The Changing Face Of Managed Care

Managed care plans face the challenge of satisfying marketplace preferences for less restrictive care while holding down costs.

by Debra A. Draper, Robert E. Hurley, Cara S. Lesser, and Bradley C. Strunk

ABSTRACT: Managed care plans—pressured by a variety of marketplace forces that have been intensifying over the past two years—are making important shifts in their overall business strategy. Plans are moving to offer less restrictive managed care products and product features that respond to consumers' and purchasers' demands for more choice and flexibility. In addition, because consumers and purchasers prefer broad and stable networks that require plans to include rather than exclude providers, plans are seeking less contentious contractual relationships with physicians and hospitals. Finally, to the extent that these changes erode their ability to control costs, plans are shifting from an emphasis only on increasing market share to a renewed emphasis on protecting profitability. Consequently, purchasers and consumers face escalating health care costs under these changing conditions.

On multiple fronts—consumer, purchaser, provider, and regulatory—managed care plans are facing mounting pressures to change. Consumers are becoming more active health care participants and are demanding more choice, greater flexibility, and fewer restrictions on access and service delivery. Employers (purchasers) are demanding less restrictive managed care to appease employees and at least so far have been willing to absorb most of the higher ensuing costs. Consumers' and purchasers' preferences for broad and stable networks give providers the upper hand in contract negotiations with plans. Also tipping the scales in favor of providers is consolidation among both physicians and hospitals and the reappearance of capacity constraints for many hospitals. With their new clout, these providers are pressuring plans to pay more and reduce the scope of risk in risk-contracting arrangements; others are pressuring plans to replace risk payment

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with fee for service (FFS) payments (for physicians) or per diem and case-rate payments (for hospitals). Federal and state regulations sought by consumers and providers in response to perceived problems with health maintenance organizations (HMOs) are prompting additional changes. Also, declining HMO enrollment is pressuring plans further.

Based on data from markets around the country, this paper examines how managed care plans are responding to these evolving marketplace pressures. It first examines the shifts in business strategy that plans are making. It then discusses various implications of these changing managed care strategies for health care costs, the affordability of health insurance, and other important matters. The paper concludes with some speculation on the durability of the strategies that plans have recently adopted.

Data And Methods
The data on which this paper is based are from the Community Tracking Study (CTS), a longitudinal study conducted by the Center for Studying Health System Change (HSC). That study uses multiple data sources, including site visits to twelve nationally representative communities—Boston; Cleveland; Greenville, South Carolina; Indianapolis; Lansing; Little Rock; Miami; northern New Jersey; Orange County, California; Phoenix; Seattle; and Syracuse—to examine changes in local health care systems. These communities are geographically diverse and vary in size and health system characteristics, including experience with managed care, and all areas have seen major changes take place (Exhibit 1).

This paper draws most heavily on the round of site visits conducted between June 2000 and March 2001; it also draws on the two previous rounds conducted in 1996–1997 and 1998–1999. Research teams conducted 895 interviews with key participants in the local health care markets during the latest round of site visits, including approximately 220 managed care plan interviews representing more than fifty plans. For each of the twelve communities, five plans were targeted for study: a large national plan, a large Blue Cross Blue Shield plan, a large local or regional plan, and two additional plans. Structured interviews using standardized protocols were conducted with top officials at each plan, including the chief executive officer; the medical director; and executives responsible for marketing, network operations, Medicare, utilization management, care management, and pharmacy. Researchers also interviewed employers and other health benefit purchasers, insurance brokers, benefit consultants, providers, and policymakers.
EXHIBIT 1
Population And Managed Care Characteristics Of Community Tracking Study Sites, 1996–2000

<table>
<thead>
<tr>
<th>Study site</th>
<th>2000 population</th>
<th>HMO penetration</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>4,536,430</td>
<td>36.9%</td>
<td>47.7%</td>
</tr>
<tr>
<td>Cleveland</td>
<td>2,250,871</td>
<td>19.8%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Greenville</td>
<td>962,441</td>
<td>5.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>1,607,466</td>
<td>20.2%</td>
<td>24.4%</td>
</tr>
<tr>
<td>Lansing</td>
<td>447,728</td>
<td>39.5%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Little Rock</td>
<td>583,845</td>
<td>18.1%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Miami</td>
<td>2,253,362</td>
<td>52.9%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Northern New Jersey</td>
<td>2,032,989</td>
<td>21.1%</td>
<td>23.9%</td>
</tr>
<tr>
<td>Orange County</td>
<td>2,846,289</td>
<td>40.5%</td>
<td>45.3%</td>
</tr>
<tr>
<td>Phoenix</td>
<td>3,251,876</td>
<td>33.1%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Seattle</td>
<td>2,414,616</td>
<td>20.8%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Syracuse</td>
<td>732,117</td>
<td>18.0%</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

* HMO penetration data were adjusted to better reflect the geographic definition of Boston in the Community Tracking Study.

Managed Care Plans’ Changing Strategies

Managed care plans historically have relied on two key strategies to enable them to offer expanded benefits with limited financial responsibility for consumers and cost containment for employers and other purchasers. One is to use traditional managed care technology—limited provider networks, primary care gatekeeping of access to specialty services, medical necessity authorizations, and negotiated payments including provider risk sharing—to aggressively control health care costs. The second is to grow plan membership to gain leverage in provider negotiations and achieve economies of scale. Plans have pursued this strategy, at times forgoing near-term profitability, through low pricing, adding new product lines, and market expansion.

Between 1999 and 2001, plans departed sharply from these two strategies, through three strategic shifts: offering less restrictive products and product features; reconstituting their often adversarial, friction-ridden contracting relationships with providers in order to establish a more peaceful coexistence; and focusing more clearly on profitability than on growth in market share.

- **Offering less restrictive managed care products.** Virtually all of the more than fifty plans interviewed are adding less restrictive products to their product mix and revamping existing products to relax restrictive features. Some of this repositioning is a response to regulatory impositions prompted by consumers and providers who
“The distinction between HMOs and PPOs is becoming less clear as HMOs offer broad provider networks and no gatekeeper.”

are unhappy with certain aspects of managed care. By offering consumers greater flexibility and choice and providers more autonomy and control, plans hope to reduce dissatisfaction with managed care.

New products. In the first two rounds of site visits, managed care plans in several communities were beginning to move toward offering products that gave consumers fewer restrictions, more choice, and enhanced flexibility. In the latest round of site visits, the movement toward such products was even more apparent, as all but one of the communities saw the addition of HMO products that did not require a gatekeeper.

The drive to offer new, less restrictive products is especially noteworthy in markets with high HMO penetration rates (Exhibit 1). In Phoenix, for example, United Healthcare’s direct-access product reportedly accounts for the majority of its membership; four of the market’s other largest plans introduced similar direct-access products during the past two years. In Miami the success of United Healthcare’s direct-access HMO in attracting new business has prompted other plans in the market to introduce similar products during the past two years; several plan executives in Miami note that offering direct-access products was important because of high market demand, especially in acquiring new accounts.

The distinction between HMO and preferred provider organization (PPO) products is becoming less clear as HMOs increasingly offer broad provider networks and no gatekeeper. Premium differences between HMOs and PPOs are shrinking as well. In Seattle, plans report that prices in HMOs have increased more rapidly than prices in PPOs. Similar price convergence between HMOs and PPOs, which some respondents attribute to a disproportionate regulatory burden on HMOs, has been reported by plans in Greenville, Indianapolis, Lansing, Little Rock, Phoenix, Seattle, and Syracuse.

As health plan enrollment migrates toward less restrictive products, the market position of traditional HMOs such as Kaiser and PacifiCare becomes less clear. Some traditional HMO companies report diversifying their product mix in response to changing preferences. In a number of markets, for example, PacifiCare is actively developing a PPO product to offer employers as an alternative to its traditional HMO product (and to reduce its reliance on Medicare–Choice). The challenges of product diversification by traditional HMO companies are noteworthy, however, because many of
these companies delegated major administrative functions and responsibilities to their network providers and never developed the infrastructure to operate a traditional insurance business.

Existing products revamped. Evidence from the latest round of site visits in 2000–2001 compared with the earlier site visits indicates that managed care plans are also increasingly moving to eliminate or relax many of the controls associated with the heavily managed products, such as the traditional HMO. In all twelve communities, plans report moving away from requiring preauthorization for health care services to a prenotification process, although the level to which this has occurred varies both within and between markets. Plans in several communities have relaxed their preauthorization requirements in response to new legislation. In Boston, for example, new state regulations require plans to send detailed letters to members and physicians for each utilization management decision made, whether favorable or unfavorable. Respondents say that some plans in Boston have relaxed their preauthorization requirements to avoid the administrative burden and costs associated with these new communication rules.

Plans also are relaxing restrictions by streamlining the referral process, and some plans report having eliminated the process altogether. In Lansing, where plans say that the greatest source of member dissatisfaction is the referral requirement, several plans are moving to an electronic system that should simplify and speed up the process. Plans in Miami and Seattle report similar movement towards a simplified referral process.

Managed care plans in the twelve communities are looking for other innovative ways to loosen controls. In Orange County, for example, Blue Cross of California is attempting to reposition the gatekeeper function as a "medical concierge" to fill a more facilitative and coordinative role rather than being an impediment to members seeking care.

Aside from relaxing their cost control practices, some plans are also pursuing other, "softer" approaches to consumers that feature direct interaction with members. Several plans are promoting electronic information exchange and communication. Others report increased use of condition-specific case management and disease management programs during the past two years. Some plan respondents were skeptical that such initiatives could contain costs and improve clinical outcomes for members with chronic conditions such as asthma and diabetes. But other plan respondents appreciated the opportunities that case management and disease management programs created for plans to work directly with their members.

Seeking less contentious contractual relationships with

HEALTH PLANS & THE MARKET

HEALTH AFFAIRS - January February 2002
providers. Managed care plans are seeking to rebuild damaged relationships with providers, which have become increasingly fractious. Plan executives acknowledge that contentious relationships with providers are costly for plans because they increase the cost of contract negotiations, consume a large amount of resources trying to mediate, and often result in considerably higher payment concessions than may have occurred otherwise. Various respondents say that these disputes also foster distrust between plans and providers, which, although less tangible, is difficult to dispel and sows disharmony in negotiations and other dealings. These ill feelings also may get passed along to consumers, who then become less satisfied with their managed care plan.

Providers' pushback on plans. It was evident during the second round of site visits that providers were pushing back against managed care plans and their practices; this “pushback” had gained considerable momentum in all twelve communities in the recent round. Across markets, providers cite various reasons for their dissatisfaction with managed care, including low payment rates and loss of autonomy. Also, providers say that plans’ poor business practices, such as their failure to pay claims promptly and their seemingly arbitrary service authorization denials, also contribute to providers’ dissatisfaction.

Conflicts arising from these issues have led to deteriorating relationships between plans and providers, often resulting in contract terminations and network instability. In Orange County, for example, St. Joseph’s Health System cancelled its contract with PacificCare in the fall of 2000, affecting nearly a third of the plan’s local enrollment. In Seattle more than 150 specialists cancelled their contracts with Regence Blue Shield in December 1999; the situation prompted several large employers to seek performance guarantees from the plan, holding the plan financially accountable for providing a broad and stable provider network. Additional evidence from the recent site visits indicates major tensions and flare-ups in plan-provider relationships in Boston, Greenville, Miami, northern New Jersey, and Phoenix. In some instances, leverage gained by providers because of consolidation also has helped to fuel tensions.

Providers’ resistance to risk-contracting arrangements. When the first round of site visits was conducted in 1996–1997, health plans and providers were anticipating rapid enrollment growth in HMOs. They were actively preparing for—and in some markets, such as Orange County, already engaged in—risk-contracting arrangements. Two years later, as risk-contracting organizations began to fail, costs such as those for pharmaceuticals started to soar, backlash against managed care grew, and regulatory scrutiny of risk relationships increased. Plans and providers were growing more cautious of risk-contracting. 

By the 2000–2001 round of site visits, many of the changes occurring in the markets had made risk-contracting less attractive. In Orange County, contract negotiations were beset by changes. In Lansing, they having failed, they have little interest in pursuing them.

In some markets, the interplay between plan and provider leverage in setting rates for example, in Connecticut, providers seeking the organization was clear. In Boston, the presence of competitive networks, with their ability to offer full-risk plans, also have pressures for moving away from risk-contracting.

Shifts in risk-contracting arrangements for the past few years of uncertainty have been intense pressures for health plans with the years of uncertainty also restoring competitive bidding, keeping premiums from unreasonably high. Large plans in markets, such as Miami, for example, have felt intense pressure to keep pace with increasing premiums across emerging competitors, and find that they must develop new strategies to attract new enrollees.
risk-based contracting arrangements.\textsuperscript{11}

By the most recent round of site visits in 2000–2001, some providers in markets where risk arrangements were common, including markets with high HMO penetration such as Boston, Miami, Orange County, and Phoenix, report aggressively resisting risk-contracting arrangements with plans and demanding major changes. Plans and providers in other markets, including Greenville, Lansing, Little Rock, northern New Jersey, and Syracuse, say that they have essentially rejected risk contracting and have little, if any, interest in pursuing these types of arrangements in the future.\textsuperscript{12}

In some markets, changes in risk-contracting arrangements between plans and providers are expected to defuse or forestall some provider pushback brought about by providers' displeasure with low and often declining reimbursement levels. In Orange County, for example, risk arrangements continue, but plans report paying providers much higher rates, taking back pharmacy risk, and weakening the impact of government mandates on provider risk-bearing organizations. Although risk contracting also remains prevalent in Boston, there has been some decline in the number of these arrangements, with plans paying much higher rates to providers to ensure network stability. In Miami, United Healthcare began converting its full-risk physician contracts to individual FFS arrangements during the past two years. In Phoenix, respondents report that FFS arrangements for physicians and per diems and case rates for hospitals also have been rapidly replacing risk arrangements.

\textbf{Shifting emphasis to safeguarding profitability.} The noted shifts in managed care strategies have created significant cost pressures for plans, and they continue to do so. These trends coincide with the turn in the underwriting cycle, as financial losses from years of underpricing to gain market share led plans to focus on restoring profitability. By 2000–2001 plans were responding by raising premiums, eliminating marginal lines of business, and retreating from unprofitable markets to alleviate or avert eroding profitability.

Large premium increases. In the first two rounds of site visits in 1996–1997 and 1998–1999, plans in the twelve communities reported intense price competition, particularly among new market entrants and existing plans launching new products.\textsuperscript{13} By the most recent round of site visits in 2000–2001, managed care plans, struggling to keep pace with rapidly rising medical cost trends, were levying large premium increases on purchasers—increases averaging 11 percent across employer groups nationally.\textsuperscript{14} In many communities employers find that plans are no longer willing to use pricing strategies to attract new members. Small employers have been hardest hit. In Miami, for example, employers with fifty or fewer employees are