

MANAGED CARE

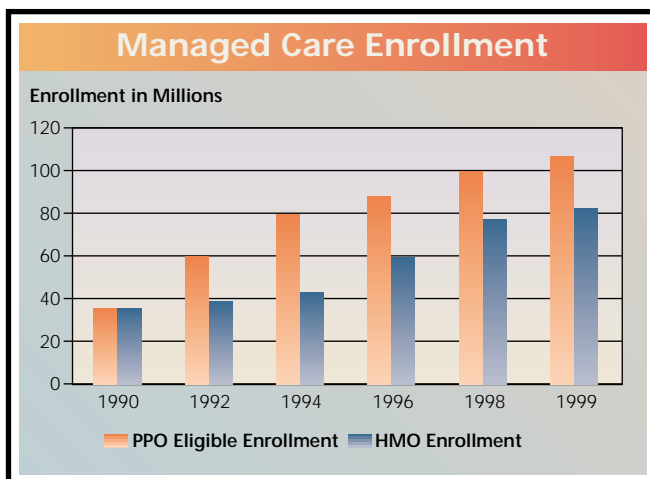
REPORTS OF ITS DEMISE ARE PREMATURE

By Howard J. Bolnick

"Health plans in the marketplace have failed to control health care costs, and they have failed to fill the gaping voids in coverage. Yet politicians continue on a path to increase the involvement of these failed models of 'reform' by expanding their participation in our public programs. . . It is long past time for our nation to open up the dialogue on replacing these antiquated health plans. . ."

The New York Times
Letter to the Editor
December 26, 2000

"Failed models . . . antiquated." Is this the fate of managed care after such a brief existence? Today we may operate at Internet speed, but has managed care really failed so catastrophically and so soon? Do we need a replacement? Or, as I believe, have we simply reached a plateau in managed care effectiveness that requires refined strategy before we move forward again?



Managed care enrollment has exploded in the 1990s. HMOs report enrollment growth of 244% to 81.3 million people in 1999 (source: InterStudy). PPOs report even more spectacular growth of 310% to 106.5 eligible enrollees (source: American Association of PPOs).



Managed care has been effective. It has provided tens of millions of Americans with lower cost health care without any documented interference in our health. It has grown from nearly nothing only a few decades ago to cover as many as 190 million Americans, depending on how we define managed care. It has totally changed the competitive landscape. In the 1970s, large mutual insurance companies dominated health insurance: Equitable, Prudential, Metropolitan, and John Hancock were leading brands. Health maintenance organizations (HMOs) such as United Health Care, Aetna, Kaiser, and Wellpoint, many of

Managing costs is not the same as managing care, as many HMOs have discovered to their detriment.

© SIS/CHRISTOPHER BALDWIN

which didn't even exist when mutual insurers ruled the roost, dominate today's marketplace.

So, how did managed care come so quickly to be charged by many critics as "failed" or "antiquated"? And what does this current bout of general scorn mean for their future?

Founders of managed care expressed an original vision for their new approach to health care that was based on four basic premises.

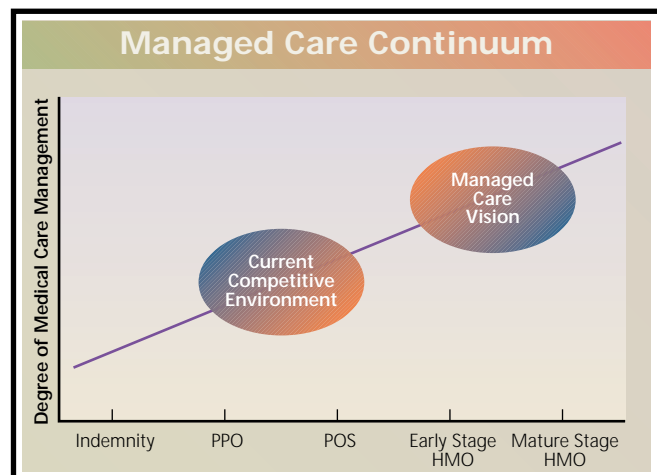
- *Evidence-based medicine.* Managed care was intended to facilitate replacement of the "art" of medicine with a "science" of

medicine. Despite a strong scientific basis in the study of the human body and human disease, medical practices have rarely been subject to thorough scientific investigation. As John E. Wennberg of Dartmouth so clearly showed in his widely cited studies of variations in medical practices by area, what has developed in the healing arts is a wide range of expert opinions about how to approach solving various medical problems.

For example, Wennberg found that in 1994-1995, the rates of back surgery, carotid endarterectomy, lower-extremity bypass, and radical prostatectomy varied from 6:1 to 10:1 by hospital referral area, despite evidence that the underlying pathology didn't differ nearly as much (*The Dartmouth Atlas of Health Care* 1998). Managed care held out a hope that widespread use of capitated provider payments would encourage clinical effectiveness studies that, in turn, would result in a beneficial shift from "art" to "science" in the healing professions.

- *Health prevention and maintenance.* Long-term relationships between providers and patients are an ideal setting for encouraging preventive measures, developing incentives for lifestyle changes, and carefully managing chronic disease. Managed care plans were seen as having potential to provide such settings. It was hoped that managed care, through health promotion and health maintenance programs, would improve the quality of health care while, at the same time, lowering costs by reducing acute and chronic disease.

- *Medical care delivery by accountable, interrelated medical professions and facilities.* By creating strong, ongoing, exclusive relationships between providers and managed care plans, a different type of interaction and incentives would develop among medical professionals. Instead of discontinuous, uncoordinated movement of a patient through unrelated medical practitioners and facilities, managed care held out the hope for co-



This chart depicts how the current array of managed care plans fall short of the original managed care ideal. Rather than having evolved to competing mature-stage HMOs, competing health plans range from preferred provider organizations (PPOs) to early-stage HMOs. Characteristics of PPOs are far enough removed from the ideal that they were not even thought of as effective managed care plans for many years.

ordinated care among institutionally related practitioners and facilities. This would establish a continuum of care with providers that share a common vision for how best to provide high-quality health care. This managed continuum of care would also allow an effective response to managed care plans' use of capitated provider financial incentives.

● *Value-based medical care purchasing.* Managed care was also designed to appeal to purchasers of medical care, generally businesses, that pay for most of their employees' costs. Managed care held out the hope for introducing important factors other than cost to the purchasing decision. Ideally, health outcomes and quality indicators would be available that prove the notion that lower-cost managed care is also high-quality care. Armed with quality data, businesses would be motivated to choose managed care plans that could "prove" they add value to businesses' health care purchases.

These four basic premises sound quite idealistic to us today—and, of course, they are. Managed care, as it has evolved since its originators espoused this vision, has fallen well short of these ideals. An assessment of the current internal and external competitive environment reflects these realities.

Perhaps the most notable internal reality is that managed care plans, to date, have depended far more on managing costs than managing care. Focus on costs, rather than care, occurred for a number of interrelated reasons.

Perhaps the biggest barrier arose from difficulties inherent in determining an optimal course of care. Developing scientific practice guidelines is a daunting task. Organizing and conducting studies of the literally thousands of medical procedures and their complicated interactions in multiple disease situations requires a wide base of study resources (researchers, data, and patients), many years, and large amounts of money.

The usual difficulties in marshaling these resources have been compounded by the lack of a compelling widespread interest from providers and medical facilities in helping to design and conduct studies. Two problems feed this trend.

First, managed care had envisioned the migration of historically independent providers and medical facilities into interrelated, often integrated, medical care provider organizations. These large organizations would have provided the scale needed to manage care based on capitated payments and the resources to conduct large-scale clinical effectiveness studies.

Unfortunately, this hasn't happened. Providers almost always maintain a large number of managed care contracts—far too many for them to identify themselves as part of any single managed care plan.

Second, in most areas, capitation has not become a significant means for compensating and motivating providers. Had capitation become the norm, providers might have had a strong financial incentive to conduct medical outcomes studies.

Internal realities mirror external (customer) realities. As discussed above, managed care was supposed to be based on competing, minimally overlapping networks of providers and facilities. Businesses, their employees, and individual purchasers, though, didn't find minimal or closed-panel managed care plans attractive.

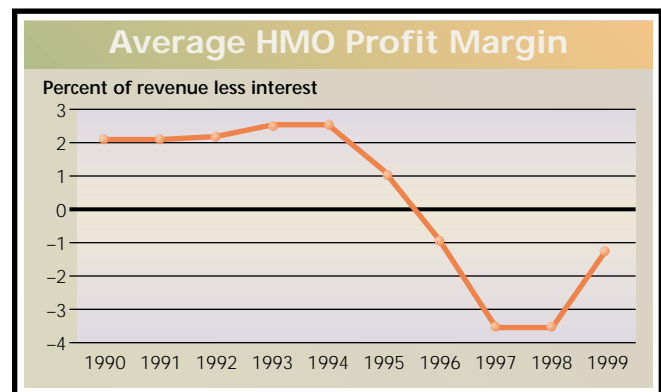
Marketplace success is often based on the popularity of minimally constrained health care systems. The most attractive plans—HMOs and preferred provider organizations (PPOs)—are forced to include most local primary care physicians and facilities and to provide direct access to medical specialists. This externally attractive competitive characteristic clearly found wholehearted support from providers that resisted pressures to change their economic incentives and to give up their status quo practices.

Thus, rather than creating an environment in which providers banded together around mature HMOs, learned how to truly manage care, and prospered under capitated payment systems, providers have tended to stay financially and organizationally independent of managed care plans and have joined a wide array of plans based largely on their giving fee discounts to HMOs and PPOs.

This environment undercut the financial and organizational incentives for true, scientific care management, and significantly delayed medicine's movement in this direction. It created an environment that sustains theoretically less effective PPOs. And, by delaying the use of scientific standards, it encouraged continued use of prescriptive, intrusive forms of care management. These consequences have created significant barriers to further movement toward mature HMOs.

The growth of managed care has led to shifting competition. In the infancy of HMOs, competitors were large mutual life insurance companies. After struggling for more than a decade, in the late 1980s a small number of HMOs began enjoying lower costs than traditional health insurance plans, despite HMOs, generally higher benefits.

The time had finally come when HMOs found it relatively easy to increase market shares. Successes led to competitive shifts. Initially, rapid growth in the number of HMOs continued to build their aggregate market presence at the expense of traditional health insurance coverage. Some traditional indemnity insurers successfully countered this growth by developing PPOs. Other traditional insurers exited the market as their profits fell to unsustainable low levels. The result was that managed



As competition among HMOs and between HMOs and PPOs heated up, and as providers adopted aggressive contracting tactics, profit margins dropped precipitously (source: InterStudy).

care (including both HMOs and PPOs) has become the predominant form of health coverage.

In the mid-1990s, managed care plans stopped competing with their easy-to-beat traditional health insurance rivals and began competing head-on with other managed care plans. Limited by a failure to truly manage care, HMOs have been unable to distance themselves from well-run PPOs, resulting in today's marketplace with its large number of managed care competitors.

Managing costs rather than managing care, the continued popularity of minimally constrained health care systems, and shifting competition have resulted in managed care not having continued its climb up the managed care continuum toward effective competition among mature HMOs. Instead, we find ourselves "stuck" in today's far less effective reality of competition based on a fairly level playing field among PPOs, point of service (POS) benefit plans offered by HMOs, and HMOs.

Two potentially serious problems have arisen in today's competitive environment: customers and providers are reacting negatively to managed care plans' operating methods, and plans' historically high profits have dropped, at least temporarily.

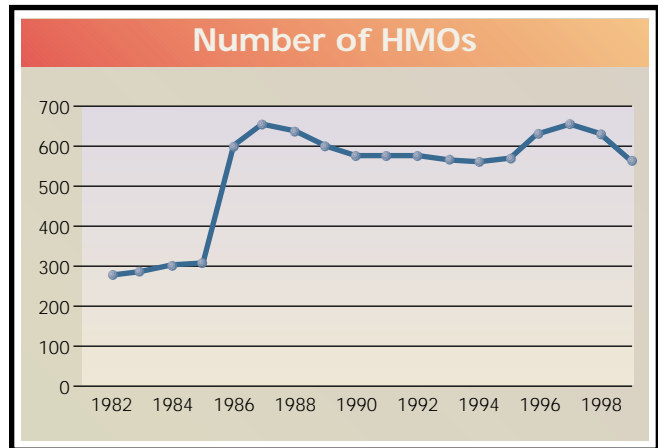
In today's era of modestly effective managed care, most providers and some patients experience frustrations with intrusive care management. In addition, providers developed disdain for managed care plans' continually squeezing their fees and concerns about their own administrative costs and inefficiencies caused by maintaining multiple managed care plan relationships. These problems have led to a severe managed care backlash.

Managed care bashing has become a popular media pastime. This is true despite a recent Harris Poll showing a continued high level of customer satisfaction with their own health plans (69 percent of respondents rate their own plans as A or B). Media anecdotes about poor practices have led to legislative inquiry and legal restrictions such as drive-by delivery laws, emergency room access requirements, constraints on provider gag rules, and, most notably, wide-ranging state and federal interest in patient protection laws. This media-driven backlash has also spurred interest from successful, tobacco-fee-rich plaintiff's attorneys in making HMOs their next big victim.

A more level and larger competitive playing field has ended the years of plenty for HMOs and PPOs. More competitors, with a lack of clear differentiation among them, and more aggressive provider contracting tactics have led to lower profit margins. The days when managed care plans could "shadow price" their higher-cost traditional insurance company competitors while reaping high growth rates and high profit margins may be over forever.

More recently, the period 1997 to 1999 has seen a drop in historically high membership growth and a severe drop in profits. In fact, the majority of HMOs have experienced losses. But the news seems to be getting better: Weiss Ratings reported an aggregate HMO industry profit for the first half of 2000.

Similar trends can be expected from PPOs. However, because of the organization and legal standing of these plans, meaningful aggregate PPO data are quite hard to find.



While the number of HMOs is relatively stable, small plans without enough clout to obtain sizable and salable provider discounts or to operate at competitive administrative margins are being forced to leave the market.

New Direction Needed

It's easy to see how managed care might be considered antiquated. But does this mean managed care is finished? I doubt it. Managed care, however, is clearly at a strategic crossroads. To respond to the current malaise, managed care needs to find new vitality and new paths to continued success. This requires a new vision, a clear and relevant statement of competitive value added, and a choice from among new competitive strategies.

Given our more than two decades of experience with managed care, with its healthy dose of reality, the original vision for managed care is in need of change. However, I will argue that needed changes are refinements backed by hard work, and not a total rewrite.

Looking at each point of the original managed care vision, I would suggest the following refinements.

Evidence-based medicine is still essential to our vision. We do need to recognize the large-scale task involved with developing scientific clinical guidelines and the institutional barriers that exist to getting the job done. However, if managed care is to progress, and I believe that it will, managing care must become even more important than managing costs, and clinical effectiveness studies must underlie this change.

A fundamentally important question for the future of clinical guidelines is who will develop and control this information. As noted above, managed care plans have generally developed intrusive and prescriptive approaches to guidelines. This much derided "cookbook" approach has had modest success. For example, hospital days per thousand, which have been a major focus of prescriptive guidelines, have dropped significantly. And a marked slowdown in the growth of U.S. health care spending is widely attributed, at least in part, to a shift to managed care. However, this success has been buried beneath disdain for the methods used.

Effective managed care must get past these often bureaucratic barriers. To accomplish this, physicians need to develop and im-

plement successful guidelines using information sharing and mutual learning experience strategies. Managed care plans' main challenge is to develop the institutional environment to facilitate physician-to-physician learning and to allow a supportive care management environment to develop and flourish.

Gaining value from a focus on health prevention and maintenance will be far more difficult and less effective. This is because long-term relationships between patients, providers, and managed care plans are very hard to develop. In a world characterized by employee turnover, options to choose from among various health plans, and multiple competing health plans, long-term relationships will remain the exception, not the rule.

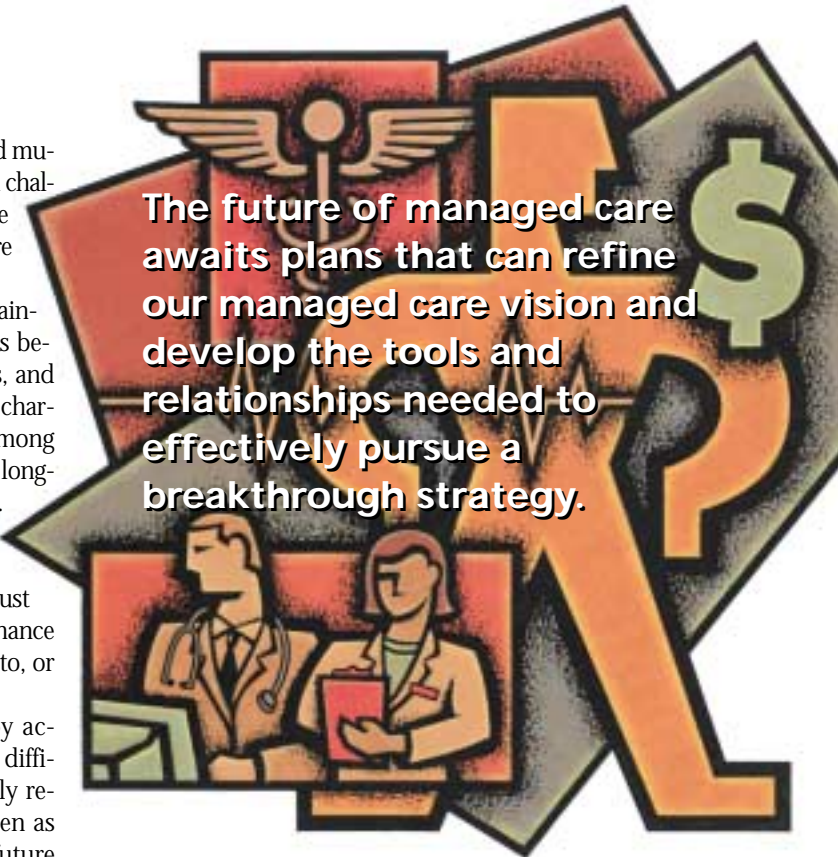
In addition, the initial hype has been replaced by a far more realistic understanding that good preventive medicine doesn't result in large cost savings. Therefore, our vision must be refined to recognize that health prevention and maintenance have limited value, but that this value isn't likely to accrue to, or to be aggressively pursued by, a single managed care plan.

Envisioning a future with medical care delivered by accountable, interrelated professionals and facilities is also difficult. Future generations of providers will almost certainly remain relatively independent of managed care plans, even as group practice continues to grow. This implies that the future won't find us with unique relationships among providers, health care facilities, and managed care plans. An environment with multiple relationships will continue to exist.

We can, though, expect to develop virtual relationships on the Internet between largely independent providers and managed care plans. Virtual relationships will need to be strong enough to allow managed care plans to create value added from their provider relationships. Strong virtual relationships will be based on patient flow, information sharing, and voluntary physician participation in a quest for better care management. While capitation arrangements will exist, solid virtual relationships won't depend on capitation for their success.

Value-based medical care purchasing seems likely to be a bust. It needs to be replaced with something similar, something that satisfies real needs and desires of non-provider stakeholders (members, patients, businesses and other purchasers, and government). A lesson still being learned is that solid information about health plan quality is hard to obtain. Competition for members in the future will still be based heavily on price. Quality information may help sophisticated purchasers, and certainly needs to become an integral part of managed care plans' care management and administrative oversight. But I don't believe quality information will have the powerful effect on consumers that was originally envisioned.

This refined vision for managed care emphasizes effective evidence-based medicine developed and utilized in a supportive learning manner, less emphasis on health prevention and maintenance, development of effective "virtual" communities of independent providers, and more concern for smoothing out the "rough" edges of today's managed care that cause customer backlash. This is a refined vision for a health care environment that is much more effectively managed than today, and, may well be



The future of managed care awaits plans that can refine our managed care vision and develop the tools and relationships needed to effectively pursue a breakthrough strategy.

as effective as the original vision in its management of health care resources. We can reach the original goals for care management outcomes by using different, more acceptable means.

To a large extent, a refined vision for managed care requires less of managed care plans themselves and more of providers with virtual relationships to the plans. This shift in responsibilities means an adjustment in managed care plans' value-added proposition and a refocusing of their business strategies and tactics.

A properly refocused managed care plan will produce value added from a number of key strategic activities.

- *Information* will underlie value added in care management. To effectively manage care, providers need information about patients' medical care needs, best demonstrated medical practices, and comparative information about providers' performances versus a "standard."

Useful information must be delivered to providers as needed. This information will come from the enormous data-handling capacity, sophisticated analyses, and sophisticated information technology (including the use of Internet applications) developed by successful managed care plans.

- *Organized networks of providers with effective virtual relationships to managed care plans* need to develop and maintain interest in managed care plans' sophisticated information. This will enable them to make effective use of these extremely valuable resources.

To be effective, virtual relationships need to be built around managed care plans that have large local market shares. Without providing significant portions of providers' patients, there is no real reason for providers to value a plan's information and technology, making any virtual relationships ineffective.

- *Provider discounts* will still be an essential ingredient in managed care plans' success. Discounts provide a base of cost savings

to which savings from effective care management can be added.

- *Low-cost, highly effective, and efficient administration* will form another key component of managed care plans' value added. A need for significant local market shares means that successful managed care plans must appeal to their customers' needs and concerns. Innovative products, ease of customer interface with providers and plan administration, ease of provider interface with plan administration, and efficient and effective distribution will all be attributes that contribute to meeting this need.

Our refined vision and value-added propositions apply to a future in which competition moves from today's moderately effective plateau toward a more effective managed care market. This won't happen in all local managed care markets or for all managed care plans. All managed care plans, though, will have to place their own strategic bets on how managed care will evolve in their local markets and decide how they intend to compete.

The likely evolution of managed care provides senior executives and boards with four high-level options for their organizations:

- Making a commitment to planning and executing a breakthrough to the refined vision;
- Deciding that current market realities are as good as it gets;
- Thinking of their organization as just another insurance company with a different (HMO or PPO) label;
- Deciding that the organization sees no solution and de-emphasizes health or exits the market.

A managed care plan embarking on a breakthrough to the refined vision will need to design and execute a number of new competitive strategies and tactics:

- High local market share becomes a competitive imperative;
- The plan will need to develop, properly introduce, and manage sophisticated information and technological dissemination strategies;
- Local providers need to be organized using a virtual relationship based on a cooperative physician-to-physician model;
- The plan will need to address customer and provider concerns about managed care;
- The importance of information and administrative ease will almost certainly lead to the need for effective use of the Internet as the primary information-gathering and information-sharing tool.

These strategies are based on a number of interrelated competitive attributes: significant local market share; effective proprietary medical management information used by a virtual network of mutually supportive providers; sophisticated technology; and low-cost, effective, and efficient administrative services. This combination of attributes will result in lower-cost, high-quality medical care, weak local competition, and good customer and provider relationships. This is a prescription for a sustainable competitive advantage and a solid profit margin.

Another option for management is to decide that the current competitive environment is as good as it gets. If competing plans are either unwilling or unable to break through to a more effective form of care management, then competitive success will rest with plans that do the best job in the current environment.

- A competitive plan must gain enough local market share to capture competitive provider discounts;
- Care management will be best focused on managing exceptional and costly patient situations and medical provider outliers, and not on routine care;
- Customer needs and anxieties will need to be met by low-cost, efficient, and effective administrative services;
- Product breadth will be needed to serve a wide range of customer preferences.

A managed care plan following this strategy may be able to garner a mid- to long-term competitive advantage by building a strong local presence supported by targeted, nonintrusive medical care management, "no hassle" administration, and a wide range of attractive products. Medical care and administrative costs may be marginally better than those of competitors, and profits may be marginally higher.

This strategy, though, has a number of significant weaknesses. There are few barriers to other competitors targeting the same locale and doing an equally good or better job. A more serious challenge will arise if a competitive plan, having adopted a breakthrough strategy, brings its technology into the local market. An "as good as it gets" competitive advantage is sustainable only if other managed care plans don't compete effectively in the local market.

"Breakthrough" and "as good as it gets" strategies are both based on the value of effective care management. If management feels that care management has only marginal value, it may choose to adopt a strategy of being just another insurance company with a different (HMO or PPO) label. This strategy differs significantly from the two above by denying the importance of local market share and vastly improved care management as strategic drivers.

For this strategy, national market share and brand name matter more than local market share. Competitive success depends largely on product breadth and innovation and high-quality administrative services.

Competitive advantage will be based on brand recognition, consumer oriented services, and creative products. In this environment, effective competition will continue to be felt from an array of traditional insurers, PPOs, and HMOs, none of which will be able to distance themselves from the others based on lower costs driven by larger discounts or more effective care management. A competitive advantage will be difficult to develop and even more difficult to sustain.

Last, and most drastically, management might well decide that competitors' financial and business resources put them in a superior position to create competitive advantages. Taking a hard look at their own resources and chances of success, management might decide its best strategy is to de-emphasize health (if possible) or to exit the market. This strategy avoids wasting precious time and resources on unproductive activities.

In the past decade, as traditional health insurers have faltered in the highly competitive market, many have chosen to exit their health insurance business. Recent financial losses in the HMO sector are now causing management of smaller, weaker HMOs

to look at taking this same drastic action. PPOs with weak networks or business based on a costly “network of networks” may also find an exit strategy attractive. In any future scenario, we’re likely to see private-sector health financing increasingly dominated by a few large players and a moderate number of also-rans trying hard to find niches in which they can survive.

Future movement from today’s moderately effective plateau toward competition among highly effective mature HMOs isn’t without potential threats. Four main threats have already entered the environment.

- Customer acceptance of deconstructionist approaches to funding medical care could create alternatives to managed care. These approaches (defined benefit plans, self-directed health plans, and models offering employee choice among competing plans) undermine the control-and-plan provider relationships needed to effectively manage care. At present, companies espousing these ideas are mainly in their developmental stages, and haven’t yet built meaningful market interest. This could change, however, with very negative consequences for the future of managed care.

- New legal constraints enacted in response to the managed care backlash could undermine key operating methods and either hinder or destroy movement toward more effective managed care.

- Industry-wide institutional exhaustion could sap the creative and developmental energies needed to fix managed care.

- The continued dearth of clinical effectiveness studies could delay introducing the scientific basis for moving medicine from a healing “art” to a healing science and, with it, the basis for truly effective care management.

These threats bear watching and careful consideration by senior managements and boards charged with overseeing the future of their managed care plans.

Of course, the future of managed care and the evolving shape of competition are, at best, difficult to predict. However, a brief look at public remarks and analyses of a few major managed care plans may be helpful. These brief remarks suffer from being based solely on public information. What managed care plans are actually doing can easily differ from their stated strategies.

Kaiser Permanente is in the enviable position of being a group-model HMO with exclusive relationships between the plan and its providers. This has provided Kaiser with a strong competitive advantage in California, the Northwest, Hawaii, and Colorado. Unfortunately, the model doesn’t travel well everywhere. Kaiser has had difficulties establishing itself in new geographical areas where it has not established the Permanente Medical Group culture. Kaiser has in place the organization and provider relationships needed to manage care to the fullest extent possible. They’re well positioned to make use of effective care management information, care management techniques, and technology as they become available.

My reading of available information leads me to believe that both United Health Care and CIGNA are capable of pursuing breakthrough strategies. These managed care plans seem to be focusing their resources on a limited number of local markets where they seek significant market share. Notably, United Health

Care, which has a very large investment in proprietary information, announced in late 1999 that it was stopping use of its prescriptive, intrusive medical care certification program.

Aetna might also have found itself in this potential breakthrough category. However, having become an amalgamation of health plans through a series of large, expensive, and often incompatible acquisitions, it has so many internal problems to solve that actually executing a breakthrough strategy is probably many years off. Aetna’s problems, though, may well bring industry focus on unwinding some of the more intrusive and unpalatable managed care techniques. Aetna is currently considering changes in the way it does business (precertification, physician profiling, “cookbook” medicine, and certain types of financial incentives) as part of talks to settle a fraud and racketeering suit brought against it and other large HMOs.

Blue Cross/Blue Shield (BCBS) plans, by their very nature, have always focused on building local market shares. This gives BCBS plans that can design and execute a breakthrough strategy a tremendous head start over many other competitors. Unfortunately, many BCBS plans have been slow to react effectively to managed care and have often suffered from relatively uncreative and weak management. A small number of well-managed, larger, often multi-state plans such as Healthcare Services Corp., Trigon, and Anthem have the ability to become dominant breakthrough competitors. On the other hand, most of the smaller, usually single-state BCBS plans may not be capable doing more than pursuing “as good as it gets” strategies.

Wellpoint appears to be taking yet another strategic direction. Wellpoint executives have made public comments and have pursued acquisitions consistent with a “just another insurer” strategy. Wellpoint’s Unicare brand is no more than a national PPO.

In choosing among these four long-term strategies, a managed care plan needs to keep firmly in mind that building a competitive advantage isn’t solely in its management’s and board’s hands. What competitors do is equally important. Among the available options, the most effective strategy is one based on a breakthrough strategy, with its market domination, lower cost, and higher quality. It takes only a single competitor to change the competitive landscape by effectively pursuing this strategy. Managed care plans betting on “as good as it gets” or “just another insurance company” risk finding themselves left behind if even a single plan using an effective breakthrough strategy enters their competitive environment.

Thus, the moral of this story is that the future of managed care awaits plans that can refine our managed care vision and develop the tools and relationships needed to effectively pursue a breakthrough strategy. If this happens, and I for one think it will, then managed care will move beyond its current malaise into a much more effective and efficient future. ●

HOWARD J. BOLNICK TEACHES A COURSE IN RISK AND INSURANCE AT KELLOGG GRADUATE SCHOOL OF MANAGEMENT AND IS INVOLVED IN THE MANAGEMENT AND GOVERNANCE OF TWO COMPANIES RELATED TO MANAGED CARE THAT HE HELPED TO FOUND. HE IS A PAST PRESIDENT OF THE SOCIETY OF ACTUARIES.