**Editorial**

**THE ESSENCE OF MANAGED CARE**

The indemnity portion of group health insurance is shrinking rapidly. In 1984 indemnity programs represented 99% of commercial insurers' group business; six years later the percentage was 77. Nearly a quarter of the business had become "managed care." What is managed care? What does it mean? Why did it happen? What does this mean to the physician in the insurance industry?

Managed care is different things to different people. Indeed, one has only to observe the Health Care Financing Administration (HCFA) office that deals with managed care to see how terms change. It was the Office of Prepaid Care; now it is the Office of Coordinated Care and Policy.

Managed care is more than simply a definition—it is often described as a "way of life," "a religion." Continuing the analogy, to understand and participate, it is necessary to be a "believer." It is easy then to articulate what managed care is and what it is not. It is the conscientious attempt "to effect a balance in the utilization of health care resources, cost containment and quality enhancement." It is not a pre-certification program; it is not discounts with providers or contracts with selective networks; it is not a fee schedule; it is not a certificate to operate as an HMO, nor a membership in a trade organization.

Sporadically throughout the country for many years, there have been efforts at managing health care, principally being those organizations which deliver service under prepayment arrangements. Several of them have been highly successful health care operations, such as the Kaiser system in California. It was not, however, until specific California legislation in the 1981-82 session enabling insurance companies to contract directly with providers, that "managed care" became a significant potential.

The intent of the California legislation, since duplicated in many states, either in law or regulation, was to alter fundamentally the relationship between physician and patient. It brought accountability into the equation. Before this event, there was a relationship in which the physician could be an advocate for the patient, and the patient was responsible for paying bills. Most often this was a satisfactory relationship, the care given was professional, appropriate, and of high quality. In some cases it was anything but professional, appropriate, or high quality.

The landmark California legislation altered that relationship, and in so doing added to the advocacy of the physician and the financial responsibility of the patient for services rendered. Not only was the physician to be an advocate for the patient, but the physician became accountable to another party. The patient was encouraged "not to collude" with the physician in the supply of unnecessary medical services. The payor also assumed responsibilities, namely, to pay for service in a timely manner, to administer the benefits fairly, and to be the body to which the physician became accountable.

Accountability took another giant step forward with the release in the *New York Times* in March 1986 of the Health Care Administration (HCFA) Mortality Statistics. Although perhaps crude initially, the fact that there were statistics, and that in the proper context should be in the public domain, has forced hospitals and physicians alike to review what they do and become accountable to an even greater extent.

Ottensmeyer, in his article on the expanding opportunity for physician executives, stresses the discipline of medical management. In fact, his description of the discipline of medical management, with few changes, describes the essence of managed care. "The structure: an organizational structure; opportunity for control; measurement, accountability and feedback. The process: appropriate financial incentives, management control and the use of information systems to facilitate operational decision making and the outcome; namely the balance of health care resources, cost containment and quality enhancement." (words in bold are those of the editor)

What does it mean? Masso and Haesler, in their article on the impact of managed care on the health insurance industry, lead into "new dimensions of expertise." Their thesis is that to cope with managed care, commercial insurers lacked the "fundamental component central to creating an effective managed care operation—expertise." This postulate is particularly pertinent as these authors write from the perspective of the managed care department of the Health Insurance Association of America, the industry's trade organization. The article continues by discussing critical elements to a managed care approach: product viability, market flexibility, medical and management information systems, effectiveness measurement, and quality.

The second and third articles in the cluster address the external milieu and the internal circumstances that are occurring in the evolution of health care delivery. The second article, by Chollet, develops the thesis that the most popular insurance plans, those that are employee-based, are fundamentally altering because of the cost. The shift from a high rate of employee coverage has occurred in the last decade mainly due to creation of new jobs in which health insurance was not included as a benefit. There is also an increase in cost sharing. In other words, the employers who are becoming cost conscious are attempting to have their employees involved in the process of obtaining value for their contribution.

The third article in the cluster addresses the impact of AIDS on health insurance. The relevance to the inclusion of this article is that it is prototypical of an answer to "Why did it (the advent of managed care) happen?" We, society, have nearly reached the limit of unrestricted resources for health care, yet there are disease (AIDS), technology (MRI, PET scans, transplant surgery), epidemiology (the aging of America), and social (the uninsured) examples of sudden and enormous demands on resources. Satisfying these demands may "starve" other areas unless that there is a "managed care" approach to current resources.
The fourth and fifth articles in the cluster are "managed care" from the perspective of medical directors, one of whom is directly responsible for a commercial insurer's program and who has "the expertise."2 The other article6 answers the question, "What does this mean to the physician in the insurance industry?"

Davies6 describes his views in reactive terms. He lists five major shock waves; spiraling cost of health care, legislative issues, increasing litigation, employee safety and health, and interdisciplinary communication. His message is that to remain current with the times, "the dog must learn some new tricks."

I would be remiss if I did not make the observation that still a primary role of the insurance medical director is to be a consultant to the life underwriting department. It has fascinated me that, while I was an academic cardiologist interested in the structure and process of diagnosis and treatment of congenital heart disease, outcome, although important, did not take its rightful place until total quality management began to be accepted. Meanwhile, decades ago, the life insurance medical directors were well versed in outcome statistics—indeed, putting "their money where their mouths were!"

Perhaps a last, sobering thought is that landmark legislation occurred in the early 1980s, in California, to bring "management" to health care, particularly to the health care delivery in the employee benefits area through enabling payors to contract directly with providers.

This year landmark legislation has been passed allowing "managed care" to be a cost-containment tool in the automobile insurance field in Colorado and in Florida. Other states indicate that there are statutes currently in existence which allow managed care for Personal Injury Protection (PIP) and no-fault insurance.

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REFERENCES

1. Masso AR, Haesler WK. The Impact of Managed Care on the Health Insurance Industry.