THE IMPACT OF MANAGED CARE ON THE HEALTH INSURANCE INDUSTRY

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Introduction

Managed care has revolutionized the health insurance industry. Instead of merely serving as claims payers and underwriters, commercial health insurers are now actively involved in managing both the delivery and financing of health benefits to beneficiaries. Their role extends from creating innovative provider contracts to analyzing patient utilization data. Physicians, as well as hospitals and other providers, are encouraged to provide only appropriate and necessary medical services. Patients benefit from receiving more coordinated and useful medical care.

The transformation of health care delivery within the commercial insurance industry began in the early 1980s and continues today. To compete effectively with the alternate delivery systems that flourished in the 1970s (namely, HMOs), insurers needed to acquire new skills, as well as improve or highlight existing competitive advantages. In 1984, managed care represented less than one percent of commercial insurers' group business, compared to almost 23% in 1990.[1] This phenomenon will continue as the value of managed care becomes evident to more and more purchasers of health benefits.

Additionally, managed care techniques are being increasingly applied to all lines of insurance business. Insurers are incorporating utilization management activities, such as preadmission certification and case management, into their indemnity business. In 1987, 32 percent of health plans were conventional plans without utilization management features; in 1990, the percentage dropped to 5%.[2] Disability and workers compensation programs are also beginning to incorporate managed care elements in the design of their plans. To be sure, managed care is not a type of product; it is a reformation in health insurance that is reconstructing the delivery of health care in this society, affecting not only the health insurance industry, but physicians, hospitals, and consumers.

Indeed, managed care has influenced virtually every facet of the health insurance business. It is requiring that insurers acquire new dimensions of expertise and modify existing products or invent new ones. Managed care also demands that insurers collect data for new applications, and demonstrate quality through evaluating patient outcomes and defining effectiveness measurements. As the abundance of managed care organizations and options make competition ever tougher, insurance companies will continue to encounter pressures that promote the development of better systems and products. Their ability to adapt and lead in this changing environment are key.

New Dimensions of Expertise

In venturing into managed care, commercial insurers at first lacked the fundamental component central to creating an effective managed care operation—expertise. While insurers have long had sophisticated claims payment systems and competent sales forces, they needed to acquire skills that would enable them to manage health care and its associated costs. Central to managed care operations, but not historically sustained by insurers are such functional categories as provider relations, medical management, and member services. Insurers are now creating departments centered around these functional areas and are thus strengthening their knowledge in this regard.

Provider Relations

In a traditional claims-payer environment, insurers have little personal interaction with physicians, hospitals, or other providers. Moving into managed care means developing provider networks, which requires the insurer to negotiate with and educate providers. Because these networks of providers, in essence, become the product, insurers need to give attention to developing and maintaining their relationships with providers to avoid selling an inadequate product. Skills necessary to accommodate this important task include negotiation and persuasion, financial analysis, and the ability to understand and communicate with physicians, medical personnel, and administrators. Managing a provider network requires a different set of skills from paying claims. Consequently, insurers have begun training employees and hiring personnel to perform these functions.

Credentialling physicians (and other providers) and monitoring their performances are other new responsibilities for insurers. Features crucial in developing provider networks include verifying that (1) the providers are licensed, board certified practitioners; (2) that they have clear and current licenses and appropriate liability insurance; and (3) that they have appropriate hospital privileges and peer recommendations. Such activity is not undertaken in non-network based health plans.

Medical Management

Controlling health care costs by managing the utilization of medical services is the signature of a successful managed care organization. The lack of expertise in this area represents one of the most important opportunities for insurers' to make significant advancements in the managed care arena. The expertise of physicians and nurses is vital to developing

utilization management programs that manage and track patient utilization. Insurers are hiring physicians and nurses to serve as medical directors, case managers, and utilization review specialists. These individuals bring with them clinical experience and knowledge that is not only instrumental in instituting medical management programs, but serves to lend credibility to the insurers' efforts to become more active in arranging the delivery of care.

Staff model insurer-sponsored HMOs, of course, hire clinicians to deliver medical care to enrollees and, therefore, engage in activities more extensive than those of a traditional insurance plan. While only 9% of insurer-sponsored HMO enrollment is in a staff model plan, any involvement in hiring medical personnel to deliver care represents a dramatic shift in commercial insurers' activities.[1]

Member Services

While traditional health plans typically provide some customer service functions, the complexity of calls associated with a managed care operation is more demanding than those of a traditional health plan and the volume of calls is greater. Since a managed care organization is more active in arranging for the delivery of medical services, the customer service representative is likely to encounter a greater number of complex consumer issues. These include assisting an enrollee select a primary care physician, obtain a referral to a specialist, or arrange for an elective surgery.

Product Variability

Although managed care embodies a fundamentally different paradigm to health insurance, it also translates into selling very different products. Most traditional managed care products, particularly HMOs, contain few similarities to a conventional health plan. Although both collect premiums and pay claims, the plans differ drastically in other areas. A traditional insurer has little contact with providers or consumers, is removed from the management of provider behavior and development of fee structures, and is not active in managing patient utilization of services. Therefore, insurers have little incentive and few opportunities to implement cost-containment mechanisms. A managed care organization differs from the traditional insurer in all of these important areas. Managed care organizations are closely involved with provider and consumer issues, actively manage utilization, and negotiate provider fee structures.

In 1990, 18% of commercial insurers offered an HMO, while 59% offered a PPO. As recently as 1986, only 5% offered an HMO and 26% a PPO.[2,6] Managed indemnity—traditional health plans that incorporate certain managed care techniques—is another new product of insurers that evolved as a consequence of the popularity of managing health care costs. As of 1990, the largest percentage (57%) of employer-sponsored health coverage was through a managed indemnity product.[2]

Market Flexibility

Managed care has compelled insurers to become more adaptable. In response to the pressures of losing clients to HMOs, insurers quickly began to develop their own HMOs. They proceeded to sponsor PPOs, IPA networks, EPOs, and other managed care variations.

To further accommodate the demands of purchasers, insurers are now developing hybrid options, like point-of-service (POS) plans (also called open-ended HMOs). As of 1990, at least nine commercial insurers (representing 45% of total premium revenue for HIAA member companies) offered a POS plan, covering 1.8 million enrollees (7% of total managed care enrollment.[1] According to a recent Group Health Association of America (GHAA) survey, 39% of commercial insurer-sponsored plans offer a POS product in 1990, the highest percentage of any type of HMO.[3] The POS plan has become increasingly popular with consumers. The list of large employers that have implemented such a program is expanding; a partial listing includes Marriott, Sears, American Airlines, and Mobile Oil.

Medical and Management Information Systems

Managed care system not only need more information than do traditional health plans, but different kinds of information. Managing medical care and developing provider networks requires collecting and analyzing information not necessarily found in a claims database. Furthermore, managed care systems have created new uses for the data.

Utilization Data

For example, there are certain measures of utilization typically maintained by a medical management program: hospital bed days per one thousand (1000) enrollees, hospital admissions per 1000, hospital discharges per 1000, total number of physician (or other provider) encounters, and number of provider encounters per person. These measures (and others) are used to gauge how effectively the organization is managing patient utilization and containing medical costs. Such information is obtained by collecting physician encounter and hospital discharge data. Because insurers generally have advanced computer systems, they are well positioned to sort the information to meet the new data requirements associated with a managed care arrangement. While much needs to be done to develop effective management information systems for the demands of the 1990s, the proper steps are being taken to invest resources, define needs, and produce a superior product.

Utilization data takes on useful applications in a managed care setting. In order to influence physician behavior, it is imperative to compare each physician's individual experience with that of the group. Over 95% of insurer-sponsored PPO business is subject to physician profiling, while less than 7% is for conventional plans.[1] Managed care aims to educate physicians while conventional approaches do not. Moreover, prior utilization data is critical in developing and renegotiating physician and hospital reimbursement structures, particularly for capitated or full-risk arrangements. Properly influencing provider behavior through timely and accurate information reports is a mechanism increasingly embraced and refined by successful managed care companies.

Financial Data

Most insurers' claims systems are capable of gathering the financial information important to a managed care arrangement. Collecting and disseminating financial data is valuable for the insurer (or managed care organization) in managing

its relationships with the client and provider networks. Common categories of financial data are: per member per month (PMPM) costs for types of medical services (e.g., physical therapy, general surgery) and costs per day for hospital services (e.g., obstetrics). The insurer tracks and analyzes the information for a variety of reasons—to ensure that revenues are adequate and that provider incentives are sufficient, to demonstrate to the client the successful management of patient utilization, and to effectively negotiate financial arrangements with the providers.

Effectiveness Measurements

Managed care, in its quest to offer cost-effective health care by eliminating the delivery of inappropriate or unnecessary medical services, highlights the deficiencies of the entire health care system.

Perverse Incentives of Conventional Insurance

In the confines of traditional insurance, there exist few incentives for any of the participants to be accountable for their choices. By structuring a reimbursement system on a fee-for-service basis, physicians are given incentives to deliver more services, or at least have no motivation to provide fewer. Consumers then defer medical decision-making solely to the physician, and they turn over the responsibility for financial payment to the insurer. A patient's role under a conventional plan is limited to filling out forms and satisfying any necessary deductible and coinsurance responsibility.

Employers—the primary purchasers of health care—have historically not played a role in managing employee health benefits. Viewing their primary responsibility as overseeing their respective businesses, employers have preferred to impart the authority to design and "manage" health benefits to the insurer. Insurers were not inspired to become active players until employers, in response to escalating health care costs, began to demand it of them. Ultimately, this disorganized system serves few, since little benefit is gained from delivering inefficient health care.

Managed Care Demands Participation

Managed care developed in response to fee-for-service inefficiencies, and unlike conventional insurance, managed care demands accountability from all of its participants. Physicians and hospitals are stimulated to eliminate wasteful use of medical resources by providing appropriate and needed services. They are encouraged to work closely with patients in managing their health care and determining appropriate courses of treatment. By developing partnerships with physicians, insurers guarantee a more responsive product, since health care is seen by the consumer as merely the interface between patient and physician.

Consequently, consumers are active players in medical decision-making, ranging from selecting a personal primary care physician to choosing home care in lieu of hospitalization. While most managed care beneficiaries receive first-dollar coverage (a feature thought to encourage greater use of medical services), research reveals that HMO enrollees seek care at a slightly lower rate from that of the general population. In 1989, physician encounters per HMO enrollee was 4.4 compared to 4.8 for the general population.[4]

Awakened by skyrocketing health care costs, employers have begun to demand better value for their dollar and seek out managed care as an alternative approach. Increasingly, employers are immersing themselves in managing their health care dollars—designing benefit packages, developing managed care networks, and hiring staff to oversee these activities. (Xerox, IBM and Digital Equipment are prime examples.) Faced with demands by employers for more cost-effective health care, and pressures from traditional managed care competitors, insurers were thrust into the role of actively managing health care and consequently developing more efficient approaches to health care delivery.

First Things First

The hallmark of a managed care approach is its emphasis on preventive care. Primary care visits (including physical exams), prenatal care, and well baby care, as well as preventive diagnostic procedures are almost always covered by a managed care plan.[3] Conventional health plans are less likely to extend such coverage for these services. A 1989 survey by the HIAA reflected that while most enrollees in HMO plans were covered for adult physical exams, only 34 percent of enrollees in conventional plans were.[5] Similar disparities in coverage exist for other preventive services.

Additionally, managed care plans frequently stress patient settings other than acute care facilities. For example, individual case management programs routinely work with patients and families to provide the most appropriate setting for medical services, such as relocating institutionalized patients to less-intensive, skilled nursing facilities or home settings, recommending one-day surgery or early discharge, and arranging for preadmission laboratory work to be performed in the physician's office.

Transferring Efficiencies

By enabling patients to seek medical care prior to the onset of illness or injury and offering appealing situs options, managed care uses resources efficiently. The success of this approach encourages other non-managed care programs to adopt similar techniques, as evidenced by the prevalence of utilization management in conventional health plans. The efficiencies associated with managed care will have positive implications for the entire health care system, as managed care arrangements assume a larger role in covering beneficiaries.

Evidence already exists to support this premise. In 1990, the rate of increase in employer-sponsored group health premiums declined for the first time in three years. The average premium increase was 14% in 1990, compared to an average increase of 24 percent in 1989—a 41% drop in the yearly escalation rate.[2]

Quality

In addition to managed care prompting a re-evaluation of efficiency, it has stimulated an effort to acquire knowledge that has previously been unattainable—data on patient outcomes. Outcomes management can best be defined as collecting data on patient's clinical status, quality of life, and satisfaction with care relevant to the treatments given; the purpose of outcomes management is to define practice guidelines and evaluate the effectiveness of different medical interventions.

Outcomes

Management Projects

Within the last few years, efforts to quantify the outcomes of medical treatment have been pursued by insurers and employers. Interstudy, under the director of Paul Ellwood, MD, oversees an outcomes pilot project initiated by the Managed Health Care Association, a group of major employers involved in managed care. This consortium of employers and their insurers have launched a feasibility study to determine if the data on patient clinical status and satisfaction levels can be collected and, ultimately, if it will be useful for making decisions relating to appropriate medical treatments. Participants in the project include Aetna, CIGNA, Metropolitan Life, Prudential, and Travelers.

Another outcomes measurement project is called the Michigan Project, comprised of nine HMOs in Michigan, including the big three U.S. automobile manufacturers (General Motors, Ford, and Chrysler), the United Auto Workers, and the Michigan Department of Health. Initiated in the late 1980s by the National Committee for Quality Assurance (NCQA), the project brings together employers and managed care entities to develop standards for measuring quality. The project will evaluate plan performance in four different areas in enrollee satisfaction, internal quality assurance processes, attributes of mental health and substance abuse services, and technical quality of medical care. Additionally, it will assess the quality of care given to members by monitoring member satisfaction through the use of satisfaction surveys.

Total Quality Management

Total quality management (TQM) is a systematic way of identifying internal and external customer needs and developing processes and products that meet or exceed customer needs and expectations. The goal is to produce the products and services while emphasizing continuous improvement instead of minimum standards. In employing TQM, organizations must make quality an integral part of production and distribution.

Japanese companies have long used TQM to advance competitively by continually refining their products; such U.S. giant as Xerox and Federal Express are now adopting TQM. The focus on TQM has led employers to expect the same emphasis on quality from their health benefit organizations. Managed care organizations will continue to give importance to the quality management aspect of health care delivery as the marketplace becomes more sophisticated in the pursuit of value for its health care dollar. The TQM represents a more sophisticated element on the continuum of managed care by-products.

The Search for Quality Shapes the Next Decade

The focus on quality instigated by managed care will have profound implications for the provision of and demand for health care in this country over the next decade. Myths and illusions of how much care is necessary and what treatments are appropriate will be shattered by empirical data that will reshape the motivating factors in health care delivery and consumption. Insurers are central players in this effort to define and measure quality and will continue to play a vital role in designing products and services that serve the needs of health care purchasers and consumers.

Conclusion

Managed care will not only stimulate change within the commercial insurance industry, but will influence all payers, purchasers, and consumers of health care, and will transform the relationships between the three primary payers in the private sector: commercial insurers, HMOs and Blue Cross/Blue Shield plans.

Before managed care, these three payers were very distinct entities with indifferent attitudes towards each other. As competitors, their key objective was to enroll the most individuals, without attempting to make basic delivery system changes. As managed care garnered greater acceptability, commercial insurers and "the Blues" began adopting managed care approaches closely tied to proven HMO principles, and a mutual learning environment ensued. Today, there is a greater sense of compatibility between these payers as each group embraces strategies found successful by the other. As a result, distinctions are blurring and the entire health care system benefits.

The effects of managed care on the insurance industry are far-reaching and irreversible. Not only is managed care altering many business practices of insurers, but it is dramatically changing their approach to providing health insurance coverage to employees and their dependents. Insurers are firmly committed to providing to businesses greater value for health care services by offering managed care products or incorporating managed care techniques in their other business lines. In addition to prompting insurers to develop new areas of expertise, managed care has already spot-lighted the importance of functional areas where insurers have traditionally excelled. Managed care is inspiring a new era in health care delivery and financing and its influence will long be felt as it continues to transform our health care system.

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