Contemporary Managed Care: Readings in Structure, Operations, and Public Policy, and: The Managed Care Blues and How to Cure Them (review)

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The past two decades have witnessed a profound change in the nation's approach to organizing and financing health care. Seemingly overnight, large health care companies providing integrated health care insurance products burst upon the scene, literally absorbing large numbers of "mom-and-pop" physician practices and hospitals as they grew. Two great bodies of federal law account for—and indeed enabled—this transformation. The Employee Retirement Income Security Act of 1974 (ERISA) enabled employers, battered by spiraling health care costs, to bypass the provider-dominated insurance industry that had flourished for nearly half a century, in favor of virtually deregulated, self-insured coverage arrangements that used selective purchasing techniques, competitive pricing, and the threat of market exclusion to tighten their control over provider pricing and conduct. Insurers ultimately adopted these same strategies in order to keep their buyers’ business (Rosenblatt, Law, and Rosenbaum 1997).

Federal antitrust laws in turn barred physicians, hospitals, and other
suppliers of health services from banding together to prevent the financial and organizational transformation. These statutes represent the second pivotal body of federal law that helps explain the speed and totality of the transformation to a competitive health care environment. While antitrust cases involving collusive conduct by physicians date back to the 1940s, the elimination of the “learned professions” antitrust exemption in the late 1970s, as seen in Goldfarb v. Virginia State Bar (421 U.S. 773 [1975]), opened the door to the full-fledged application of market principles to the health care arena. By the early 1980s, as the true impact of ERISA (whose primary purpose was to protect pensions) was beginning to be appreciated, courts were enjoining as anticompetitive the very practices—such as unilateral price-setting, division of markets, and barring entry by competitors—that physicians and other health professionals had used to effectively control both the cost and quality of care. Indeed, antitrust laws not only prevented professional resistance to market forces but also encouraged the strong purchasing tactics that are the hallmark of vertically integrated medical care systems that purchase goods and services from competing suppliers.¹

By the mid-1990s, the transformation of American health care from small, autonomous professional businesses to giant companies offering virtual health care systems stitched together through a cascade of contracts—and competing for lives and market dominance—was pretty much complete. Three quarters of all privately insured Americans (Gold: 13), more than half of all Medicaid beneficiaries (HCFA 1998), and over 10 percent of Medicare recipients (Kaiser Family Foundation 1998) were enrolled in some form of what today is known as “managed care.” Armies of insurers and other investors (including the very medical professionals and institutions that resisted the change to begin with) and their lawyers, financial analysts, actuaries, systems managers, and accountants built these companies. Perhaps the greatest irony of all was that the very insurance enterprises that realized immense wealth from this transformation opposed President Clinton’s managed competition–style national health insurance plan on the grounds that it would lock Americans into tightly controlled health care systems that deprived them of choice and reduced quality, mounting their attack at the same time that they were poised to accomplish much the same goal, but in a deregulated environment (Johnson and Broder 1997).

During the early 1990s, news accounts regularly touted managed care's potential to improve quality, control costs, and ultimately help insure more Americans without the need for regulatory intervention. In the second half of the decade, however, after prospects for health reform were dashed, public perceptions about managed care began to shift substantially. The transformation to managed care, it seems, did not come without a significant price tag. Price tags are not a bad thing as long as the price is understood and planned for. With managed care, however, this definitely did not appear to be the case. By the middle of the decade, several aspects of the new system that were well understood by prepaid group practice experts but were overlooked in the deluge of early, laudatory reporting on managed care's promise, came to the fore; it turned out that the public did not like these features at all (which helps explain why, before the days of universal managed care, so few Americans chose to enroll in prepaid plans).

The first problem was the apparent loss of choice in one's physician, hospital, and other health care providers. By its very vertical structure, managed care is designed to emphasize the vertical system (i.e., the managed care company) and deemphasize the individual suppliers (i.e., physicians and hospitals), who in a competitive system represent no more than mere parts suppliers, much like steel makers represent raw input in cars and trucks. The documented refusal of managed care companies to negotiate individually tailored agreements with health professionals (Ambrose v. Aetna Health Plans of New York, sup., n. 1), and the companies' insistence on take-it-or-leave-it contracts underscore the degree to which the belief in the concept of substitution in health care (as in other market goods) is key to the success of the new model. However, this concept appeared to run directly counter to Americans' expectations. As employers increasingly awarded sole-source contracts to companies with tightly controlled physician panels, member unhappiness grew.

The second problem was the public perception of lost accountability and a growing remoteness in the health care system. As health care companies attempted to occupy space that had once been filled by individual doctors and hospitals, the public began to believe that rather than improving quality, managed care actually increased the potential for poor-quality care by distancing people from their doctors. Stories of heartless corporate conduct, injurious or deadly health care delays, and poor-quality care blossomed in the same newspapers that had only a couple of years before extolled the benefits of managed care. Indeed, the news media appeared to forget the fact that malpractice and uncaring physicians had been issues in the old system as well.
Moreover, by the early 1990s it had become evident that at the intersection of ERISA and managed care lay legal preemption of beneficiary rights to recover damages for injuries and death sustained as a result of the wrongful denial of care. Prior to the enactment of ERISA, privately insured Americans could seek and recover damages when they suffered injury or death as a result of the negligent or bad faith refusal of insurers to provide coverage to which they were entitled (Rosenblatt, Law, and Rosenbaum 1997). In the post-ERISA world, however, state common law remedies against insurers for bad faith breach of contract were barred, and an increasingly angry judiciary found itself in the position of having to deny recoveries for even heinous cases of insurer-caused injury and death because of ERISA’s preemption of state law (Turner v. Fallon Community Health Plan, Inc., 127 F. 3d 196 [1st Cir. 1997]). As the public came to understand that a managed care company could withhold lifesaving treatment and—legally speaking at least—get away with it, the backlash against managed care grew. Rather than improving care and promoting quality, managed care appeared to be a means of isolating people from their doctors and insulating faceless corporations from liability for their conduct.

The problems with managed care extend beyond its potential effects on the physician-patient relationship and the loss of remedies for terrible harms. It also has become increasingly clear that without substantial reforms, many of the most important components of the American health care system, that historically have thrived on financial cross subsidization, are fundamentally incompatible with the competitive thrust of managed care. Not only does price competition threaten health care access among uninsured Americans, but it also poses access problems for insured individuals whose income, age, or disability make them unattractive investment prospects for health care corporations. For example, while some companies made a limited incursion into the Medicaid managed care market for a few years, many have since pulled out (Hurley and McCue 1998).

Competition also created new problems for public hospitals, health centers, and other safety net providers that for decades had fulfilled their responsibilities and missions not only with operating subsidies from federal, state, and local funds, but also through cross subsidization with public insurance programs (Hawkins and Rosenbaum 1997; Gage 1997). Increased competition also raised issues of survival for academic health centers, health professions training programs, and essentially any health professions undertaking that was potentially unprofitable either because
of high cost or its tendency to attract high health risks (Reuter and Gaskin 1997).

Despite the fact that the philosophical, operational, and practical implications of managed care probably were predictable (its legal implications are still unfolding, perhaps because it takes so many years for issues to gel and reach the courts), virtually nothing was done to accommodate the health care system to this new mode of health care delivery. Even today, as the nation finds itself deeply enmeshed in managed care, there continues to be a widespread unwillingness to invest in the organizational, financial, and legal changes that are needed to ensure appropriate operations.

Public and private purchasers are unwilling to help bear the cost of ensuring universal access in a competitive health system. Employers refuse to subsidize private coverage for more workers and the federal and state governments fail to put a viable public alternative into place. Purchasers insist on what companies view as absurdly low rates and refuse to pay higher fees for the poorest and sickest enrollees. Purchasers appear to be unwilling to make the major technological investments that are necessary to build in quality measurement and improvement systems; even if they did, it is not clear that the technologies currently exist to perform “real-time,” reliable, or meaningful quality outcome measurement for more than a handful of medical conditions (Eddy 1998). Even more modest interventions to counter the access-reducing effects of competition, such as enhanced funding for clinics and public hospitals, are devilishly difficult to accomplish. State policy makers struggle to enact at least limited health care quality protections; but they can accomplish little until Congress fixes the “ERISA problem.” At this point in time, however, Congress seems disinclined to tackle ERISA in any meaningful way. In short, the problem is not so much managed care as the willful refusal on the part of public and private policy makers to finish the job, as it were, and make the series of systemic reforms that are necessary if we are to depend on this particular model of health care delivery.

While policy makers cast about for solutions to difficult health care problems, there is no shortage of researchers, pollsters, and analysts willing to research these problems or write tracts about how to fix them. There probably never has been a more fervent time in health services research or health care policy analysis. Public and private policy makers alike have invested millions of dollars on commissions, meetings, institutes, and other strategies for understanding the policy challenges that managed care produces as well as for attempting to provide effective, yet
politically popular remedies. Researchers churn out analyses in a struggle to understand managed care’s long-term consequences for health care cost and quality. They study effects of managed care on health expenditures, health care quality, health care providers, selected subgroups of sick, disabled, and elderly managed care populations, and even those left out of the managed care revolution because they are uninsured. Managed care opinion polls (published on what appeared to be an almost daily basis during the summer and fall of 1998, before the presidential crisis brought a temporary halt to federal reform efforts) reveal either that consumers are either basically happy with managed care or hate it, depending on which poll one reads.

Confronted with a nearly absurd mountain of articles, exposes, studies, accounts, and other assorted materials on the impact and wisdom of managed care, politicians at all levels of government are trying to figure out what new type of legal structure they want to build to contain the system. (As a coauthor of one of the most voluminous of all managed care studies [a three-thousand-page analysis of Medicaid managed care contracts], as well as a coauthor of a fifteen-hundred-page textbook, much of which concerns one aspect or another of managed care), this reviewer judges herself to be in a particularly strong position to reflect on the sheer volume of research being done).

Two new books add to this body of information. The first, *Contemporary Managed Care: Readings in Structure, Operations, and Public Policy*, edited by Marsha Gold, is a compilation of peer-reviewed essays (most but not all of which have been published elsewhere) on various aspects of managed care. Gold is one of the nation’s most respected managed care researchers, as well as one of its most prolific (the book could have been named the Marsha Gold Reader, since she is an author of ten of the book’s nineteen chapters as well as its editor). In *Contemporary Managed Care*, Gold has assembled an impressive body of essays on a range of subjects. Some of the material is a bit dated (this is not by any means the fault of the editor: the landscape is changing so rapidly that it is virtually impossible to write articles on the subject that are both scholarly and contemporaneous). Nonetheless, the book makes an important contribution to the field and is a valuable reference source for students of managed care theory, practice, and organization.

The book is divided into four parts, each of which has several chapters. Each part opens with a summary and then proceeds through a series of thematically related chapters. Part 1, “The Evolution of Managed Care,” provides an excellent overview of the rise of managed care, trends in the
development of managed care organizations, and a particularly good chapter by Gold and Robert Hurley that explores the types of “products” offered by managed care plans. For persons who are not intimately familiar with managed care, this chapter does an especially good job in underscoring the degree of variation among managed care products and therefore the problems inherent in attempting to make generalizations.

Part 2 is quite possibly the strongest section of the reader, most importantly because it features what I consider to be Gold’s seminal study (coauthored with Hurley, Timothy Lake, Todd Ensor, and Robert Berenson), of arrangements between managed care organizations and physicians. (This study, which was conducted for the Physician Payment Review Commission, originally appeared in the *New England Journal of Medicine*). Suzanne Felt-Lisk’s essay on the structure of HMO primary care delivery arrangements is also very good. Compared to its companions in this section, the chapter titled “Delivering Women’s Preventive Services under Managed Care: Opportunity and Promise,” by Nancy Heiser and Robert St. Peter, is relatively thin. The chapter reviews certain preventive practices by managed care organizations in “women’s health.” Unfortunately, however, the article contains no indication of whether the study plans are representative of the industry as a whole, or even whether their reported practices are indicative of the practices in which they engage in all of their product lines (the importance of this point is underscored by Gold’s and Hurley’s admonition in part 1 that there is no single managed care product).

Part 3 explores the issue of managed care and public programs, specifically, Medicare and Medicaid. This part contains the highly influential study by Randall Brown et al. (originally printed in the *Health Care Financing Review*) that explores the adverse financial effects of managed care on Medicare. Part 3 also contains several fine studies by Gold, Felt-Lisk, Wooldridge, Ku, Ellwood, Dubay, St. Peter, Sparer, and others that examine the early results of a series of mandatory Medicaid managed care experiments that burst onto the scene in the first half of the 1990s and that were encouraged by the Clinton administration through the use of its research authority under Section 1115 of the Social Security Act (Rosenblatt, Law, and Rosenbaum 1997).

As it encouraged states to implement large scale managed care demonstrations, the Clinton administration had simultaneously commissioned a series of evaluations that are ongoing, along with companion evaluations funded by the Commonwealth Fund and the Henry J. Kaiser Family Foundation. Taken together the evaluations point to the difficulties
inherent in converting a benefits program as complex as Medicaid to one that acts as a purchaser of managed care–style health insurance. The studies examine issues that arose in enrollment, enrollee education and information, reconfiguration of beneficiaries’ health care delivery systems, and quality oversight when states attempted to achieve a rapid transformation to managed care. The studies suggest that rapid conversion and unrealistic initial expectations, rather than the structural realities of Medicaid, were the chief causes of the initial difficulties that many states experienced. In my opinion, the opposite probably will turn out to be true for a number of reasons; the most important one being the highly unstable eligibility among the beneficiary population (which invites service interruptions and potential system gaming). The standard managed care products that may work relatively well in an employer market may turn out to be infeasible in the case of Medicaid because of the singular nature of the program, the instability of the coverage it offers, and the level of illness among the population. Additionally, the 1996 welfare legislation may exacerbate these problems because it eliminates the historical link between cash assistance and Medicaid enrollment. Not only will this change make Medicaid coverage even more unstable, but as healthier families return to work or are deterred from seeking assistance, the welfare reform could lead both to a decline in Medicaid enrollment and to a greater concentration of sicker individuals among remaining enrollees, which would have profound implications for the program (Rosenbaum and Darnell 1997; Ellwood and Ku 1998).

Perhaps the weakest part of the book is the final section, “Cross-Cutting Issues Emerging for Public Policy and Research.” This section lacks the coherence found in earlier sections. It tends to read like a collection of items that did not fit neatly into other sections of the book. For example, while Gold’s chapter in this section reviewing the effects of managed care on academic health centers is important, it is only one of many pressing policy matters raised by the managed care conversion. Moreover, the final section simply does not offer a policy synthesis of the enormously important materials presented throughout the reader. Indeed, it reads as if Gold sort of ran out of steam, which is perhaps understandable given the monumental amount of research that is presented in the first three parts of the book.

The second book, The Managed Care Blues and How to Cure Them, by Walter Zelman and Robert Berenson, is a real curiosity. Zelman and Berenson are nationally recognized analysts and thinkers in the field of managed care (indeed, Berenson is a coauthor of quite possibly the best
chapter in the Gold reader). Both were members of President Clinton's Health Care Task Force from prominent health policy positions. Zelman now lectures in health policy at the Harvard School of Public Health, while Berenson currently directs the Center on Health Policy Plans and Providers in the Health Care Financing Administration. Despite the authors' credentials, the book is essentially a managed care apologia by two guys who care, replete with “alternative” chapter titles that are meant to appeal to some unknown audience and are lifted from an eclectic group of songs ranging from Gershwin to the Rolling Stones (e.g., “The Managed Care Record: Better than You Think (Sympathy for the Devil),” “Protecting the Floor (You Can't Take That Away from Me)"). This device doesn't add much; indeed, it makes the book come across as flip and somewhat silly.

There are many reasons to explore critically whether a system that integrates financing and service delivery is inherently more capable of controlling costs and improving quality. Indeed, at least in theory, the integration of financing and service delivery is an essential step to improving quality and controlling costs. However, The Managed Care Blues not only fails to offer a probing analysis of this question but moreover, leaves one dismayed at the thinness of the justification for departing from the old way of doing things.

In reading this book, one cannot help but ask oneself what Zelman and Berenson were thinking about when they conceived it or whom they could have been intending to reach when they wrote it. The authors state at the outset that they wrote the book to show us that managed care isn't nearly as bad as we thought. They also say they want to persuade readers why “to the extent that managed care does need fixing—and it certainly does—it is far from clear that government regulation is the best or most potent tool for that task” (p. xi). The problem is that the book is weak. It fails to explain convincingly why managed care is not bad—or even for that matter why Zelman and Berenson think that this issue needs rehashing, since like it or not, managed care is the health system of today for the nondisabled working-age population. Moreover, the book fails miserably to offer reasons why we should think that the market will simply fix everything or even most things, since in the authors’ own view, the real buyers of managed care are unfortunately not individual health care consumers who are concerned about quality, but instead large institutional public and private purchasers with price on their mind.

The book begins with two chapters (alternatively titled, “The Thrill Is Gone” and “I’ve Been Loving You Too Long”) that report that the fee-
for-service system had price and quality problems and, moreover, that the freedom of movement that consumers counted on to offset quality problems offered no real protection at all. The book then reports on the rise of managed care and extols the ways in which managed care’s inherent structure permits it to hold down costs while improving quality.

In the sixth chapter (with the bizarre alternative title, “Stop in the Name of Love”) the authors offer a critique of the managed care backlash while acknowledging that managed care does raise real issues for consumers and providers. They then attempt to respond to the issues raised by this backlash in a chapter (with the alternative title “Sympathy for the Devil”) that reviews the positive aspects of the managed care record. Not only does the alternative title undercut the authors’ premise in its very name, but also the chapter is laced with assertions for which the authors offer no evidentiary justification. For example, they state that “many of the consumer protection proposals now before state and federal legislatures would certainly increase costs” (p. 120). Maybe some do and maybe some do not; but the authors offer no explanation for this charge, nor do they in any way attempt to evaluate critically whether the costs might be offset by savings in other parts of the health care system: the theoretical strength of public health care policy is that, unlike privately ordered policy making, it is not necessarily bound only by considerations of policy reform’s effects on insurance premiums but can instead consider the systemic effects of reform as well. Despite their backgrounds in public policy, the authors do not acknowledge this.

Other examples of blanket statements that lack any evidentiary backup are that the fee-for-service system “had no means of improving efficiency or reducing unnecessary or inappropriate care” (p. 121), or that “when physicians are at risk they become more conservative in their use of resources” (p. 124). The fact that the U.S. fee-for-service system failed to police itself either costwise or qualitywise is a gross overstatement; moreover, to the extent that it did not do so, this most certainly is not because the system was inherently unable to do so. That many nations use fee-for-service payment mechanisms dispels the notion that this structure is inherently incompatible with cost containment or quality review. Similarly, the term conservative used by the authors implies wisdom and prudence. Yet they offer no evidence that prudence is the outcome of financial risk; indeed, they have already told us that managed care quality measurement is too young to permit extensive quality measurement.

By far the most interesting part of the book and the section that should be widely read is the chapter entitled “Rule of Price; Cult of Choice; Cost
of Quality.’” This chapter does a good job of exploring the fundamental paradox in managed care: on the one hand, in order to achieve the gains offered by the model, the use of vertical, closed-panel systems that permit control of cost and quality is essential; on the other, Americans’ demand for choice of physicians and their insistence on bonding with individual health professionals has caused such distortions of the model that its goals may be unachievable. Unfortunately, the authors’ basic answer to the dilemma is to tell readers to get over the notion that choice is a proxy for quality. This advice is not much of a solution, however, in the absence of irrefutable evidence that medical care, like other consumer products, lends itself to substitution. For the average person, the chief quality input is a trust relationship with an individual physician. Given the shortcomings of quality time measurement failings, which Zelman and Berenson acknowledge, this is not likely to change soon. As a result, managed care organizations, to lure customers, will continue in the near future to undermine the very structure that the authors argue will produce advances in medical care.

As is true of the Gold reader, this book offers little in the way of solutions. Surprisingly perhaps, given the intellectual strength of both sets of authors, both books fail to discuss the problems in applying a managed care model in a health system without universal health coverage. Perhaps this oversight should be a signal to health policy analysts everywhere that in the unending dissection of managed care’s strengths and weaknesses, the nation once again can’t see the forest for the trees.

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References


