Managed care in the USA: an assessment

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The economic prosperity following the Second World War led to a dramatic growth in the American health-care industry. By the 1970s, Americans outspent everyone else on health care. Yet, most public health indicators showed that US lagged behind most industrialised countries and up to one in five Americans had to rely on charity to get their health care. When governmental efforts failed to check the growth of spending on health care, the market responded with a system that came to be called Managed Care (MC).(1) Driven by a motive to contain costs, many of the changes have had a profound negative impact on patients, hospitals, medical education and research.

Impact of managed care on patients

By 1995, the rising cost of health care had mostly eliminated free health insurance as a benefit of employment. Not only were most employees now under some form of MC; they were also paying for an increasing share of the cost of insurance. Today, younger and healthier patients have much higher out-of-pocket expenses as they are paying a greater share of the premium. But older, sicker patients actually pay less than they did before: apart from a flat premium there are no additional costs. However there are greater hassles. Patients have less choice in the selection of their physician and hospital. Their access to emergency room care is restricted and they often have to wait longer for appointments. A specialist visit requires prior approval and not all treatments, procedures or drugs, are available. (2) A change in job often means a change in physicians. This further compromises care of the sicker patient with chronic disease in need of coordinated care.

On the positive side, patients enrolled with good managed care organisations (MCOs) receive far more preventive care than they ever received under the fee-for-service (FFS) system. Patients with chronic diseases such as heart failure, diabetes and asthma probably get better coordinated care under case-management protocols often overseen by nurse practitioners. Previously a 50-year-old with hypertension, diabetes, arthritis and post-infarction seizures went to four different specialists. Under managed care, these visits are combined into just one visit to the primary care physician (PCP). A specialist is involved only when necessary.

Impact of managed care on physicians

Until the early 1990s most physicians were in solo practice or worked in small groups. As MCOs transferred costs to physicians through capitation arrangements, solo practitioners could not absorb the financial risk. Economics thus forced physicians either to work as salaried employees of the MCO or join large physician groups, with an inevitable loss of autonomy. (2)

It is therefore not surprising that most surveys of physicians show discontent and dissatisfaction.(3) The loss of autonomy, the increased administrative burden that physicians view as unproductive, and the reduced income are the major reasons. (4) However, the wording of survey questions and the bias of the researcher also have an impact on the conclusions. Authors often focus on the minority of physicians who are dissatisfied. Most survey data suggest that physician discontent is more with the (for-profit) MCO rather than the philosophy of managed care *per se*. It is therefore quite likely that if managed care were presented differently, such as under a not-for-profit, single payer system, physicians may change their attitudes. Indeed, in a survey of more than 100,000 medical students, interns, residents, and faculty, Simon et al found that though most respondents rated FFS superior to MC in terms of access to care, ethical conflicts, and the quality of patient-physician relationship, more than 30 % of the respondents rated MC superior to FFS for chronic care. When a single payer option was added in, most preferred a single payer system over either MC or FFS.(4)

Impact of managed care on community hospitals

Hospitals of antiquity were primarily shelters for the dying poor. The first general hospital in America to care for sick people was established in the 18th century. After World War II, the federal government provided generous subsidies for the construction of community hospitals across the nation. While initially hospitals were modelled on the British system where any credentialed physician could admit and take care of her/his patient, under MC they are increasingly shifting to the European model of salaried 'hospitalists' caring for patients referred by PCPs practising exclusively in the outpatient clinic.(5)

Under MC, community hospitals are increasingly losing their links to their community. To maximise cost-containment, MCOs are acquiring or contracting with the lower cost community hospitals in preference to high-cost teaching hospitals. (2) As community leaders are replaced by MCO-appointed trustees and physicians, the links with the neighbourhood are lost. Many free-standing community hospitals wishing to retain their independence, share risks and improve their bargaining position with MCOs, have joined networks of local, regional or national health systems. This further compromises the role and control of the local community in their community hospital.

Impact of managed care on academic medicine

Academic medical centres typically consist of a large tertiary care hospital with an attached medical school. The hospital is staffed by the medical school faculty. Although providing only 18 % of the nation's acute care beds, the

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major teaching hospitals provide half of all charity care.(6) Under the FFS system, private insurance and government paid the higher *per diem* charges of the academic medical centre: an implicit subsidy for graduate medical education, research and charity care.

With the advent of MC with its emphasis on cost-containment, MCOs are preferentially contracting with community hospitals rather than the more expensive academic medical centres. They refuse to subsidise medical education and research and are averse to paying for charity care for the 20% of the population that is uninsured. MCOs also demand a much greater time commitment of the academic physician to clinical activities rather than teaching and research. Thus, under managed care, academic centres lose revenues, staff time for teaching and research, and the patient population necessary to sustain medical education and research.

To counter the trend, academic medical centres are creating their own networks with community-based physicians, a breed looked down on in the past. To attract more patients, some have offered medical services at a discount or for a global fee. The academic centres have also pressed for the creation of separate funds for teaching, research, and charity care to which all payers, insurance companies as well as government would be required to contribute, but this is unlikely to happen soon. James A. Lane, a senior vice president of the Kaiser Foundation Health Plan, a large non-profit MCO, said, "We believe that education and research are public goods, and they should be paid for with public funds." (6)

Impact of managed care on health care quality

Quality means different things to different people. To PCPs committed to evidence-based care, quality is judged by adherence to practice guidelines. To patients, quality is measured by how promptly they were seen and how satisfied they felt at the end of their encounter. Problems with quality of health care can be categorised as overuse, under-use, and misuse. Under-use is prevalent in the care of patients with chronic disease. For instance, many patients with diabetes do not have regular glycosylated haemoglobin measurements and retinal examinations. Under-use also occurs in acute care, e.g. a failure to use aspirin in myocardial infarction. Misuse is a pervasive problem.(7) Primarily concerned with reducing costs and maximising profits, reducing overuse had become the main focus of MCOs.

The National Center for Quality Assurance (NCQA) was formed in 1979 by physicians seeking to improve medical care. In 1990, MC trade associations, hoping to fend off federal monitoring of health plans and to reduce competition from newer HMOs, engineered a restructuring of the NCQA's board. Now the NCQA has two main voluntary activities: the accreditation of HMOs and the publication of measures of performance, HEDIS (Health Plan Employer Data and Information Set). (7) Though most employers do not insist on NCQA accreditation as yet, 30 large corporations and the federal government will not contract with health plans that are not accredited by the NCQA. Ironically, although employers tend to associate higher quality with lower costs (achieved by reducing overuse and misuse), the NCQA's HEDIS measures focus mainly on the under-use of health care, the correction of which raises costs.(7)

As a result of pressure from physician activists who persuaded large employers and the government to demand high-quality care from MC plans, MCOs are now paying attention to under-use as well as overuse. More than half of the MCOs have chronic disease management programmes in place. More than 80% monitor patient satisfaction and most also measure outcomes on a regular basis.(2) Almost all HMOs have implemented practice guidelines, performance measures and improved information infrastructure. Most have written standards for medical records and two-third use standardised problem lists. Most review records for accuracy and provide feedback to physicians. Some even use results of quality improvement studies at the time of renegotiating contracts with individual physicians.(2)

However, true assessment of quality requires independent verification: this is sadly lacking. Indirect evidence suggests that current quality assurance activities have yet to achieve significant improvement in outcomes.(2)

Impact of managed care on health-care spending

Health-care spending consists of the actual cost of providing health care, administrative costs and surplus profits of the MCOs. Under MC, the actual cost of providing health care has decreased.(8) Factors contributing to the reduction include reduced hospital stay, lower payments to doctors, lower pharmaceutical charges, reduced use of tests due to adherence to practice guidelines and utilisation review, physician reimbursement policies that penalise those ordering excessive tests and selective enrollment ('cherry picking') of younger, healthier persons.

Few HMOs report administrative costs separately. One of the few reports available is from the state of Minnesota.(9) In most industries increased productivity results in a reduction in administrative costs. However, in Minnesota, from 1980 to 1991, the increase in MCOs' administrative expenditure was more than twice the increase in enrollment and consequent medical care expense.

It therefore seems that the health insurance industry entered managed care mainly to increase its profits by 'managing' patients, hospitals and the pharmaceutical industry. Because of their large size, MCOs were able to force patients to accept less health care and physicians and hospitals to accept lower fees. They also recruited younger, healthier patients who needed less care. They also successfully lobbied the government to protect them from law suits. More recently patient complaints to the media and the legislatures has forced MCOs to reverse some of their excesses such as 'drive-by deliveries' and 'gate-keeper' functions limiting patient access to health care and thus raising costs for MCOs. At the same time, corporate resistance to increasing premiums has severely limited MCO profitability. In 1997, only half the MCOs reported a profit. and the average profit margin was a meagre 1.2%. As there

is a finite limit to which health insurance premiums can be raised, the future of for-profit MCOs is uncertain. Will the marketplace find a solution?

Legal challenges to managed care

Under the FFS system, disputes between the patient and the insurance company are resolved under contract law that governs voluntary agreements between two legally competent parties. Law courts and legislatures intervene only when an agreement is felt to be excessively one-sided or violates some principle of public policy.

Disputes between the patient and physician/hospital fall in the realm of tort law. (10) Tort law covers three basic areas — compensation, deterrence, and accountability — and establishes the legal standards of care. Physicians are expected to provide the same care to all patients irrespective of payment arrangements. Most cases are heard in state courts and governed by rules established by legislatures in each state.

Under FFS, when an insurance company denied payment for care already delivered, it only affected payment of a bill. More often than not, the patient received the care needed. However, under MC, where the insurance company also provides care, denial of the benefit now includes both denials of care and of funds. Contract law defines the market mechanisms while tort law establishes medical accountability. Clearly, the issues under the new system of health-care delivery overlap aspects of both contract and tort law.

In passing the Employee Retirement Income Security Act (ERISA) in 1974 the US Congress exempted MCOs from lawsuits in state courts. To the extent that medical malpractice falls under state courts, ERISA granted MCOs immunity from lawsuits under tort law. Subsequently federal courts have generally focused only on the contractual role of MCOs as financiers and have ignored the health-care provider function which would have been considered under tort law. Thus MCOs have escaped medical malpractice lawsuits. In response to public outcry, lawmakers have been considering several measures designated as 'right to sue' laws to protect patient rights. Lawmakers have been trying to develop legislation that would protect the cost-containment provided by MCOs while allowing legal challenges to quality of care. So far, no satisfactory compromise has emerged. Even in absence of legislative action, it is quite likely that, as courts improve their understanding of how health care has changed under MC, many of the protections under ERISA will vanish. Even judges agree that ERISA goes too far in protecting MCOs. (10)

Physicians, to protect their economic interests and professional autonomy, have challenged economic credentialing, selective contracting, etc., and have tried to use anti-trust laws to gain entry to physician panels of MCOs. The courts have so far sanctioned the use of economic credentialing and selective contracting. An area where physicians have had some success involves due process in deselecting a physician from any MCO panel. (11)

Conclusion

Managed care today is dominated by for-profit organisations whose primary interest is to maximise profits and who would go to great length to assure this. However, non-profit health insurance based on a capitated MC network model with a strong emphasis on utilisation review, has the potential to improve quality. Corporate purchasers of health insurance could make informed decisions based on HEDIS quality and outcome data. With an emphasis on prevention and the ability to collect data on population-based samples to guide management of chronic disease, health care could be improved significantly.

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