reportedly facing premium increases in excess of 20 percent—more than double the increases for larger employers. Similar premium spreads are also reported in Greenville, Little Rock, and Seattle. Many plans report emphasizing features other than price—including broad and stable networks, responsive customer service, high quality, and firm reputation—to sell their products.

**Higher consumer cost sharing.** To mitigate large premium increases, managed care plans had begun to implement higher consumer cost sharing for some services, and this trend was widely expected by plan respondents to increase as the labor market softened. In all twelve communities, three-tier pharmacy benefit structures have been implemented for commercial products. Both between and within markets, however, the level of consumer cost sharing varies greatly among the tiers. Plans also have adopted market- and plan-specific changes in consumer cost-sharing arrangements, often with major customization by the individual purchaser. In Lansing, for example, Blue Cross and Blue Shield of Michigan recently implemented a fivefold increase in the physician office copayment for General Motors employees (raising it to $10 from $2). In Miami, United Healthcare nearly tripled its emergency room copayment. In Orange County, Kaiser instituted for the first time a copayment for emergency room visits, which the plan reports many employers opted out of by paying higher premiums.15

**Reduced rate guarantees and premium caps.** Managed care plans also are reducing—and, in some cases, eliminating altogether—multiyear rate guarantees and premium caps for purchasers, which had been prevalent in some markets since 1996. In Seattle, as multiyear contracts have expired during the past two years, plans report moving away from these types of arrangements. Plans in Boston, northern New Jersey, and Phoenix report taking similar steps.

**Fewer unprofitable lines of business.** In 1996–1997 managed care plans in the twelve communities were actively developing new lines of business—including Medicare risk, Medicaid, small-group, and individual insurance products—in an effort to increase their market share. By 1998–1999 plans had begun to lose optimism about some of these products.16 By 2000–2001 there was a definite shift among plans in some markets to retreat from or eliminate lines of business deemed unprofitable.

This retreat has been most dramatic in Medicaid and Medicare. In Cleveland, Greenville, northern New Jersey, and Seattle, plans have eliminated their Medicaid product lines, citing poor financial performance as the major reason. Historically, plans have expressed little interest in participating in the Medicare-risk business in low-payment markets such as Greenville, Indianapolis, Lansing, or
"As plans move to less restrictive managed care products, they lose their ability to control costs."

Syracuse. Now, interest in participating in this line of business is waning in other markets as well. Exceptions are Miami, Orange County, and Phoenix, where Medicare managed care penetration continues to exceed 40 percent and plan participation is more prevalent. Many plans remaining in the Medicare-risk line of business report having instituted premiums and reduced and/or eliminated pharmacy benefits in an effort to curb financial deterioration. Others have engaged in "silent withdrawals" by eliminating marketing efforts or freezing enrollment.

Although plan exits from public-sector programs such as Medicare have been more highly publicized, plans have also ceased or severely curtailed their participation in other lines of business deemed financially unsustainable. In Greenville and Little Rock, for example, some plans report eliminating their small-group product lines; and in Seattle all major plans serving the individual insurance market report closing enrollment to new members. In several markets, including Little Rock and Syracuse, CIGNA stopped offering an HMO product after failing to gain sufficient membership to ensure the product's financial viability. Reportedly, many of the affected members moved to CIGNA's PPO.

Retreat from market expansions. In both 1996-1997 and 1998-1999 plans in the twelve communities were actively pursuing market expansion strategies, often entering multiple states, to grow market share. A key component of these strategies was to enter markets with products offered at prices considerably below those of competitors.

During the past two years these approaches have proved financially burdensome for some plans. In Boston, for instance, financial losses during the past several years have forced Harvard Pilgrim Health Care and Tufts Health Plan to greatly retreat from service areas in other New England states. An unsustainable pricing strategy in the expansion markets was a major factor cited in the financial difficulties for both plans. Following an unprofitable attempt to enter and build membership in California, United Healthcare is withdrawing from most markets in the state, including Orange County. In Seattle, QualMed Health Plan reportedly withdrew from the market for financial reasons as well.

**Implications Of Plans' Changing Strategies**

For the nearly eight in ten privately insured consumers nationwide
who are enrolled in some form of managed care, including eighty
million HMO enrollees, changes in managed care plans' strategies
have particularly important implications. As plans move to less
restrictive managed care products, they lose their ability to control
costs. This trend is likely to contribute to further premium in-
creases, leading to fewer affordable insurance options for employees,
particularly employees of small firms—a situation that is likely to
raise uninsured rates and increase pressure on public programs.

If employers' health care costs return to rates of increase experi-
enced in the early 1990s, they are likely to look for relief in a number
of ways. Less expensive products are an option, including products
with greater restrictions such as limited or tight provider networks.
In the near term, however, greater financial responsibility on the
part of employees is more likely, particularly when the preservation
of choice and flexibility are important. The option of less expen-
sive products is already evident in the use of cost-sharing tiers for phar-
macy benefits, and the option is likely to be applied to provider
network structures (such as tiered provider networks) and other
benefits in the future. Some employers may drop coverage or raise
employees' premium contribution levels. More extreme versions of
employee financial responsibility could include some type of
defined-contribution strategy for employers, although widespread
movement in this direction is not yet evident.

Plans' movement toward less restrictive managed care, especially
via non-HMO products such as PPOs, has additional implications.
First, the less restrictive products typically do not offer comprehen-
sive benefits, which is the hallmark of HMOs. Features such as
disease management, preventive care, and wellness programs are
usually not a part of non-HMO products, although employers have
the option to pay extra for them. Second, less restrictive products
make risk-based contracting between plans and providers less fea-
sible, because plan members have more freedom to seek care from
providers other than those in risk-bearing provider groups. What-
ever influence risk contracting has in helping to control costs, there-
fore, could be eroded.

Third, shifting enrollment to more loosely managed non-HMO
products is likely to result in an overall weakening of plan account-
ability. Industry performance standards, including the National
Committee for Quality Assurance's Health Plan Employer Data and
Information Set (HEDIS), are primarily HMO-based, as are many
states' efforts to provide consumers with plan comparison data. In
addition, state licensure and reporting requirements typically are
applicable to or more stringent for HMO products than for non-
HMO products. Consequently, consumers are likely to have less
information available to assess the performance of health plans when making decisions about insurance coverage and services.

Product line and market exits are likely to create major service disruptions for some consumers—notably, the seventeen million Medicaid and Medicare beneficiaries enrolled in managed care and the many persons who obtain health insurance from the small-group and individual insurance markets. From 1998 to 2000 the number of plans serving Medicaid beneficiaries dropped 15 percent nationally. In Medicare the two-year decrease was 20 percent. The withdrawal of plans from these public programs presents a formidable challenge for program administrators and policymakers, who must ensure adequate capacity to serve beneficiaries. Indeed, recent experience suggests that the underwriting cycle—and the associated cyclical nature of plans’ expansion and retreat activities—promises that this will be a recurring challenge for public programs that rely on the private health insurance market. Similarly, this phenomenon is likely to present enduring challenges for consumers in the small-group and individual insurance markets. For those affected by plan retreats in these markets, securing new, affordable coverage will be difficult, if not impossible, because plans’ participation in these lines of business is limited in most markets. Service disruptions are inconvenient and may have adverse health consequences for consumers.

**Managed Care’s Future**

Although evidence from the latest round of CTS site visits indicates that managed care is continuing to evolve, an important question is, What is the durability of managed care’s most recent strategic shifts? Much of this will depend on purchasers. Shifting strategies of health plans—moving to less restrictive managed care, rebuilding relationships with providers, and safeguarding profitability—were implemented at a time when national and local economies were particularly robust with tight labor markets and general prosperity. Should cost concerns lead purchasers to revert to their aggressive posture of the early 1990s, managed care plans may find that their recent strategy shifts will have to be reconsidered.

It does not appear, however, that an inflection point has been reached or that the pendulum has started to swing back yet. As medical inflation continues to increase and the economy weakens, a major challenge for plans will be to balance marketplace preferences for less restrictive care while at the same time holding down costs when purchasers finally conclude that they cannot or will not absorb large price increases. The end of managed care as we know it could be upon us, as some have suggested, but the search for afford-
able health care will continue. What role managed care plans will play in this search merits close tracking.

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NOTES
1. For additional details, see the special issue on the managed care backlash, *Journal of Health Politics, Policy and Law* (October 1999).
2. HMO enrollment declined by nearly 1 percent between 1999 and 2000. During this same period the number of HMOs in operation declined by nearly 9 percent, from 613 in 1999 to 560 in 2000. *InterStudy Competitive Edge III, Part II: HMO Industry Report* (St. Paul: InterStudy, 2001).
8. Prenotification differs from precertification in that the former does not require a medical necessity review by the plan before care is authorized. Prenotification provides plans with a mechanism to identify, early on, potentially high-risk, high-cost members who may require more active care management.
“Update on the Nation’s Health Care System.”

10. From the twelve study sites there are numerous examples of plan-provider confrontations. For further details, see B. Strunk, K. Devers, and R. Hurley, Health Plan-Provider Showdowns on the Rise, Issue Brief no. 40 (Washington: HSC, June 2001).


12. Ibid.


14. Throughout the early 1990s medical cost trends were decreasing, but in 1995 that trend reversed. Since then medical inflation has been increasing with the most dramatic changes occurring since 1998: Health care spending per person rose nearly 7 percent in both 1999 and 2000. See B.C. Strunk, P.B. Ginsburg, and J.R. Gabel, “Tracking Health Care Costs,” <www.healthaffairs.org>, 26 September 2001.


17. Across the twelve markets the number of plans participating in Medicare+Choice dropped from sixty-five to forty-six between the 1998–1999 site visits and the most recent round. In Miami, Orange County, and Phoenix the higher Medicare managed care penetration rates are not accounted for by payment rate alone. For example, the 2002 Medicare payment rates for these markets are $834 in Miami, $640 in Orange County, and $553 in Phoenix. For additional details, see R. Hurley, B. Strunk, and J. Grossman, “The Medicare Managed Care Lifecycle” (HSC Working Paper, August 2001).


19. These plans have renewed attempts to expand geographically by contracting with a national PPO to serve employers with out-of-state workers.


22. InterStudy Competitive Edge II, Part II: HMO Industry Report. Of the seventeen million Medicaid and Medicare managed care consumers, eleven million are in Medicaid and six million are in Medicare.

23. Ibid. The number of plans participating in Medicaid decreased from 254 in 1998 to 215 in 2000, although not all plans participating in Medicaid are listed in the InterStudy report. The number of plans serving Medicare beneficiaries decreased from 273 in 1998 to 219 in 2000.