Commentary

Can Managed Care Control Costs?

by Donald W. Moran and Patrice R. Wolfe

With the debate over fundamental reform of the health care system moving into high gear, reformers are considering ways to control costs with the goal of expanding access to health care. Proponents of expanding insurance coverage are compelled to stake out a position on the question of whether costs will be controlled through centralized regulatory mechanisms or through methods designed to internalize incentives for cost control in an otherwise pluralistic system.

In the debate to this point, proponents of central control show strong interest in the concept of global budgeting, as it is perceived to be practiced in other industrialized countries. While details differ, the main thought is to impose spending ceilings on health care providers. Funds would then be allocated among competing demands for services through negotiation at the public-sector level.[1] Proponents of pluralistic strategies, by contrast, rely on the proposition that managed care allows providers to internalize incentives for cost control while avoiding central regulation. According to this concept, transforming the delivery of health care from unfettered fee for service into clinically integrated networks of physicians and other providers will curb unrelenting growth in volume of services throughout the health care system.[2]

It is not certain which strategy will ultimately prevail. Insurance plan sponsors from both the public and private sectors have been unable to solve the pandemic cost problems that intensified during the 1980s with the wave of the "managed care" magic wand. This has led to nagging doubts that managed care could contain costs more effectively than could central regulation. Before we conclude that central budgeting is inevitable, however, we should investigate the proposition that managed care has failed to live up to its early cost containment potential because, as with communism (or supply-side economics), the "real thing" has never been tried widely enough to ensure success.

Donald Moran is a vice-president and Patrice Wolfe is a senior associate at Lewin/ICF, a consulting firm in Washington, D.C.

In this Commentary, we assess whether a comprehensive managed care strategy could, in fact, succeed at containing costs. At times, we speculate about how the health care delivery system might be organized under such a regime and what this means for health care costs. While our reasoning about these matters has been heavily influenced by valuable insights offered over the years by our colleagues at Lewin/ICF, we hereby absolve them from all responsibility for our more extreme opinions.

Has managed care really been tried? *A priori,* we see several reasons to suggest that the persistence of chronic cost problems is due at least in part to insufficiently applied managed care efforts. First, most Americans receive care that is managed by nothing more than the most rudimentary utilization management techniques.[3] When Americans are offered access to efficient delivery systems, many elect not to participate. This can lead to powerful selection effects, which can drive up the overall cost of care.[4]

Even among those who enroll in health maintenance organization (HMO)-style benefit programs, 41 percent enroll in loose, individual practice association (IPA) HMOs that until recently have failed to offer the degree of clinical integration offered by closed-panel staff- and group-model HMOs.[5] Even for those enrolled in the "real thing," there is some evidence that the premiums paid for their coverage reflect the ability of HMOs to raise their prices to match those of competitive alternatives in the unmanaged care sector, rather than reflecting the cost economies that are possible.[6]

What might the "real thing" look like? One might be led to conclude that, to give managed care a fair chance, the entire population must enroll involuntarily into systems based on closed networks of providers operating with a high degree of clinical integration to produce economically efficient care. If this extreme version of managed care is what is required for success, however, then the "managed care strategy" is merely a utopian vision that flies strongly in the face of both popular and professional medical preferences and thus is impossible to enact in a democracy.

An effective managed care strategy, if indeed one can be found, must be designed to accommodate the important political realities that have thus far dampened the demand for more widespread diffusion of the "real thing." Here we outline these critical impediments and investigate whether it is possible to accommodate these concerns and permit sufficiently widespread application of health care management techniques to offer some reasonable prospect of success in controlling costs.

Impediments To The Acceptance Of Managed Care

Physician/patient relationships. Based on our work in evaluating

managed care systems around the country, we see three major impediments to the widespread acceptance of the "real thing." The first of these obstacles is the widespread perception that systems that tie beneficiaries to a defined list of providers disrupt existing relationships between physicians and patients. Setting aside political rhetoric about "freedom of choice," we see that two sorts of relationships are of particular relevance. The most common source of friction is the extent to which enrollment in managed care, particularly of the "primary care gatekeeper" variety, impedes relationships with routine primary care providers, notably obstetrician/gynecologists and pediatricians. A less common but equally important set of relationships involves patients under active treatment for chronic conditions.

Exclusive arrangements. The second major impediment is the apparent unwillingness of many physicians to voluntarily associate exclusively with clinically integrated provider networks. Although the number of young physicians who join organized staff and multispecialty group practices is rising, most physicians involved in "managed care" are really fee-for-service practitioners who enter into a multiplicity of contracts with different IPA HMOs to deliver care in their own offices. While it is likely that economic pressures will induce ever-greater practice consolidation over time, it seems unlikely that all practicing physicians will freely choose to associate exclusively with closed panels any time soon.

Specialization. In theory, these two attitudinal barriers to the diffusion of managed care could be overcome with a draconian dose of economic and regulatory pressure. Even if the political will could be mustered, however, a third impediment may not be easily legislated away: the ongoing trend toward specialization.

Increased specialization creates increasing economies of scale in the delivery of health care. In the world of general medicine, an individual physician can effectively serve a population base of three to five thousand patients. Even in smaller communities, it is technically feasible for an individual health plan to develop exclusive relationships with such physicians that would support their entire practices (although sparsely populated rural communities may never support locally based organized delivery systems). In the world of tertiary and quaternary subspecialization, however, the population base required to support an individual physician can rise above that of many U.S. urban centers. One practical effect of subspecialization is to confer quasi-monopoly powers on certain providers of care and thereby frustrate the ability of organized delivery systems to develop meaningful economic relationships with them.

If the cost of care were relatively homogeneous across the population, it would be possible to visualize a strategy that left these highly specialized

providers outside the organized boundaries of "managed care," to concentrate on the great majority of medical practice that is more conducive to the application of managed care techniques. Unfortunately, however, most benefit costs for a defined population, in any given year, are attributable to a small percentage of the covered population. In the typical U.S. employer group, 5 percent of beneficiaries typically consume more than half of annual health expenditures.[7] Most of such costs represent the costs of hospitalization and the services of specialists, not the services of primary care physicians. The upshot of this is that costs to health plans often are concentrated in areas that are the most difficult to internalize in an organized delivery system with a fixed geographic base.

Due to this fact, even the best-run managed care systems have turned increasingly to specialized subnetworks to manage such services as psychiatric care and pharmacy benefits. Over 50 percent of all U.S. HMO beneficiaries, for example, now have their behavioral health benefits managed by a contractor outside the HMO.[8] As it has become increasingly clear that the management of specialized care is a critical determinant of success for managed care, the managed care industry has itself become increasingly specialized, building regional or even national intervention strategies designed to address the impossibility of internalizing management of costs within a geographically defined network. This trend toward what might be called "counter-specialization" has become a growing force in the way managed care is delivered.

We maintain a database on private vendors offering specialized managed care programs—ranging from psychiatric benefits management to drug utilization review to "foot care PPOs" (preferred provider organizations). Our last round of data collection identified more than 350 such firms. At present, we have identified at least twenty distinct specialty areas within "managed care" that are now operational or in active development. As claims data analysts and benefits consultants zero in on increasingly specialized problem areas, it appears certain to us that the trend toward specialization—and subspecialization—will accelerate. Today, for example, many of the firms that specialize in relatively mature areas of case management, such as rehabilitation case management, are developing subspecialized programs focused on workers' compensation and auto insurance beneficiaries.[9] While commercial insurers are acquiring many of these companies to provide support to their national managed care networks, our experience in monitoring specialized managed care firms shows that the growth rate of new start-ups substantially exceeds the rate of consolidation.

There is also some preliminary evidence that managed care systems that match up specialized case managers and reviewers with specialized

health care professionals experience greater acceptance by the professional community than the traditional, arm's-length utilization management activities staffed by nurse reviewers (or primary care gatekeepers) with limited or no experience in particular subspecialty areas. This potential for professional acceptance is further heightened in those models that concentrate on the organized delivery of care in particular areas, such as behavioral disorders, in which the specialized physicians themselves are responsible for the system's design and management.

The Second-Best 'Real Thing'

Based on the foregoing, it seems clear to us that if we expect managed care to have a significant and permanent impact on costs, it will look far different from the "dueling HMO" model long envisioned by health care "competition" advocates.[10] While comprehensive alternative delivery system models undoubtedly will continue to make sense for some physicians and patients, we would expect many or even most managed care systems in such a world to amount to a group of competing "general contractors," who would develop contractual arrangements that associate individuals or groups of beneficiaries with a customized cluster of specialized managed care vendors for the delivery of a specific mix of benefits.

As is now increasingly the case in IPA HMOs, the "network" side of the equation in such a system would comprise a cluster of different business entities, potentially combining networks of differing geographic scope. For benefits associated with conditions requiring extended institutionalization of patients, competing national networks likely would involve institutions that specialize in specific areas, such as spinal rehabilitation or respiratory disease.

For benefits associated with routine primary care and basic medical/surgical services, by contrast, network elements would undoubtedly continue to be local. Based on what we have observed regarding specialized vendors under contract to existing managed care networks, we would not anticipate that such a market would be exclusive. National vendors, in particular, might contract with multiple plans offering benefits in a local market. Local plans, to promote competition on price and service, might maintain contracts with multiple sources of the same services.

The major design concern in such systems would be the extent to which they would possess some central element that would be responsible for performing triage functions and routing patients throughout the system. Benefit designs likely would vary depending on patients' characteristics and preferences. While some patients would be willing to accept plans that subjected all referrals to the discipline of case management, it seems

possible to permit "carve-outs" for routine gynecological or pediatric care, provided that more active case management and oversight could be used when conditions warranted. In many cases, physician-based primary care case management could be eliminated altogether in favor of central referral mechanisms that routed patients to appropriate specialists based on triage algorithms operated by nonphysicians.

Implications For The Organization Of Health Services Delivery

Such a heterogeneous managed care "system" would have different implications for different types of physicians and institutional providers. For routine primary and preventive care, such as pediatrics and gynecology, we would expect the existing alternatives of prepaid group practice and fee-for-service medicine (however organized) to continue, although practitioners in both settings would experience considerably greater influence from case management systems designed for patients with particular conditions. For general internal medicine and surgery, by contrast, the closed-panel delivery model would be far more pervasive, since beneficiaries show greater acceptance of referral management in such areas.

For specialties that can be supported by a subset of the local population (for example, psychiatry), we would expect the trend toward specialized network development to accelerate. Although multispecialty group practices would not disappear entirely, specialized networks may prove a superior ability to contain costs via customized protocols and peer reinforcement. So far, physicians in such single-specialty networks have not drawn their entire patient bases from a single managed care organization. However, we believe such formation is a distinct possibility over time.

For low-density specialties, by contrast, we expect the dominant mode of organization to be based on solo or small single-specialty group practices linked together via regional or national referral networks. Over time, we would expect such networks to achieve an increasing degree of clinical integration, as network builders recruit physicians willing to develop a common philosophy of practice.

The implications of such a managed care system for institutional providers seem somewhat less clear-cut, although we would expect the implications to flow naturally from the reorientation of physician relationships. In areas where closed-panel physician groups could obtain efficient capacity, mutually exclusive relationships between hospitals and the closed panels could emerge. At current HMO inpatient hospital utilization rates, a 200-bed hospital would require a population base of 177,000 to achieve an 85 percent occupancy rate. Given this, we expect

that such exclusive relationships would be found primarily in larger urban areas.

Even in smaller areas, however, hospitals will face increasing pressures to specialize. At one extreme, hospitals could become national referral centers linked to national specialist referral networks. The most obvious candidates would be those offering treatment and rehabilitation protocols for diseases that are typified by longer lengths-of-stay, where patient immobility is not a barrier to transfer of patients from all over the country to a central facility. Within local markets, exclusive relationships between distinct hospital units and closed physician practices will continue to develop. For many areas of care, such arrangements could eventually transform hospitals into (at least partial) condominiums, with distinct units dedicated under exclusive contracts to physician-controlled specialty networks.

The murkiest region of our crystal ball is the likely impact widespread application of managed care will have on technology diffusion in health care. Significant efforts by managed care organizations to actively control the medical technology infrastructure are thus far limited to the few large, closed systems, such as Kaiser Permanente, that manage their own institutional delivery configurations. Private network builders, however, have recently begun to concern themselves with the extent to which network physicians are tied through economic arrangements to specific equipment configurations. If one reasons solely from the facts available, it seems most likely that active control of technology diffusion would be most intense in specialized networks, where protocol-driven treatment patterns could, over time, come to have a major influence over the diffusion of new technologies.

Could Such A System Contain Costs?

We believe that a "system" of the type described could successfully manage volume to contain costs and that the magnitude of the impact could be substantial. The lion's share of service use is concentrated in the relatively small percentage of the population that actively consumes acute and chronic care services at any point in time. The basic techniques of managed care—selective contracting of efficient providers, limitations on patient self-referral to services, and coordinated efforts to promote efficient practice patterns—have, in our judgment, proved to be most effective in just such settings.

For example, implementation of network-based psychiatric case management systems has been very effective in constraining service volume in the past few years. In the late 1980s, beneficiaries in employee groups

without focused psychiatric benefits management typically experienced approximately 120 inpatient hospital days per thousand beneficiaries. Application of only rudimentary utilization management strategies, such as focused psychiatric inpatient precertification, typically reduces utilization to the range of 90 days per thousand. In network-based systems, where physicians have the opportunity to substitute more cost-effective outpatient treatment for hospitalization, hospitalization rates in the range of 40–60 days per thousand are common. Since hospitalization typically accounts for more than half of the cost of overall psychiatric/substance abuse benefits, the degree of cost containment achieved by such systems is substantial (15–30 percent reductions in overall benefit costs).[11]

Of course, not all areas of acute and chronic care are likely to yield such savings. Yet even a 10 percent reduction in costs for the 5 percent of the population that uses services most heavily would amount to more than $30 billion in first-year savings due to lower utilization—even assuming that "managed care" had absolutely no effect on the service use patterns of the remaining 95 percent of the population. When combined with the administrative economies that could be achieved through widespread application of exclusive plan/provider relationships, a comprehensive managed care strategy has sufficient cost containment potential to merit consideration.

How Might We Get There From Here?

Developments to date in the direction we have envisioned have resulted from decentralized private experimentation. In fact, most public-sector efforts to intervene in this evolutionary process—through mandated benefit requirements, regulation of utilization management programs, and the like—have probably constituted net impediments to further technological innovation.

Given the urgency of rising health care costs, however, we expect the private managed care industry to continue to slog on in the direction of devising new strategies to address previously intractable cost management problems. Those who find these developments constructive, therefore, must be forgiven if they look with skepticism on cost containment schemes that would delegate detailed decision making about resource allocation in the health care field to the quasi-legislative (and not-so-quasi-political) negotiating processes envisioned by advocates of global budgeting and central regulation.

NOTES

1. Adherents to this approach commonly point to the budgeting processes of the Canadian Medicare system as a model.
2. The most visible articulation of this approach is embodied in the "managed competition" model envisioned by Alain Enthoven and Richard Kronick. A. Enthoven and R. Kronick, "A Consumer-Choice Health Plan for the 1990s," *The New England Journal of Medicine* (5 January and 12 January 1989).
3. While a recent Health Insurance Association of America (HIAA) survey reported that 95 percent of all health benefit plans required patients and physicians to comply with some form of utilization management, that number would fall to less than 25 percent if only network-based plans with stringent utilization controls (such as primary care gatekeepers) were considered. C. Sullivan and T. Rice, "The Health Insurance Picture in 1990," *Health Affairs* (Summer 1991): 109.
4. As part of a Lewin/ICF study performed for the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, on the future of employer-sponsored health insurance, we looked at the impact of adverse selection on multiple-choice plan offerings. In reference to the point-of-service plan, we found that if incentives against out-of-network use are weak, the plan becomes virtually indistinguishable from a standard indemnity product in terms of cost performance. Lewin/ICF, *Projecting the Changing Employer Health Insurance Environment: 1987–1994* (June 1990).
5. *The InterStudy Edge, Managed Care: A Decade in Review, 1980–1990* (Excelsior, Minn.: InterStudy, 1991), 3.
6. This effect, labeled "shadow pricing" by observers of HMO actuarial practices, is often exacerbated by the tendency of benefit designs to fatten up the HMO benefit package as an enticement to induce enrollment. While we are not aware of any vigorous analysis that confirms the hypothesized effect, the perception of "shadow pricing" approaches conventional wisdom in the benefits consulting industry.
7. Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).
8. "What Does the Future Hold for Managed Behavioral Health Programs?" *Open Minds* (February 1991): 4.
9. Lewin/ICF Managed Care Vendor Data Base.
10. D.W. Moran, "HMOs, Competition, and the Politics of Minimum Benefits," *Milbank Memorial Fund Quarterly* (Spring 1981): 190–208.
11. "Aetna Survey Says 'Focused' MHSA UR Lowers Employee Cost by $35," *Managed Care Outlook* (1 February 1991): 7.