a vehicle by which consumers can purchase insurance. Consequently, consumers struggle unsuccessfully in the marketplace for individual insurance. Health-care costs and premiums rise in the face of an aging population, advances in medical technology, and soaring pharmaceutical costs. The public decries differential access to health care. Medical technology costs spin out of control, creating an incentive to use technology assessment. These forces push the government to step in. Legislation is signed that expands the Federal Employees Health Benefits Plan (FEHBP) to include private purchasers and purchasing coalitions.

Coverage

Health insurance is offered through a large purchasing-pool program, which is designed as an expansion of the FEHBP. Competition still exists, but in a regulated marketplace that the federal government dominates. Commercial health plans bid for inclusion in this program, which covers most people in the United States. The federal government sets a floor for benefits that plans may not go beneath when offering their bids. The government determines a fixed-dollar amount for each person participating in the program, and commercial purchasers follow their lead. This predetermined contribution is derived from a weighted average of all the participating plans' premiums.

There are a variety of plans to choose from, with varying benefit packages, but a direct cost is passed on to the consumer who wants a plan with richer benefits. People who choose the most basic package pay little out of pocket for their health care. This basic package is adequate and tightly managed. Those who want richer benefits pay more out of pocket for "cadillac" plans, many of which include coverage for lifestyle drugs and elective surgery.

The government mandates that prescription drugs be covered by all plans participating in the program. Pharmaceutical companies also bid for contracts with the government so that a basic, highly generic, national

Health-care costs and premiums rise in the face of an aging population, advances in medical technology, and soaring pharmaceutical costs.

Clinical and administrative information technologies are standardized and widespread.

formulary can be included in the basic plan. Beyond the basic plan, drug companies operate in the private market, where they enter into contractual arrangements with plans that include their products in a formulary.

Providers

Providers participate through networks with plans and with the government. Providers' organizations compete with plans in bids to participate in the government program. They must meet solvency and other fiduciary requirements to qualify to participate. Large health plans still dominate, however, and only a few well-organized providers' groups that have learned to manage risk effectively can compete in the federal program. Primary-care providers become population health managers and operate their own registries of patients. Hospitals either partner with large plans or compete directly to participate in the federal program. Professional nurses and pharmacists substitute for physicians, and they thrive. Chronic diseases are cared for under a disease-management protocol. Government-funded demonstration projects that link reimbursement to clinical performance and quality assurance are commonplace. As the transcendent purchaser, the government sets the standards for clinical quality and cost by which all providers participate.

Technology

Clinical and administrative information technologies are standardized and widespread. The government sets data-sharing standards and mandates the use of clinical and administrative technology systems by plans and providers. The government reimburses for Internet-based care delivery. There is a national data system with standardized technological terms for use in clinical and payment functions. Scientifically proven medical technologies are used to reduce the number of inpatient clinical interventions. Care and monitoring with sensors and other types of remote clinical practice are reimbursed. Technology assessment is used to ration technologies, but there is no preferential treatment in their distribution. There is still a private market for technologies that the government does not cover and that wealthy consumers pay for out of pocket.

Consumers

Consumers use the Internet to review plans that are offered under the FEHBP-style program. The government mandates that insurers participating in the program offer their plan descriptions on the Internet. A separate government Web site contains the menu of participating plans, their prices, and the benefits they offer, to permit consumers to compare plans when enrolling. There is an annual enrollment period during which consumers can change plans. Health-care brokers enjoy a thriving trade, serving health-care consumers. Brokers upload performance data on physicians and plans on the Internet, and they evaluate and generate comparisons among participating plans and provider organizations. These brokers are trusted intermediaries with no ties to the health-care industry.

Regulation

The regulatory environment in this model is quite strong, although it has not stifled competition. The bottom line rests with the government, but it fosters competition through a bidding system—not through direct price controls. The government contracts with pharmaceutical management firms for the purchase of drugs under the basic plan. Beyond that, pharmaceutical companies operate in the commercial market. States experiment with government dollars to create new models of care for their Medicaid and SCHIP populations. States are free to do so, as long as the coverage is as comprehensive as that of the basic package offered by the federal government.

Drivers

- An economic downturn triggers a failure in the employer-paid insurance market, increasing the number of people who are uninsured
- Health-care costs escalate out of control (19 percent of GDP) due to advancements in technology and an aging population
- The e-health-care market fails as a vehicle by which consumers can buy insurance
- As medical technology costs spin out of control, the public decries differential access to treatments

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Barriers

- The health-care industry lobby opposes governmental regulation
- The pervasive perception among the public is that government cannot provide high-quality health care because of bureaucracy and lack of expertise
- Advocates insist that this version of government protection is not adequate because the system is still inequitable as long as consumers with higher incomes can purchase high-end plans
- Innovation is stunted by government regulation
- Providers oppose oversight of their activities by the government
- Negotiating power between purchasers and providers is restricted

Consumers Meet E-Markets

In a continuing effort to control their costs, the purchasers of health care—largely employers—shift an increasing share of the health-care bill to consumers. At the same time, employers invest in educational programs to enable employees to become more aware of the cost and quality of the health care they choose. Consumers pay for a larger percentage of their insurance premiums than they did just five years ago, but they are being offered a growing menu of health-care goods and services. As a result, consumers are in the driver's seat in health-care decision-making. New Consumers relish taking on this role, as they have taken on the self-determining role in other aspects of their lives, from personal finance and investments to shopping.

Capitalizing on this changing role of the health-care consumer, e-health-care companies emerge to provide the tools consumers need to make health-care decisions. E-health data include the cost and performance of providers, personalized health plans, personal health records, financial transaction tools for purchasing care, and treatment information. Online brokers and health agents assist consumers in selecting care. Privacy regulations that give consumers knowledge about who sees their medical information, and control over access to it, make consumers more

confident about the safety of personal health information. By 2010, a consumer-centered, commercial e-health-care market thrives.

Coverage

Purchasers offer their employees a fixed dollar amount for basic health coverage and an array of benefits packages from which to choose. Employees ante up for any health-care expenses that exceed the purchaser's fixed contribution. Actuarial risk is determined on the basis of the employee group's health status; not on the individual employee's health. Purchasers facilitate tax savings for employees' out-of-pocket health expenses through cafeteria plans. Consumers pay a bigger share of their premiums and nearly 40 percent of the costs for drugs. They also pay for elective procedures, such as cosmetic and laser surgery, and for some alternative therapies, such as acupuncture. As consumer demand grows, market niches arise to meet a wide variety of consumers' needs, including bargain-basement health-care coverage, comprehensive plans, disease-management plans, alternative-medicine plans, and integrative-medicine plans that combine the best of allopathic medicine with the best of alternative medicine. Even though the monetary value of employer-purchaser-paid coverage is limited, the array of services has expanded—driven by consumers' demands, not by employers' fiat.

Providers

The Internet is the providers' friend...and foe. The Internet enables providers to participate in "virtual" health groups. Traditional medical groups, hospitals, and lone practitioners participate in online groups. For some of them, this means expanded and direct access to large groups of consumers for the first time. Traditional health plans also offer their provider networks through the Internet. However, there is a price for increased contact with consumers—an unprecedented amount of information on the cost and quality of providers is available to consumers. While this scrutiny creates a push for better quality in some sectors, it also creates pressures from the low end of the market to lower the price of health care. Providers market themselves to consumers and purchasers alike based on price, degree of quality, or both. Alternative health-

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care providers also play an important role in this market. In some regions, such as the western United States, a slight shift of dollars from allopathic to alternative providers occurs.

Consumers

Many consumers enjoy more power in their relationship with providers because information about treatments and about the provider's cost and performance is readily accessible to guide their choices. New Consumers thrive as the masters of their own health care. Because of regulations on privacy, consumers are comfortable using the Internet to transmit and receive personal health information, and many are willing to trade a bit of privacy for more complete care and convenience. They maintain their personal health records, choose their providers and benefits packages, get tax breaks for the care they pay for, and can readily track claims and the status of their benefits allowances. Consumers vote with their dollars and the market responds with goods and services that make consumer-centered health-care management relatively easy and even pleasant. Health-care agents thrive, much as personal shoppers did in the 1990s.

Not all consumers have the wherewithal to successfully manage their health care in this market, however. Traditional consumers, the poor, and people who reside on the wrong side of the "digital divide" may flounder. While Medicare and Medicaid beneficiaries' benefits are secure, lower-income workers experience real losses in coverage. Thus the consumer-centered world of e-health care mirrors the health-care environment in the late 20th century—there are many tiers of access to health care.

Purchasers

The employer-purchaser is still a major source of health-insurance funding, paying for a basic benefits package. Purchasers drive the market to be responsible and ensure that the information available to consumers is complete and accurate. Coalitions of purchasers and virtual groups of small employers convene in risk pools to negotiate rates with plans. More and more often, purchasers work directly with e-health-care companies that administer their health-care benefits. These e-businesses assume the burden of benefits management for the purchasers they serve, providing value to both employers and their employees.

Technology

Advances in IT facilitate the free and safe flow of information needed to lubricate the e-health-care market. Features ensuring the security of data make consumers and providers more confident about the safety of information about their health. Standardized data-exchange protocols introduced in the late 20th century have simplified data sharing and make it easy for both physicians and patients to understand and organize health data. Wireless technologies are widely available and affordable, and they permit users to track a vast range of health-care information, from their expenses and claims to their blood sugar and blood pressure levels. Health care can be provided through the Internet; by using wireless technology, the chronically ill and, now, “cyberchondriacs” can track their health status at any time from any place.

There is a brisk market in health-care products to choose from for consumers who can afford them. Providers advertise medical goods and services directly to consumers, much as drug companies advertised antidepressants in the late 20th century. Lifestyle and cosmetic procedures boom among affluent consumers, as they go online to find the best price for laser eye surgery and tummy tucks. Physicians performing minimally invasive surgeries may also find themselves in competition, as the Internet marketplace makes information about price and outcomes available in two clicks of a mouse. The media, through editorials and advertising, tout advances in technology-driven treatments such as laser surgery, and consumers’ demand for these services grows, adding force to the upward pressure medical technology exerts on overall health-care costs.

Regulation

Regulations are in place to enforce privacy and protect security, but regulatory mechanisms are slow to adapt to the evolution occurring in the e-health-care marketplace. New and more forms of data are transferred to an increasing list of providers and across state lines. Providers, plans, and consumers, themselves, push hard to make regulations accommodate their increasing need for flexible health-care services. As a result, state licensure requirements are loosened to provide physicians with reciprocal licensure. States experiment with regulating telemedicine. An

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Providers, plans, and consumers, themselves, push hard to make regulations accommodate their increasing need for flexible health-care services.

attempt is made to regulate and assess technology for the benefit of consumers, and the government develops new fast-track systems to keep up with the fast-paced free market.

Drivers

- Costs rise relentlessly and employers suffer from “benefits fatigue”
- E-health-care companies support consumers’ health-care decision making with products such as personal health records, medical savings accounts, peer-reviewed treatment information, performance data on providers and plans, e-brokerage services, and e-health plans
- Privacy regulations are implemented that make consumers more comfortable in using the Internet as a vehicle for conveying personal health information
- New Consumers act on their need for information, choice, and control of their care, and they increasingly use the Internet to manage their own health care

Barriers

- Consumers are reluctant to sit in the driver’s seat when it comes to managing their own health care and are slow to fully use cafeteria plans to augment their dwindling health-care coverage
- E-health-care companies fail to design sustainable business models and die out as quickly as they emerge, reducing consumers’ confidence in the direct health-care market
- High-profile incidents involving violations of the privacy and security of health information make consumers wary of the Internet
- Providers are slow to make the necessary adjustments to capitalize on the Internet and to integrate IT into their practice
- Powerful health-care providers and plans successfully lobby against the publication of data about their performance and cost, and consumers’ ability to make decisions is hampered by lack of information—slowing the transition to a consumer-centered market in health care

- Changes to ERISA and employer tax laws are incremental and constrain employers' moves to free themselves of the burden of health-care benefits

GLOSSARY—MANAGED CARE

Alternative health-care provider—A provider of unconventional therapy or therapies, such as massage, biofeedback, herbal medicine, or acupuncture.

Application service provider (ASP)—An outsource for implementing and managing information technology and its infrastructure. ASPs rent application software to many organizations but host the applications at a single center. Applications are delivered over networks on a subscription basis.

Capitation—A flat periodic payment to a physician or health system for each person covered under a specific health plan. The provider assumes the risk of covering the cost of care for each patient within the payment amount.

Carve-out—The practice through which insurers avoid adverse selection by providing group coverage to healthy people while allowing people with special needs to purchase more expensive, high-risk pool coverage. The process of excluding specific services from the general capitated rate and providing those services on a fee-for-service basis.

Case rates—Fixed payments to providers based on an assumed average cost for treatment of a particular illness.

Closed panels—Groups of physicians and other providers belonging to a specially formed, legally separate group servicing only the enrollees of an HMO.

Community health center (CHC)—An ambulatory-care center (defined under section 330 of the Public Health Service Act) serving a catchment area with scarce services or a population with special care needs. The CHC attempts to coordinate federal, state, and local resources to provide health and social services to a defined population.

Consolidation Omnibus Budget Reconciliation Act (COBRA)—Federal law enacted in 1985 requiring that employers of 20 or more workers must continue former employees' health-insurance coverage at the employee's expense for up to three years for qualified beneficiaries, including dependents.

Copayment—A method of cost sharing that sets a fixed amount of money to be paid by a health-plan enrollee at the time of service, while the health plan pays the remainder of the charge directly to the provider.

Deductible—The amount of money an insured person must pay before the insurer will cover the remainder of the costs.

Defined contribution plan—A health plan in which the contribution by the employer is fixed, and the employee pays for any additional cost of services or coverage desired.

Disease management—An integrated, systematic approach to delivering care to populations of patients who have specific chronic diseases.

Electronic data interchange (EDI)—The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include the submission of claims and payment, assurance of eligibility, and authorization of referrals.

Employee Retirement Income Security Act (ERISA)—Federal law adopted in 1974 in response to fraud and mismanagement of employees' pension funds and benefit plans. ERISA preempts state regulation of health plans offered by self-insured employers and offers remedies for improper denial of health benefits.

Federal Employees Health Benefits Program (FEHBP)—A voluntary group-health-insurance program for federal employees, retirees, and dependents that allows members to choose from among many different provider plans nationwide. The Office of Personnel Management administers the program.

Fee for service (FFS)—The traditional method of payment for health care, in which a fee is charged for each service performed by a health-care provider.

Formulary—A list of all prescription drugs covered by a particular health plan.

Freedom of Choice Waiver (1915)—A waiver excusing states from the requirement to offer Medicaid beneficiaries a choice of health care coverage, which is usually mandatory for states wishing to cover Medicaid recipients through managed care.

Gag clause—A provision of a contract between a managed-care organization and a health-care provider that restricts the amount of information a provider may share with a beneficiary or that limits the circumstances under which a provider may recommend a specific treatment option.

Gatekeeping—The practice of a person (usually a primary-care physician) who coordinates and determines the care services provided to a patient. This person usually provides the first level of care before possibly referring the patient to a secondary-care physician or specialist. This practice is commonly used by managed-care plans to eliminate the costs of unnecessary care.

Health Insurance Portability and Accountability Act (HIPAA) of 1996—This law was enacted as part of a broad Congressional attempt at incremental health-care reform. The “administrative simplification” aspect requires the U.S. Department of Health and Human Services (DHHS) to develop standards and requirements for maintenance and transmission of health information that identifies individual patients. These standards are designed to: (1) improve the efficiency and effectiveness of the health-care system by standardizing the interchange of electronic data for specified administrative and financial transactions; and (2) protect the security and confidentiality of electronic information regarding patients’ health. This initiative also protects health-insurance coverage for workers and their families when they change or lose their jobs. The

primary intent of HIPAA is to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs.

Health Maintenance Organization (HMO)—An organization that ordinarily provides health care to members through a closed group of physicians, often in conjunction with its own hospital or allocated beds in other hospitals. Patients covered by this plan ordinarily receive all medical care and health services through the HMO for a predetermined fixed fee.

Health Employer Data and Information Set (HEDIS)—A set of standardized measures of managed health care plans that includes data about quality of care, members' access to care, patient satisfaction, utilization and membership services, and financing. HEDIS is sponsored, supported and maintained by NCQA (the National Committee for Quality Assurance).

Indemnity benefits—Insurance benefits that provide cash to beneficiaries rather than services. Payment for services may go directly to the provider in the form of fees or to the beneficiary in reimbursements.

Independent Practice Association (IPA)—A provider organization in which physicians maintain their own practices but agree to furnish services to patients who have signed up for a prepayment plan in which the physician's services are supplied by the IPA.

Inpatient care—Care to patients lodged within a health-care facility, such as a hospital.

Medical savings account (MSA)—A mechanism to help a person provide funds for health care by forming a savings account under regulations and tax treatment similar to an IRA. Cash in the account is available to pay for deductibles, copayments, and services not covered by the person's health plan.

Outpatient care—Any care that takes place without lodging the patient in a health facility.

Preferred Provider Organization (PPO)—An alternative health-care delivery system involving a contract between health-care providers and purchasers, such as employers or other third party administrators, under which the PPO agrees to provide health and medical services to a defined population for predetermined fixed fees.

Premium—Payment required to enroll in an insurance plan for a specified period of time.

Primary-Care Case Management (PCCM)—The use of a primary-care physician to manage patients' medical or surgical care. PCCM programs usually pay for all care on a fee-for-service basis.

Purchasing coalition—Public or private organizations that secure health-insurance coverage for the employees of all member employers. The goal of these organizations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans, and providers in order to reduce the administrative costs of buying, selling, and managing insurance policies.

Risk sharing—The division of financial risk among organizations that furnish a service, in which all parties are liable if expenses exceed revenue.

Research and Demonstration Waiver (1115) —A waiver allowing states to waive certain laws related to Medicaid for the purpose of conducting pilot, experimental, or demonstration projects that are “likely to promote the objectives” of the Medicaid program. Through this waiver, states can change provisions of their Medicaid programs, including: eligibility requirements; the scope of services available; the freedom to choose a provider; a provider's choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program.

Safety net—Term referring to any of the network of health departments, public hospitals, clinics, and community health centers that provide care to low-income, uninsured populations.

State Children’s Health Insurance Program (SCHIP)—Established by the Balanced Budget Act of 1997, this program enables states to initiate and expand child-health assistance to uninsured, low-income children. Assistance is provided primarily through either or both of two methods: (1) a program to obtain health-insurance coverage that meets regulations related to the amount, duration, and scope of benefits; or (2) expanding eligibility for children under the state’s Medicaid program. This program is a capped entitlement for states.

Self-insured employers—A payer manages an employer’s funds instead of requiring the employer to pay premiums. The arrangement exempts employers from many insurance laws and permits them full access to information about insurance claims, but it also requires employers to assume risk.

Specialist—A health-care provider whose training and practice is in a particular discipline of medicine; for example, a neurologist.

Subspecialist—A health-care provider whose training and practice is in a particular, focused area of a broader specialty discipline; for example, a pediatric neurologist.

Technology assessment—The evaluation of the costs and the benefits of technologies. In health care, it is used to assess technologies for diagnosing and treating medical conditions, surgical procedures, and drugs.

Utilization review—The examination and evaluation of the efficiency and appropriateness of any health-care service.