The Death of Managed Care as We Know It

Katherine Swartz

Journal of Health Politics, Policy and Law, Volume 24, Number 5,
October 1999, pp. 1201-1205 (Article)

Published by Duke University Press

The Death of Managed Care as We Know It

Katherine Swartz
Harvard School of Public Health

On occasion, a firm loses customer trust through strategic mistakes. McNeil attempted to play down first indications that unknown persons were tampering with packages of Tylenol. Intel was initially dismissive when a mathematics professor discovered a minor error in the computation routines of the first Pentium chip. But customer trust is a critical asset, and once each firm realized the damage it was doing to its market position, it quickly moved to create a remedy.

At other times, a firm loses customer trust through a structural problem, a problem inherent in the product for which no solution exists. Here, even the most intelligent managers may be powerless to fix the situation and the product may be doomed to lose market share. The growing consumer wariness and antagonism toward managed care organizations suggests that managed care may suffer from a structural problem of this kind. The question facing managed care organizations and affiliated health care providers is whether the loss of customer trust is so great that managed care's zenith has passed.

Consumer Trust and Managed Care Incentives

To appreciate the problem, it is useful to compare bringing one's health symptoms to a doctor with bringing one's car's symptoms to a mechanic. Each transaction involves potentially high stakes and potentially high costs. And each transaction involves large information asymmetries—

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

the provider usually knows much more about the problem than the consumer. In such transactions, the consumer must trust the provider not to exploit the informational advantage. In the absence of such trust, the consumer will invariably worry that he or she has been cheated and will start shopping around for someone better.

In the fee-for-service world of health insurance that existed before managed care organizations had a large proportion of the U.S. population as enrollees, consumer trust in physicians was based on three mechanisms. First, the consumer recognized that the physician had no financial incentive to ration medical care. To the contrary, a doctor, like a mechanic, had financial incentives to do more than might be absolutely necessary. But the second mechanism at work in fostering consumer trust in a physician was the insurance system, which diffused the doctor's charges among all policyholders. Hence, the individual consumer paid less attention to the possibility of physician overcharging or overprescribing of tests and visits. Last, the consumer lived in a world with free choice of providers. If a patient feared that a particular provider was advising too many diagnostic tests or unnecessary invasive surgery, he or she could seek out a different physician or other health care provider. Together, these three mechanisms—no incentive for underprovision of medical care, no fear of overcharging, and the option to change providers—were enough to counter the information asymmetry inherent in health care transactions and maintain consumer trust in providers and health insurance.

To a large extent, managed care has undermined these mechanisms. Capitated payments create financial incentives for health care providers to withhold care—incentives consumers recognize. The payments are designed to improve welfare in the aggregate: reduce unnecessary and wasteful care, and consumers will receive the savings. But to any individual consumer, the cost of an error in judgment about a diagnosis is extremely high—we all fear learning that a disease or condition might have been easily treatable if diagnosed at an earlier stage. In a country that for two generations has almost idolized expansion of medical technological capability for diagnostic and curative care, consumers do not want to risk having health care providers skimp on their care.

Managed care organizations also altered consumers' long-standing ability to choose their own providers. Managed care plans obtained cost savings in part by limiting the set of providers available to enrollees. Such restrictions on consumer choice of physician or access to a specialist or particular hospital heighten consumer antagonism toward an organization when the consumer's trust in a particular provider falls.

The problem of eroding trust is compounded because these changes coincide with greater patient participation in their own medical care decisions—a phenomenon that has been building since the 1970s. The push for a patient's participation in decisions about his or her own medical care grew out of a belief that patients could help control health care costs if they asked their physicians more about the choices for treatment options, questions that did not arise naturally when insurers simply paid providers' usual and customary bills. Health care providers also were eager to elicit increased patient participation in difficult choices so as to avoid malpractice suits. The explosion of pharmaceutical advertising aimed at consumers in the 1990s has reinforced the notion that "you, the consumer" have a right to be involved in medical decision making. Today, that right is directed at the quality of care consumers are receiving.

Promises Implied by Managed Care

The problem of eroding consumer trust is but one of the problems plaguing managed care. Proponents of managed care and managed competition made two basic promises to consumers. The first was that managed care organizations could deliver better quality medical care at lower prices. Better quality medical care would result from good management and better information systems that would enable physicians to learn and practice "best medical practices," and so deliver the same (or better) output at lower cost. The second promise was that competition between managed care organizations—managed competition—would force health care markets to be more competitive and the organizations to be more efficient. The proponents of managed competition argued that competition would force prices downward. Implicit in this promise was the assumption that health care providers and insurers had previously been able to set prices above true marginal costs of providing care and insurance.

Today, the public believes that neither of these promises has been fulfilled. In fact, both promises are victims of bad publicity. The media are full of stories about consumers/patients who have been denied coverage for a new protocol or experimental drug, or choice of a provider outside the managed care organization's network. Ironically, the actual data (poor though it may be) on denial of care indicate that managed care organizations have rarely practiced outright denial. These organizations—eager to avoid bad publicity and to attract new enrollees and providers—

have not been willing or able to really manage medical care and cut out the unnecessary actions.

Nonetheless, stories about people who have been denied care or choice of providers cause enrollees in managed care plans to question (at least in their own minds) physicians' motives in suggesting courses of action in response to symptoms or complaints. Is the "wait and see" recommended course of action a reasonable one or is it motivated by a physician's desire to keep more of the capitated payment? Is a mental health provider eager to prescribe mood-altering drugs rather than suggesting counseling sessions because the budgetary consequences of the prescription are less than the counseling? Are automated voice-answering devices, with long menus of choices, designed to discourage patients from seeking care or to lower personnel costs?

Reduced amenities or delays that do not reduce a person's health outcomes might be accepted by consumers if managed care organizations and managed competition delivered on the promise of lowering costs. But managed care has not caused health care costs to fall or even to grow more slowly. In part, this is because the last five years have seen an upsurge in the number of new pharmaceuticals available, as well as higher prices for the new drugs, and an increase in the number of prescriptions written per person—driving up expenditures for pharmaceuticals in managed care organizations' budgets. Similarly, many new diagnostic techniques are being used as complements rather than substitutes for treatments, raising total costs for treating some conditions that affect many people (e.g., coronary heart disease). In addition, managed competition's ability to control health care cost growth has been foiled by the drive of managed care organizations to expand their provider networks. Expansion of managed care organizations has been accomplished in the 1990s by contracts with providers and provider groups, who more often than not have contracts with other managed care organizations, too. In these circumstances, it is very difficult for a managed care organization to create nonfinancial incentives for the provider to be concerned about costs of care.

The result has been the worst of both worlds: consumers continue to lose trust in the care they receive while the cost of that care does not appreciably fall. It should not be a surprise, therefore, that consumers are lashing out at managed care. Thus, the problem facing managed care organizations and providers of health care in the current backlash era is one of rebuilding consumer confidence in providers' decisions.

Is There a Future for Managed Care?

For at least two reasons, the backlash against managed care is hard to reverse. First, managed care's financial incentives for providers to skimp on care make it difficult for patients to trust that an advised course of action is in a patient's true best interests. Second, consumers want to be able to choose their own providers, which makes it almost impossible for managed care plans to create exclusive contracts with providers. Managed care's ability to restrain physicians' and providers' expenditures for patient care is far higher when a plan has providers that serve only the plan's enrollees. Consumers want choice of providers in large part so they can find providers that they feel are responsive to their needs and who will act as their agents. Physicians (and some other health care providers) are recognizing that they, too, risk losing patient/consumer trust if they do not distance themselves from managed care plans. The growing number of physician groups that have seceded from exclusive contracts with managed care plans is evidence that physicians wish to be regarded as independent of the plans in order to retain their patients' trust.

Unless the managed care industry can quickly figure out how to restore consumer confidence in managed care's ability to deliver high-quality medical care for less cost, it cannot survive in the form we have known for the past decade. Already we have seen the expansions of point-of-service options with managed care plans, permitting people to obtain care from providers not in the managed care plan network. Unfortunately, as with other markets and as with health care in the past, this development has the clear potential to permit the rich to have choice while people with moderate to low incomes will not. Moreover, the underlying problem of how to restrain the growth in health care costs remains. It may be that managed care organizations as we have known them inherently contain structural problems that make it impossible for consumers to trust physicians in managed care. If this is true, then we need to look to other organizational structures and methods to slow the rate of growth in health care costs.