

# Hospitals in the New World Of Managed Care

BY JANE H. WHITE

**E**ven though national health reform as envisioned by President Bill Clinton is now a fading memory, the health system is changing dramatically anyway. Managed care is a key factor in changing the way healthcare is delivered in the United States. And its growth appears unrelenting.

Although managed care is far from a new phenomenon in the U.S. healthcare sphere, what is new is its increasing dominance, diversity, growth in for-profit ownership of plans, and government interest in using it to control costs in public-sector health programs. With the new growth come new questions, including how best to care for vulnerable populations and how to retain a mission orientation in the increasingly competitive managed care environment.

## GROWTH AND EVOLUTION OF MANAGED CARE

**Definition** Managed care has become a catchall phrase to characterize many of the changes in the financing and organization of healthcare delivery. In its strictest sense, it is a means of integrating the financing, delivery, and coordination of care in a comprehensive way across treatment levels and sites, including an emphasis on prevention and primary care. The managed care plan contracts with physicians and hospitals to provide this care to its members. It often reimburses providers on a prepaid monthly basis (capitation) as a means of controlling costs and fostering incentives that can change provider behavior.

Managed care can also encompass strategies to control costs and manage healthcare without prepaid capitation through, for example, utilization review features of traditional indemnity insurance plans. And, in its broadest sense, managed care "refers to a practitioner who makes informed judgments of what a patient needs, and manages the patient to insure an appropriate pattern of care—an expectation that others had of reasonable primary care physicians for generations," notes Rutgers University sociologist David Mechanic.<sup>1</sup> Today, however, managed care is



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seen "more as a tool for controlling cost and utilization and less as an endeavor to insure that patients get what they need," Mechanic adds.

**Growth and Diversity** If one focuses on the capitated forms of managed care, the numbers reveal an astonishing growth rate that is changing the face of healthcare delivery. According to a December 1994 survey by the Group Health Association of American (GHAA), health maintenance organization (HMO) membership grew 11 percent between December 31, 1993, and October 1, 1994. The survey projects a 1995 mean growth rate of 9.6 percent.

Several different managed care models have emerged: the group model HMO; staff model HMO; independent practice association (IPA) model; network model HMO; preferred provider organization (PPO); and hybrid, or mixed, model; and point-of-service plan or option.

Under the group model, such as Kaiser Permanente, the HMO contracts with a medical group practice for physician services but provides the facilities and equipment. Staff model HMOs, such as Group Health Cooperative of Puget Sound, own their own facilities and have salaried physicians to provide care. These two oldest forms of HMOs grew 6 percent and 5.9 percent, respectively, in 1993, according to InterStudy, a Minneapolis-based research company.<sup>2</sup>

IPAs contract with individual physicians or specialty groups, with reimbursement varying from capitation to fee schedules. IPAs do not own their own healthcare facilities. This model now enrolls more than half the managed care population and saw a growth rate of 10.3 percent in 1993, according to InterStudy. Network model HMOs contract with one or more large multispecialty physician group practice and typically pay the providers by capitation. Network model HMOs saw a 12 percent growth rate in 1993.

PPOs manage care not by capitation but by contracting with a network of providers, usually on a discounted fee-for-service basis, and then

offering financial incentives to encourage enrollees to use those providers. If enrollees use out-of-network providers, their out-of-pocket costs are higher.

Mixed, or hybrid, model HMOs combine various elements of the above models and, as a category, represent the newest model type. They combine cost control with more flexible choice for enrollees. According to InterStudy, mixed models grew 11.4 percent in 1993, with 69 percent having origins as group-based plans. However, mixed models with an IPA origin were the fastest-growing model type in 1993.

One of the newest and fastest-growing hybrids is the point-of-service plan. This open-ended option allows HMO members to use providers who are not part of the capitated managed care plan—usually at a substantially higher out-of-pocket cost. The GHAA survey reports that nearly three-fourths of the managed care plans offered point-of-service or open-ended options in 1994 or expect to in 1995. In 1988 just 23 percent of HMOs offered such an option.

The point-of-service option has grown in response to consumers' wish to have more choice of providers. How well the option is working remains to be seen, however. For instance, a recent survey by three large employers (Xerox, GTE, and Digital Equipment) of their employees' satisfaction with managed care and traditional indemnity plans found that enrollees in point-of-service plans were least satisfied with their plan.<sup>3</sup> Yet, in a seeming contradiction, employee satisfaction with managed care plans in general was higher than it was for indemnity plans, except in the area of provider choice. So the HMO industry's notion of providing HMO enrollees with point-of-service plans to alleviate concern about provider choice limitations has somehow not yet satisfied the enrollees of these three companies at least.

HMOs' ability to continually adapt and evolve is one of the distinguishing characteristics of the managed care explosion. This rapid change requires great flexibility on the part of providers if they want to stay in the game. It also raises problems for researchers and policymakers trying to assess what works best in managed care—both in ensuring adequate patient care and in controlling cost. As Mechanic observes, "This is a rapidly growing and changing industry that customizes its products for employers, making systematic study difficult."<sup>4</sup>

**Ownership** Another major shift in managed care centers around ownership. HMOs initially were organized on a not-for-profit basis, but the past decade has seen the increasing dominance of for-

profit managed care plans. InterStudy data as of January 1, 1994, show that whether one looks at number of enrollees or number of plans, the for-profit orientation predominates. Fifty percent of enrollees were in for-profit plans; 69 percent of HMOs were for profit.

John Iglehart, editor of *Health Affairs* and national correspondent for the *New England Journal of Medicine*, observes, moreover:

This changing picture is apparent in the composition of the Group Health Association of America. With roots deep in the consumer and labor movements, the association and its policies have changed substantially in the past decade as commercial insurers and various other for-profit enterprises have become active members. In 1988, for-profit member plans had a total enrollment of 15.4 million people, whereas nonprofit plans had 17.2 million members. By 1993, total enrollment in for-profit plans had grown dramatically to 24.8 million people, whereas nonprofit plans were providing care to 20.4 million people.<sup>5</sup>

In addition to the growth of for-profit ownership, "there also has been a consolidation of ownership of managed care plans and a trend toward ownership by insurance companies and investors, instead of hospitals and other health care providers," according to the Commonwealth Fund.<sup>6</sup>

**Government Interest** Another recent trend pushing the growth and dominance of managed care is federal and state interest in managed care for public-sector health programs. Recent estimates

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## MANAGED CARE KEEPS GROWING

By October 1, 1994, nationwide enrollment in health maintenance organizations (HMOs) reached 50 million members, and it is expected to increase to 56 million in 1995, according to a December 1994 survey by the Group Health Association of America.\* A survey by KPMG Peat Marwick and Wayne State University researchers reports that in 1993, more than half of the nation's employees were enrolled in managed care plans, including HMOs, preferred provider organizations, and point-of-service plans.† Just five years earlier, in 1988, managed care plans enrolled only 29 percent of employees.

\* Amy Bernstein et al., "1994 HMO Performance Report," Group Health Association of America, Washington, DC, December 1994.

† Jon Gabel et al., "The Health Insurance Picture in 1993: Some Rare Good News," *Health Affairs*, Spring II 1994, pp. 327-336.

compiled by Howard Bailit, vice president of Aetna Health Plans, put managed care enrollment of Medicare beneficiaries at 2.8 million out of 36 million; Medicaid enrollment was 8 million out of a total 32 million beneficiaries, he said. These numbers represent a 13 percent increase from 1993 to 1994 for Medicare and a 100 percent increase for Medicaid, Bailit told participants at a September 1994 meeting of the Association of Academic Health Centers (AAHC) in Tucson, AZ. Some states, such as Kentucky, Tennessee, and Oregon, are enrolling their entire Medicaid populations in managed care plans as a means of holding down spiraling state healthcare costs.

**A Different World** These trends—the explosive growth of managed care, its shift from not-for-profit to for-profit ownership, the consolidation of its ownership, and the increasing interest of government in using it for public health programs—describe a very different healthcare world from that of just 5 to 10 years ago. Now the question for providers is: How will this continuing trend affect healthcare delivery and organization in the next 5 to 10 years? For, as Bailit observed, “Managed care is here to stay. It is the dominant form of organizing care in the United States.”

#### MANAGED CARE AND HOSPITALS

A look at the data reveals that managed care's effect on hospitals has been to tighten up the system. In a review of managed care studies, Robert H. Miller and Harold S. Luft, researchers at the University of California, San Francisco, uncovered a number of trends that indicate declining hospital utilization under managed care.<sup>7</sup> They found, for example, that hospital admission rates were generally lower under managed care than under indemnity insurance plans; hospital lengths of stay (LOS) were 1 percent to 20 percent shorter under managed care; the two strongest studies put managed care LOS at 14 percent shorter than fee-for-service LOS; and hospital days were consistently fewer for managed care enrollees than for traditionally insured patients.

Jon Gabel, GHAA's director of research, said in a conversation that downsizing of the hospital market is one of the reasons GHAA is predicting a 1.2 percent drop in HMO premiums in 1995. He warned hospitals to prepare for continued downsizing because “HMOs are going into the Medicare business. Hospital utilization is much lower for the HMO Medicare population, and there is lots of room to reduce hospital days.” Since Medicare currently accounts for nearly half of hospital revenue in the United States, the growth of Medicare-managed care is a critical

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area for which hospitals must prepare.

A number of new opportunities exist, however, for not-for-profit hospitals that are prepared to jump into the managed care fray, according to David Lawrence, chairman and chief executive officer of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals:

There is great potential for the emergence of a large number of nonprofit organized systems through the development of physician/hospital organizations (PHOs). The vast majority of hospitals in America are nonprofit, and PHOs give such hospitals and their medical staffs the opportunity to develop integrated organizations similar to Kaiser Permanente. This potential is certainly causing great worry for for-profit HMOs that have no health care delivery responsibility but that are really just brokers taking advantage of the system's excess capacity.<sup>8</sup>

Bailit, at the AAHC meeting, also highlighted some strategies for large hospitals in the new world of managed care. These include: (1) form a merger or alliance with competing or feeder hospitals, (2) own or control primary care, (3) form managed care organizations to contract with payers, (4) eventually move to direct contracts with employers and bypass the managed care organizations, and (5) position the hospital to become part of an integrated service network.

“Large hospitals that have their act together are in a good position to do this,” said Bailit. However, hospitals that are “looking to maintain their source of patients, especially tertiary care patients, haven't gotten the message that this is *not* the name of the game,” he said.

Bailit noted three stumbling blocks for hospitals as they position themselves in the new managed care environment:

- Access to capital, which will become worse in the next few years
- Conflict with the physician community as hospitals are faced with getting rid of excess tertiary capacity and specialists
- The lack, in many hospitals, of a managed care management infrastructure

William J. Cox, vice president for government services for the Catholic Health Association (CHA), also noted that few hospital leaders have been trained to answer the kinds of questions that the new managed care world is posing. In a conversation, he listed the questions Catholic facilities are facing: How is the hospital positioned in

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## HEALTH POLICY

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the market? What services does it provide? What are its connections with other facilities? What is its capacity to be the area's dominant provider? And what is its relationship with primary care and other providers? Other questions center on performance objectives. "In the past these were not a priority. Now we're really compelled to be much more efficient," said Cox. And still other questions relate to the hospital's relationship with insurers and whether it is going to develop its own insurance product.

A major concern for Catholic hospitals is that "in intensely price-competitive markets, it's going to be very difficult for hospitals to maintain their mission orientation," Cox said. CHA plans to release a workbook this spring on "low-cost, mission-driven providers" to help Catholic hospitals maintain mission, he said.

### EMERGING QUESTIONS

As the managed care-driven market becomes more competitive, with a high focus on cost control and a growing for-profit orientation, a number of questions emerge. Who will be the patient's advocate as providers are asked to take on increasing economic risk? Will the emphasis on managed care affect providers' ability to care for vulnerable populations such as the poor, the uninsured, and the chronically ill? Will hospitals that do serve the poor be able to compete and survive?

As Cox observed, "In the past, hospitals were told, 'Do not concern yourself with the economic consequences of a particular treatment or regimen for a particular patient.' Now treatment decisions relative to individual patients

do have economic consequences" for hospitals. How not-for-profit hospitals address this tension and resolve the role of being a patient's advocate in a competitive managed care market will be key themes for CHA in 1995, Cox said.

In my view, the question of who is the patient's advocate is absolutely critical in the face of failed national healthcare reform. Catholic hospitals will make a major contribution to the healthcare debate by tackling this issue head-on. Instead of national health reform, the nation has opted for what Howard Bailit calls a "typically American way of reform—brutal, chaotic, confusing, painful, but hopefully at the end we will have a better, more humane and efficient system." Here's hoping. □

### NOTES

1. David Mechanic, "Managed Care: Rhetoric and Realities," *Inquiry*, Summer 1994, pp. 124-128.
2. InterStudy, *The InterStudy Competitive Edge*, vol. 4, no. 1, September 7, 1994.
3. Harris M. Allen, Jr., et al., "The Employee Health Care Value Survey: Round One," *Health Affairs*, Fall 1994, pp. 25-41.
4. Mechanic.
5. John K. Iglehart, "The Struggle between Managed Care and Fee-for-Service Practice," *New England Journal of Medicine*, July 7, 1994, pp. 63-67.
6. Karen Davis, Karen Scott Collins, and Cynthia Morris, "Managed Care: Promise and Concerns," *Health Affairs*, Fall 1994, pp. 178-185.
7. Robert H. Miller and Harold S. Luft, "Managed Care Plan Performance Since 1980," *JAMA*, May 18, 1994, pp. 1,512-1,519.
8. John K. Iglehart, "Changing Course in Turbulent Times: An Interview with David Lawrence," *Health Affairs*, Winter 1994, pp. 65-77.