

An Empty Toolbox? Changes in Health Plans' Approaches for Managing Costs and Care

Glen P. Mays, Robert E. Hurley, and Joy M. Grossman

Objective. To examine how health plans have changed their approaches for managing costs and utilization in the wake of the recent backlash against managed care.

Data Sources/Study Setting. Semistructured interviews with health plan executives, employers, providers, and other health care decision makers in 12 metropolitan areas that were randomly selected to be nationally representative of communities with more than 200,000 residents. Longitudinal data were collected as part of the Community Tracking Study during three rounds of site visits in 1996–1997, 1998–1999, and 2000–2001.

Study Design. Interviews probed about changes in the design and operation of health insurance products—including provider contracting and network development, benefit packages, and utilization management processes—and about the rationale and perceived impact of these changes.

Data Collection/Extraction Methods. Data from more than 850 interviews were coded, extracted, and analyzed using computerized text analysis software.

Principal Findings. Health plans have begun to scale back or abandon their use of selected managed care tools in most communities, with selective contracting and risk contracting practices fading most rapidly and completely. In turn, plans increasingly have sought cost savings by shifting costs to consumers. Some plans have begun to experiment with new provider networks, payment systems, and referral practices designed to lower costs and improve service delivery.

Conclusions. These changes promise to lighten administrative and financial burdens for physicians and hospitals, but they also threaten to increase consumers' financial burdens.

Key Words. Managed care, provider contracting, utilization review, insurance benefits

The growth of managed care during past three decades has fostered the development of a variety of tools for containing health care costs and promoting coordination and efficiency in service delivery, and has fueled the diffusion of these tools across the health insurance industry (Dudley and Luft 2001; White 1999). Several tools have become widely associated with managed care because of their potential to constrain costs, reduce unnecessary

service utilization, and improve coordination of care. First, selective contracting has been used by health plans to reduce costs by excluding inefficient providers from networks and by steering patient volume to limited numbers of providers who agree to accept discounted payments (Zwanziger, Melnick, and Bamezai 2000; Mobley 1998; Bindman et al. 1998; Fisher et al. 1999). Second, risk-contracting has been used by plans to lower costs by transferring financial risk to providers, giving them incentives to reduce the costs of care (Conrad et al. 1998; Kralewski et al. 2000; Hillman, Pauly, and Kerstein 1989; Hellinger 1996). Third, utilization management controls—especially primary care gatekeeping and preauthorization requirements—have been adopted by plans to reduce unnecessary service use and improve coordination of care (Rask et al. 1999; Kravitz et al. 1998; Meyer et al. 1996; Hurley, Freund, and Gage 1991). Finally, managed care plans have offered comprehensive benefit packages with limited consumer cost-sharing in order to attract members and reduce financial barriers to routine health care that may avert the need for more costly and intensive services (Glied 2000; Frank, Glaser, and McGuire 1998; Jensen et al. 1997). Through tight management of a relatively generous health benefit package, managed care plans have attempted to lower the overall volume and intensity of services required to address the medical care needs of their members.

The diffusion of managed care tools has varied considerably across health plans and local markets during the 1990s, depending in part on the demand from purchasers for tightly managed insurance products, the willingness and ability of providers to operate successfully under these tools, and the institutional capacities of health plans to implement these tools successfully (Lesser and Ginsburg 2001). Facing tight labor markets and growing consumer dissatisfaction with the administrative hassles and restrictions of managed care, many employers have responded by offering less-restrictive health plan options (Blendon et al. 1998; Enthoven, Schaufli, and McMenamin 2001; Titlow and Emanuel 1999). At the same time, physicians and hospitals have begun using their bargaining power to push

Research was conducted at the Center for Studying Health System Change, Washington, DC, with funding from the Robert Wood Johnson Foundation.

Address correspondence to Glen P. Mays, M.P.H., Ph.D., Health Researcher, Mathematica Policy Research, 600 Maryland Avenue SW, Suite 500, Washington, DC 20024. Robert E. Hurley, Ph.D., is an Associate Professor, Virginia Commonwealth University, Richmond. Joy M. Grossman, Ph.D., is an Associate Director, Center for Studying Health System Change, Washington, DC.

back on managed care plans by terminating contracts or negotiating more lucrative payment arrangements and less burdensome administrative practices (Strunk, Devers, and Hurley 2001; Short, Mays, and Lake 2001). Policymakers have responded to this backlash by considering or adopting regulatory limits on the use of some managed care tools (Vita 2001; Altman, Reinhardt, and Shactman 1999; Marsteller et al. 1997).

All of these developments have pressured health plans to scale back or abandon the use of managed care tools at a time when health care costs and insurance premiums have returned to double-digit rates of growth. The apparent deterioration in health plans' abilities to control costs has led some to conclude that managed care has run its course and is now in decline (Robinson 2001), raising concerns about the continued affordability of health insurance. Others suggest that these developments may signal a change in the methodology of managed care as health plans shift emphasis from cost-containment tools to other health care interventions designed to improve service delivery and quality of care—such as disease management and care coordination (Dudley and Luft 2001). These possibilities highlight the need for a detailed examination of how the methods of cost containment and care management are changing, in order to gauge whether the tools of managed care have been depleted, whether such depletion appears permanent, and whether new tools are emerging to augment or replace managed care. To address this need, this paper presents a qualitative analysis of recent changes in the use of managed care tools among health plans in a nationally representative selection of metropolitan communities.

CONCEPTUAL FRAMEWORK

Managed care tools have become important components of the strategies health plans use to compete for market share and enhance profitability in health insurance markets. Consistent with economic theories of product differentiation (Hotelling 1929; Dickson and Ginder 1987), health plans compete for enrollment based on the price and nonprice attributes of their health insurance products, and managed care tools help to determine these attributes (Wholey and Christianson 1994; Gold and Hurley 1997; Grossman 2000). Three of these tools—selective contracting, risk contracting, and utilization management controls—are designed primarily to limit the volume and cost of services supplied by health care providers, thereby allowing health plans to offer insurance at premiums that attract purchasers and consumers

while also generating profits for plans (Cutler, McClellan, and Newhouse 2000). These supply-side tools potentially bolster the health plan's ability to compete based on price, but they also detract from its ability to compete based on other key attributes such as choice of providers, convenience in obtaining care, and quality of care.

Health plans have used a fourth managed care tool—a relatively generous benefit design characterized by coverage for a broad range of health services with minimal out-of-pocket expenses—to pursue several different strategic objectives. First, by reducing financial barriers to routine primary and preventive health care, health plans potentially can encourage the early identification and treatment of health conditions, thereby avoiding more costly and intensive services such as hospitalization for ambulatory care sensitive conditions (Backus et al. 2002; Friedman and Basu 2001; Dowd 1982).¹ A second and perhaps more contemporary reason for using comprehensive benefit designs is to attract membership into managed care products (Glied 1998), under the expectation that low out-of-pocket costs will compensate for managed care's less appealing product attributes. Along with its potential advantages, however, this managed care tool also brings the risk of attracting a less healthy and more costly mix of members through adverse selection.²

Health plans select the optimal set of managed care tools to use based on the array of product attributes associated with these tools (choice, convenience, benefit design), the expected demand for such attributes at various premiums, and the expected costs and cost savings to be accrued in using these tools. The expectations of demand that inform this selection are based not only the tastes and preferences of consumers and purchasers, but also on the range of competing products offered in the marketplace (Gaynor and Haas-Wilson 2001; Shaked and Sutton 1990). Although traditional HMO products typically employ a broader array of managed care tools than do the less-restrictive preferred provider organizations (PPO) and point-of-service (POS) products, the use of managed care tools can vary widely within these product types as plans tailor their products' attributes to specific market conditions and regulatory restrictions (Gold and Hurley 1997; Gabel 1997).

These concepts imply that health plans will change their use of managed care tools as the nature of health plan competition changes, including the relative importance of price, provider choice, and convenience in competing for membership. The factors likely to shape these competitive priorities include the economic conditions facing employers and their labor forces, the tastes and preferences of health care consumers, the structure of health

insurance and health care markets, and the regulatory environment (Grossman 2000; Gaynor and Haas-Wilson 2001). These forces combine to shape health plan behavior in part through the health insurance underwriting cycle, which reflects the degree to which premiums set by health plans keep pace with medical cost trends. During periods in which costs rise faster than premiums and competitive or regulatory constraints limit premium increases, health plans face strong incentives to use managed care tools for cost containment. Conversely, plans face fewer incentives to use these tools (and stronger incentives to compete on nonprice attributes) during periods in which plans are successful in setting premiums at levels that keep pace with medical cost trends, as many plans experienced during 2000–2001 (Strunk, Ginsburg, and Gabel 2001). Recognizing that many of the forces shaping health plans' competitive priorities have changed significantly in recent years, this analysis explores how health plans have modified their approaches for managing costs and care.

METHODS

Data for our analysis were collected as part of the Community Tracking Study, a longitudinal study that uses multiple data sources including site visits and national surveys to examine how local health care systems are changing (Kemper et al. 1996). As part of this study, site visits are made every two years to 12 metropolitan communities that were randomly selected to be nationally representative of local health care systems in markets with populations over 200,000: Boston, Cleveland, Greenville (S.C.), Indianapolis, Lansing, Little Rock, Miami, northern New Jersey, Orange County (Calif.), Phoenix, Seattle, and Syracuse. Collectively, these communities provide a picture of the average local health care system, yet they vary considerably in size, market structure, and experience with managed care (Table 1).

During three rounds of site visits, in 1996–1997, 1998–1999, and 2000–2001, structured interviews were conducted in each community with decision makers in leading health plans, hospitals, physician organizations, employers, insurance brokerages, and legislative and regulatory bodies at state and local levels. Approximately 850 interviews were completed during the third round of visits, including approximately 220 interviews with executives from 48 health plans. This analysis uses health plan interviews as the primary information source and uses interviews with employers, brokers, and providers to corroborate or expand upon information reported by plans. In

Table 1: Characteristics of the Twelve Community Tracking Study Communities

Community	MSA Population (Millions)	Percent Enrolled in HMOs			Number of Health Plans Interviewed
		Persons with Commercial Insurance	Medicare Beneficiaries	Medicaid Recipients	
Boston	3.4	61.3	23.2	15.1	3
Cleveland	2.3	34.0	22.7	56.5	3
Greenville, S.C.	0.9	20.7	0.0	0.0	3
Indianapolis	1.6	31.3	3.3	4.5	3
Lansing	0.4	50.6	0.0	0.2	4
Little Rock	0.6	35.7	9.0	0.0	3
Miami	2.3	58.0	45.5	45.6	5
Northern N.J.	2.0	36.9	9.1	82.0	5
Orange County, Calif.	2.8	76.5	37.8	10.3	6
Phoenix	3.3	44.7	42.1	42.9	5
Seattle	2.4	27.8	16.9	5.8	5
Syracuse	0.7	28.6	1.8	0.0	3

Source: Interstudy Competitive Edge, using data from July 2000.

Note: MSA = Metropolitan Statistical Area as defined by the U.S. Census Bureau.

each community we interviewed administrators of the largest national health plan, the largest locally owned health plan, and the largest Blue Cross/Blue Shield plan based on total membership across all products offered (HMO, PPO, POS, indemnity).³ In each health plan we attempted to interview the CEO, medical director, marketing executive, network development executive, utilization management director, and pharmacy benefits administrator. To ensure adequate coverage of the major health plan competitors, we interviewed marketing executives at up to two additional health plans in each community.

Health plan interviews probed specifically about changes in the design and operation of both HMO and non-HMO health insurance products—including provider contracting and payment, benefits packages, and utilization management processes—and about the rationale and perceived impact of these changes. To confirm and expand upon this information, we also inquired about health plans' use of managed care tools during interviews with employers, benefits consultants, insurance brokers, hospitals, and physician organizations. Data from each interview were coded, extracted, and analyzed using computerized text analysis software (*ATLAS.ti*) (Scientific Software

Development 2002). Interview responses were analyzed both within and across the 12 study communities to examine how the use of managed care tools varies across health plans and local markets. In this paper we give primary focus to information obtained during the third round of site visits in 2000–2001, and compare this information with that obtained from the two previous rounds to examine trends over the six-year study period.

RESULTS

Many of the cost-containment tools commonly associated with managed care have not been widely adopted by health plans, despite past expectations of rapid growth. Selective contracting and risk contracting practices have faded from use more quickly and completely than other tools such as primary care gatekeeping and preauthorization requirements. As use of these tools has plateaued or declined across markets, plans increasingly have moved to contain premium costs by shifting costs to consumers. Additionally, some plans have begun to experiment with new provider networks, payment systems, and referral practices designed to lower costs and improve service delivery.

Selective Contracting

Health plans in the 12 communities reported steadily increasing the number of physicians and hospitals with which they contract over the past six years, such that by 2000 few plans were actively constraining the size of their provider networks through selective contracting processes. Of the 12 plans that reported changing their provider selection processes over the past two years, nine adopted less-restrictive processes (Table 2). The three exceptions to this trend, all in Orange County, implemented more stringent reviews of providers' financial stability in response to insolvency problems with some medical groups. Health plans cited several reasons for the movement to less-restrictive provider networks: growing consumer demand for broad provider choice; the lack of reliable information for identifying efficient providers; difficulties in generating demonstrable cost savings from limited-network products; and the efforts of some hospitals and medical groups to become "indispensable" components of networks by consolidating or building consumer loyalty. Seattle's largest insurer Regence BlueShield typified this trend by discontinuing its long-standing practice of using risk-adjusted claims data to select the most efficient physicians for its point-of-service (POS)

Table 2: Recent Changes in the Use of Managed Care Tools by Health Plans Interviewed in 2000–2001

<i>Changes Made during the Past Two Years</i>	<i>Number of Health Plans and Communities in Which Change Was Reported</i>	
	<i>Health Plans (N = 48)</i>	<i>Communities (N = 12)</i>
Changes in provider selection	12	9
Less-restrictive selection process	9	8
More-restrictive selection process	3	1
Changes in risk contracting	18	9
Fewer members covered under risk contracts	12	7
Narrower scope of services covered under risk contracts	10	7
Changes in utilization management	21	12
Added HMO product without gatekeeping requirements	17	11
Eliminated preauthorization requirements	20	12
Added preauthorization requirements	3	2
Strengthened concurrent review processes for inpatient care	4	2
Changes in benefit design	35	12
Higher cost-sharing for prescription drugs	32	12
Higher cost-sharing for other covered benefits	19	12

Source: Community Tracking Study interviews with health plans during 2000–2001.

provider network. Since 1998 it has reverted to contracting with nearly every provider that accepts its fee schedule and meets standard credentialing requirements.

Differences between HMO and PPO networks have steadily diminished in many markets as plans have modified their HMO products—which historically have offered the most limited networks—to compete more effectively with less restrictive insurance products. Five of the plans interviewed had previously contracted only with medical groups and other physician organizations for their HMO products but began using contracts with individual physicians over the past two years in order to expand their physician networks and to help prevent mass network withdrawals. Faced with a growing array of contracting opportunities, physicians—rather than health plans—have become increasingly selective in their contracting decisions in many markets. Although a few health plans reported modest reductions in their provider networks over the past two years due to contract

terminations and nonrenewals, most plans have continued to expand their hospital and physician networks during this period.

Risk Contracting

Risk contracting has declined either in prevalence or in scope within most communities in recent years, contrary to the expectations of many health plans in 1996 and 1998. Although half of the 48 health plans interviewed in 2000–2001 used risk contracting for their HMO products in 1998, more than two-thirds of these plans had scaled back the use of this tool by 2000—either by reducing the number of members served through risk contracts, or by reducing the scope of clinical services covered under risk contracts by using alternative ways of paying for selected high-cost services (e.g., hospital services, pharmaceuticals, specialist physician services) (Table 2). Three plans abandoned risk contracting altogether. In communities with relatively low HMO enrollment, such as Greenville and Little Rock, risk contracting never progressed beyond the limited experimentation begun in the mid-1990s. In communities with higher HMO enrollment, such as Phoenix, Lansing, and Miami, risk contracting grew steadily in the middle and late 1990s but declined sharply in prevalence and scope in 2000–01.

Respondents from hospitals and physician organizations uniformly cited financial considerations as the primary reason for reducing or discontinuing their participation in risk contracting. Providers reported that risk contracting arrangements were financially unsuccessful for several reasons, including lower-than-expected HMO enrollment growth in markets such as Greenville, Little Rock, and Syracuse; higher-than-expected increases in medical and pharmacy costs; large administrative costs associated with maintaining risk-bearing contracting organizations such as independent practice associations (IPAs), physician hospital organizations (PHOs), and management service organizations (MSOs); and health plans' efforts to gain market share by keeping premiums and capitation payments low. In all 12 study communities, hospitals abandoned risk contracting more rapidly and completely than physician organizations—even in Orange County, which had the highest levels of HMO enrollment and risk contracting of the communities studied.

Some health plans have been successful in retaining risk contracts with physician organizations by moving from full-risk to partial-risk arrangements that require physicians to assume financial responsibility for a more limited range of services (e.g., professional services capitation, primary care capitation, or fee-for-service withhold arrangements). Ten of the 18 plans

reporting reductions in risk contracting have pursued this strategy, with most doing so because they continued to have large shares of their membership in traditional HMO products and because they have been relatively successful in using risk contracting to contain health care costs. By contrast, eight other health plans reported considerably less success with risk contracting and have pro-actively moved away from this tool for reasons that include higher utilization patterns for services not covered under capitation, problems with the quantity and quality of services provided by some risk-bearing providers, declining HMO membership, and concerns about health plan liability. Moreover, continuing a trend first noted in 1998–1999, four plans reported disassembling their risk contracts in part to make their provider networks compatible with increasingly popular direct-access HMO products that allow consumers to self-refer to any provider within the network.

Utilization Management

Over the past two years, many of the health plans interviewed have scaled back efforts to manage patients' use of services prospectively through primary care gatekeeping and preauthorization requirements—either by relaxing these requirements in existing health insurance products or by introducing new products with fewer requirements. Prior to 1998, most plans in the 12 communities required members enrolled in HMO products to obtain primary care referrals for specialty care, and most plans required physicians participating in their HMO and PPO networks to obtain preauthorization from the plan for many inpatient and outpatient procedures. Since then, 17 of the plans interviewed in 2000–2001 have introduced new direct-access HMO products that allow self-referral to specialists, and 20 plans have eliminated selected prior authorization requirements in existing HMO and PPO products (Table 2).

Plans uniformly cited consumer and provider dissatisfaction with administrative hassles as a primary motivation for scaling back their reliance on gatekeeping and preauthorization requirements. Additionally, eight of the plans that reduced or eliminated these prospective controls reported uncertainties about their effectiveness in constraining health care utilization, particularly when such controls are decoupled from risk contracting and other provider payment incentives. These plans reported that requests for specialist referrals, hospitalizations, and outpatient procedures were rarely denied, suggesting that the elimination of gatekeeping and preauthorization requirements could reduce administrative costs without triggering large increases in

utilization. Four other plans, however, indicated that such requirements helped to reduce utilization not by denying requests for services, but by discouraging physicians from requesting unnecessary services. Two of these plans reintroduced several preauthorization requirements after initially eliminating them and experiencing significant utilization growth. Plans in three markets reported that state insurance regulations have steadily weakened the ability of gatekeeping and preauthorization requirements to constrain utilization in recent years through laws mandating direct access to selected specialty services. Additionally, concerns about health plan liability prompted two plans to loosen gatekeeping and preauthorization requirements.

While reducing some prospective utilization controls, some health plans have begun to expand and refine other types of care management practices that can be implemented in the absence of gatekeeping and prior authorization requirements. First, four of the plans interviewed have adopted more stringent concurrent review processes to reduce lengths of stay for hospitalized patients, with most stationing utilization review and discharge planning staff in contracted hospitals to carry out these practices. Second, 26 plans reported introducing or expanding voluntary case management and disease management initiatives over the past two years that are designed to reduce costs and improve care delivery for high-risk patient populations. Although member participation in these programs has remained modest to date, most of the plans expected their programs to grow and become increasingly important tools for containing costs and improving care delivery (Felt-Lisk and Mays 2002). Third, five of the plans interviewed have introduced or refined physician profiling initiatives over the past two years that are designed to encourage improvements in clinical practice by providing physicians with comparative information on service utilization, costs, and clinical quality measures. To acquire data for these initiatives, plans that have eliminated gatekeeping and preauthorization requirements have replaced them with notification policies that require physicians to inform the plan of treatment decisions, so that plans can continue to track physician-directed referrals, hospital admissions, and outpatient procedures. These plans have also upgraded information systems over the past two years to support care management practices.

Benefit Design

In an effort to control escalating premium costs, most of the health plans interviewed have begun to scale back the comprehensive benefit designs

traditionally offered through managed care products. In 2000–2001, more than two-thirds of the plans interviewed reported taking one or more of the following actions: introducing new copayments or deductibles into HMO products that previously offered first-dollar coverage; increasing existing copayments, deductibles, and coinsurance requirements; replacing fixed-dollar copayments with coinsurance rates; and increasing the annual limits on out-of-pocket costs. Plans have been particularly aggressive in increasing consumer cost-sharing for prescription drugs, with 35 of the 48 plans adopting a three-tier pharmacy benefit structure that requires higher cost-sharing for costly brand-name drugs (Table 2) (Mays, Hurley, and Grossman 2001).

A few traditional HMO-based health plans—Kaiser Foundation Health Plan in Orange County, Group Health Cooperative in Seattle, and AvMed Health Plan in Miami—have resisted the movement away from comprehensive benefit designs, arguing that such changes threaten to compromise clinical quality and patient satisfaction by creating financial barriers to care. All three plans reported that they scored higher than their local competitors on measures of quality and satisfaction (e.g. HEDIS measures) and that they experienced higher rates of member retention. However, these plans also have become among the highest priced insurance products in their markets—a trend that was attributed both to the cost of generous benefit designs and to adverse selection stemming from this generosity.

Emerging Tools for Managing Costs and Care

While moving away from cost-containment tools commonly associated with managed care, some health plans have begun to experiment with alternative approaches for managing costs and care. Interestingly, these approaches largely parallel the managed care tools they are designed to replace, and include new provider networks, payment systems, and referral practices designed to lower costs and improve care delivery (Table 3). Because experimentation with these approaches was confined to small numbers of plans at the time of this study, it remains to be seen whether these approaches will emerge as important future trends within the industry.

Tiered Provider Networks. In several markets, plans are developing or considering HMO and PPO products based on multitiered provider networks that require higher premiums and cost-sharing for consumers to use more expensive providers. In effect, this is a variant on the familiar in- and out-of-network differentials found in current PPO products. Tiered network designs

Table 3: Expected Changes in the Use of Managed Care Tools by Health Plans Interviewed in 2000–2001

<i>Changes Expected for 2000–2001</i>	<i>Number of Health Plans and Communities in Which Change Was Reported</i>	
	<i>Health Plans (N = 48)</i>	<i>Communities (N = 12)</i>
Tiered network products	8	5
Fee-for-service payment incentives	9	4
Processes to steer patient volume to cost-effective providers	5	3
Higher consumer cost-sharing	17	12

Source: Community Tracking Study interviews with health plans during 2000–2001.

were under development in 8 of the 48 health plans interviewed during 2000–2001, and in 5 of the 12 study communities (Table 3). One of Seattle's largest insurers, for example, will pilot-test a product in 2002 that allows consumers to choose a network tier either at the point of annual enrollment or at the point of service. These new products are expected to preserve broad provider choice for purchasers and consumers willing to accept higher costs, while creating more affordable insurance options for those willing to accept less choice. Health plans expect that these products eventually will create strong incentives for physicians and hospitals to limit their fees in exchange for placement in lower-cost network tiers. But their acceptability to providers remains to be seen.

Payment Incentives. As risk contracting wanes, nine health plans located in Boston, Little Rock, Orange County, and Seattle have recently introduced fee-for-service payment systems offering bonus payments to providers that meet specified utilization targets in areas such as pharmacy, specialty care, and hospitalization. Four of these plans also recently introduced bonuses tied to measures of clinical quality such as surgical complication rates and delivery of indicated preventive and screening services—tools that two of the traditional HMO-based plans we interviewed have used since the mid-1990s. Unlike the risk contracting arrangements used previously, these incentives did not expose providers to considerable downside risk. Several plans, however, expressed skepticism about the ability of such incentives to influence provider behavior.

Within-Network Channeling. In five communities, plans are experimenting with mechanisms for steering patients to the most cost-effective providers within their networks. Two large plans in Seattle, for example, have begun using hospital discharge data to identify facilities with high volume and low complication rates for specific procedures such as cardiac surgery and joint replacement, and then using the data to encourage physicians to refer their patients to these facilities. Additionally, five health plans in five different markets (Boston, Cleveland, northern New Jersey, Orange County, and Seattle) have introduced or expanded “centers of excellence” models wherein patients are encouraged to obtain care from subgroups of providers that have demonstrated high-quality and cost-effective care for specific conditions such as cancer, heart surgery, stroke rehabilitation, mental health care, and assisted reproduction. Similarly, another health plan in Orange County expected to implement a system of differential copayments designed to steer patients to subnetworks of efficient and experienced providers that would be identified for major disease groupings. Plans viewed these approaches as tools for influencing the cost and quality of care delivered to members while remaining responsive to consumer demand for broad provider networks.

Customized Benefit Design. Many health plans are developing benefit packages and cost-sharing options designed to stabilize premiums without limiting choices for consumers and employers. A total of 17 plans interviewed expected to increase consumer cost-sharing requirements in some way in order to constrain premium growth. Additionally, several plans were exploring ways to allow consumers and/or purchasers greater flexibility in customizing insurance benefits and their associated costs. Two health plans in Orange County and Seattle, for example, recently introduced insurance products that enable employers to select fixed per-member premium contributions for their employees, who can then choose from an array of insurance products offering different benefit packages, provider networks, and employee premium contributions. In Greenville, two plans have introduced new variants of “minimum premium” products that allow employers to obtain lower premiums by self-funding a portion of their employees’ initial health care expenditures or by shifting these costs to employees through higher deductibles and copayments. Still other plans are developing products that offer selected benefits—such as injectable drugs, fertility treatments, or alternative and complementary therapy—through additional premium riders rather than through a standard benefit package, allowing employers and consumers to choose their preferred mix of insurance benefits and costs.

DISCUSSION

Significant numbers of health plans have reduced their reliance on managed care tools at a time when health insurance premiums have returned to double-digit rates of growth in many markets. Faced with fewer instruments for curbing utilization and constraining provider payments, health plans have attempted to mitigate premium growth by shifting costs to consumers. These developments promise to lighten the administrative and financial burdens that managed care has imposed on physicians and hospitals in recent years, while leading consumers to accept higher costs in exchange for more choice.

The net effects of these changes on patient care are as yet unclear, but they appear likely to empower some consumers while confounding others. Modest increases in consumer cost-sharing may have relatively little impact on access to needed care, but larger increases could create significant barriers to care, especially for middle- and lower-income populations and those with chronic health conditions. Similarly, the movement away from primary care gatekeeping may give well-informed patients more direct and immediate access to the care they need, while leaving other patients at greater risk of receiving uncoordinated, duplicative, or insufficient care. These changes are likely to make it increasingly difficult for health plans and providers to assume responsibility for—and be held accountable for—coordinating the health care needs of their patients. As a result, some consumers may find the insurance products now emerging in the marketplace to be no more satisfying than the restrictive managed care plans they are designed to replace.

Does the reduced use of managed care tools signal a shift away from price competition in the health insurance industry? Clearly health plans are competing more intensely on the basis of nonprice attributes such as provider choice, convenience, and ease in obtaining health care. To accomplish this, these plans have scaled back their use of the supply-side cost controls of managed care, and have raised premiums and consumer cost-sharing requirements to achieve profitability with these more loosely managed products. This response is consistent with a phase of the insurance underwriting cycle in which insurers successfully negotiate premium increases to cover the medical costs they incur—thereby reducing the incentives for adopting cost-containment technologies. However, health plans have not wholly abandoned the instruments of managed care. Rather, many plans have moved to a smaller and less-intrusive set of tools for containing costs.

Whether the reduced use managed care tools will prove to be a permanent or passing trend remains to be seen. Some health plans have

continued to rely on these tools with the expectation that premium increases and a softening labor market will generate renewed interest in strongly managed, limited-network products. Even plans that have embraced the movement to less-restrictive and less-comprehensive insurance products recognize that there are limits on the premium increases and consumer cost-sharing levels that can be sustained in the insurance market—particularly if changing economic conditions make purchasers and consumers more price-sensitive in their consumption of health insurance, triggering a turn in the underwriting cycle. Indeed, the new approaches now being tested by some health plans—including tiered provider networks, fee-for-service payment incentives, and refined methods for steering patient referrals—can be viewed as variations of traditional managed care tools. Moreover, consumer cost-sharing alone is unlikely to generate substantial reductions in the overall growth rate of health care utilization and costs, given consumers' relatively inelastic demand for health care (Keeler and Rolph 1988). Consequently, unless new and more effective strategies emerge for containing costs, traditional managed care tools are likely to resurface in some form in the years to come as managed care plans attempt to recapture the traction in cost control they once seemed to have.

NOTES

1. Federal regulations created additional incentives for the early managed care plans to offer generous benefit packages. The HMO Act of 1973 required HMOs to offer a relatively comprehensive set of benefits in order to obtain federal qualification status and thereby gain improved access to employer-based health insurance markets (Enthoven 1980).
2. One way that managed care plans have attempted to reduce and even reverse the risk of adverse selection is through expanded coverage for preventive services and other health and wellness benefits (e.g., subsidized health club memberships) that are likely to appeal to healthy consumers. Additionally, the supply-side tools of managed care—especially selective contracting and utilization management—potentially help managed care plans avoid problems of adverse selection, because less-healthy consumers are likely to place a higher value on choice and convenience in obtaining specialty care (Frank, Glaser, and McGuire 1998).
3. We limited the study to health plans that offer risk-bearing insurance products; we did not include nonrisk PPO networks or third-party administrators.

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