The Who, What, and How of Managed Care

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Journal of Health Politics, Policy and Law, Volume 24, Number 5, October 1999, pp. 1045-1049 (Article)

Published by Duke University Press

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Since the early 1970s, policy makers and researchers alike have been eagerly watching and evaluating the growth of so-called managed care plans. Many expected prepaid group practice plans (PGPs), then individual practice associations (IPAs), then preferred provider organizations (PPOs), and a host of other insurance arrangements under the managed care label, to result in a more efficient allocation of resources. Others predicted that these changes from the traditional indemnity insurance plans would lead to the denial of needed care and a reduction in the freedom of choice, both for providers and patients. It is a major problem to determine whether either change has taken place because most policy makers and researchers have been less than clear about who or what these plans are supposedly managing, much less how they are managing it. What is this phenomenon called managed care that has elicited so much hope and fear?

The confusion exists in part because researchers have used managed care as "the shorthand label for a wide variety of health plans" (Prologue 1999) with "little consensus regarding labels and few accepted criteria for categorization" (Weiner and de Lissovoy 1993: 75). Some might argue that the label is unimportant. However, without knowing what the term *managed care* is encompassing, how do we know what it is that physicians are presumably revolting against? (see, e.g., Rosenberg 1998; and Ginsburg 1997). Is it "the entire range of utilization control tools that are applied to manage the practices of physicians and others, regardless of the setting in which they practice?" (Weiner and de Lissovoy 1993:

Journal of Health Politics, Policy and Law, Vol. 24, No. 5, October 1999.

97). What is causing a consumer backlash? (see, e.g., Front Attacks 1997; Enthoven and Singer 1998; and Blendon et al. 1998). Is it some particular set of plans that directly restrict consumer choice? Alain Enthoven and Sara Singer (1998) found different levels of consumer satisfaction according to whether patients were covered by an IPA/network, Group/staff, or PPO plan. And from what are policy makers trying to protect consumers? (see, e.g., Shapiro 1998). Is it inappropriate physician behavior arising only in plans in which physicians directly benefit financially from use or nonuse of particular services?

Without a clear understanding of what is at the heart of the discontent on all sides and what changes in the system are the cause, researchers and policy makers are not in a position to recommend meaningful, effective remedies. In addition, it may be that the factors that are causing much of the discontent of providers and consumers are the very same factors that are yielding the positive effects highlighted by many researchers, namely a reduction in utilization and cost containment (Zwanziger and Melnick 1996; Enthoven and Singer 1998). Reductions in health care spending will lead to reductions in provider income; reductions in provider and consumer choice translate into increased control over their behavior for the plans.

Unfortunately, the health services research literature provides little guidance in making the link between what managed care is, the effects of managed care, and the backlash. In order to assess the impact of managed care, we need to know what common characteristic binds these plans if we are to formulate meaningful analytical models and generate testable hypotheses about the effects of these plans on utilization, costs, or satisfaction. In fact, we need to know these common characteristics even to select which plans to include in any study sample. In reality, most researchers, even if they identified the attributes they wanted to study and developed the appropriate models, are limited by data availability.

A search of 1998 citations (using HealthSTAR) yielded 624 articles with the term *managed care* in the title. While only 64 titles in 1998 contained the term *HMO* (or the words *health maintenance organization*) in the title, a substantial number of the 624 articles with managed care in the title are, in fact, analyzing only HMOs. Many articles on managed care use wording such as "managed care health plans, particularly health maintenance organizations" in their introductions (Chernew et al. 1997), making it clear that HMOs are a subset of what they consider managed care plans, while simultaneously suggesting that there are other plans that also fit under this rubric. Rarely is any attempt made to explain what

it is about HMOs that make them managed care plans, or what the more inclusive term means. Some researchers have defined managed care simply by telling the reader which plans are included in their analysis. For example, Enthoven, in his 1993 article "Why Managed Care Has Failed to Contain Costs," states in his abstract that he is looking at "managed care plans (health maintenance organizations and preferred provider insurance)." He then drops the term *managed care plan* and, after a brief inclusion of PPI, focuses on HMOs to illustrate his major points (Enthoven 1993).

No consensus emerges among the researchers who addressed the definitional issues explicitly. Robert Miller and Harold Luft, in their 1994 review "Managed Care Plan Performance since 1980," make it clear that in their opinion the management of physician practice is at the heart of managed care plans. "The selection of network physicians . . . is the single most important feature that distinguishes a managed care from an indemnity (fee-for-service) plan with utilization management" (Miller and Luft 1994: 1512). Operationally, this meant that Miller and Luft were including HMO, PPO, and POS plans. In contrast, Jonathan Weiner and Gregory de Lissovoy explicitly include indemnity plans with utilization review in their definition of managed care (Weiner and de Lissovoy 1993). Citing the lack of performance data about PPO and POS plans, Miller and Luft limit their review to the performance of HMOs.

In some studies of managed care, the focus is not on the management of physicians and their practices, but rather on the control of consumers and their utilization of physician services. In their attempt to understand the managed care backlash, Robert Blendon et al. (1998) surveyed health plan enrollees. They categorized plans as managed care versus "traditional" insurance according to the following characteristics: (1) whether enrollees were required to choose doctors from a list and pay more for those outside the plan, (2) whether they had to select a primary care doctor or medical group, and (3) whether they had to obtain a referral to see someone outside the plan. Survey respondents who said that their plan required one or more of the above were listed as enrolled in a managed care plan, which was 79 percent of the sample. Because all of the characteristics used involve restricting consumer choice, the who and what being managed in this categorization are patients and their utilization of services.

A story circulated a number of years ago about a high-ranking official at the U.S. Health Care Financing Administration (HCFA) who came back from visiting her mother and announced that HCFA had to change

the name of its new Medicare initiative. Her elderly mother had made it clear that she did not want anyone managing her—coordinating her care, yes; managing, no. It was too late, however, the train had left the station and *managed care* was the label. Perhaps the relatively low enrollment in managed care plans by the elderly reflects in part the elderly's perception that managed care seeks to dictate what care they are to receive, when, and from whom.

In the end, much of the managed care backlash may stem from a misunderstanding about who and what is being managed and how. Enrollees who thought insurers and providers were being managed and forced to reduce the "fat" in the system—as researchers and policy makers led them to believe the "managed care revolution" would do—were happy about this prospect. When these enrollees got sick, however, and found out that, directly or indirectly, their care and freedom of choice was also being "managed," trouble ensued. Consumers enjoy the lower premiums but understandably want the savings to come at someone else's expense (such as the rich physicians, those inefficient hospitals, the greedy insurers, and other negative stereotypes). They do not want restrictions on their care, not even on some of the experimental procedures that may lengthen their life.

Defining managed care is much more than a semantic argument. Because policy analysts, policy makers, and insurers have all been imprecise about what managed care actually is, many decisions have been made based on assumptions and expectations that are not universally shared and about which research can tell us very little. The resulting confusion, psychologists would predict, will cause anger and unhappiness. It will also, as economists might argue, result in many suboptimal decisions.

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