

MARKET WATCH

Managed Care Rebound? Recent Changes In Health Plans' Cost Containment Strategies

Strategies from the first wave of managed care have crept back into the practices of health plans.

by **Glen P. Mays, Gary Claxton, and Justin White**

ABSTRACT: Large increases in health care costs combined with an economic slowdown have created pressures for health plans and employers to reconsider cost containment strategies that were scaled back after the managed care backlash. In this paper we examine how plans' approaches to cost containment and care management have evolved since 2001. Plans reintroduced and refocused some utilization management techniques during 2002 and 2003 while continuing to invest in disease and case management. Some also began to experiment with new variants of managed care, including tiered provider networks and incentive-based provider payments. However, few respondents believed that these strategies alone would greatly reduce future costs.

HEALTH CARE SPENDING and private health insurance premiums have increased rapidly in recent years, raising new questions about the sustainability of these trends.¹ During the early 1990s rapid spending growth and the resulting pressure from employers and other purchasers prompted health plans to adopt more aggressive approaches for containing costs that collectively became known as managed care.² Use of these approaches—including selective provider networks, provider risk contracting, primary care gatekeeping, and utilization review—increased steadily in many health insurance markets during the 1990s, as did enrollment in health maintenance organizations (HMOs), the most restrictive form of managed care.³ By 2000, however, growing consumer and provider dissatisfaction with man-

aged care and persistently tight labor markets led employers to adopt less restrictive insurance products and health plans to discontinue or scale back their cost containment efforts.⁴ According to some observers, these developments signaled the end of managed care as a defining feature of the U.S. health insurance industry.⁵ This suggests that private insurance markets may no longer provide sufficient pressure for health care cost containment and efficiency.

Most recently, large increases in health insurance premiums combined with an economic slowdown have created pressures for health plans and employers to reconsider approaches for managing care and containing costs.⁶ One plausible response is to shift a greater proportion of health care costs to consumers through premium contributions, co-

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payments, and deductibles. However, these actions may have only a limited impact on overall cost trends, create financial barriers to needed health care, and potentially result in fewer consumers' taking up insurance coverage.⁷ Another response is to revisit the cost containment strategies of managed care under the assumption that recent premium increases and slack labor markets have made employers and employees willing to accept more restrictive health insurance products. This paper explores these possibilities by examining how insurers' approaches to cost containment and care management have evolved since 2001. Study findings provide insight into the continued viability of market-driven approaches to cost containment in health insurance.

Data And Methods

Data for our analysis were collected as part of the Community Tracking Study (CTS), a longitudinal study that uses multiple data sources including site visits and national surveys to examine how local health care systems are changing.⁸ As part of this study, site visits are made every two years to twelve metropolitan communities that were randomly selected

to be nationally representative of local health care systems in markets with more than 200,000 residents: Boston, Cleveland, Greenville (South Carolina), Indianapolis, Lansing, Little Rock, Miami, northern New Jersey, Orange County (California), 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 (Exhibit 1).

During four rounds of CTS site visits, in 1996–97, 1998–99, 2000–01, and 2002–03, structured interviews were conducted in each community with decisionmakers in leading health plans, hospitals, physician organizations, employers, insurance brokerages, and legislative and regulatory bodies at state and local levels. Approximately 1,000 interviews were completed during the fourth round of visits, including approximately 260 interviews with executives from 71 health plans. In each community we interviewed administrators of at least one national health plan, local or regional health plan, Blue Cross/Blue Shield plan, and a plan serving primarily Medicaid

EXHIBIT 1 Characteristics Of The Community Tracking Study (CTS) Communities, 2003

Community	MSA population (millions)	Percent enrolled in HMOs			Number of plans interviewed ^a
		People with commercial insurance	Medicare beneficiaries	Medicaid recipients	
Boston	2.8	50.5	16.0	19.8	9
Cleveland	2.1	22.0	16.1	47.0	10
Greenville (SC)	0.6	11.8	0.0	13.1	7
Indianapolis	1.6	23.0	0.0	56.6	11
Lansing	0.5	42.2	0.0	26.3	6
Little Rock	0.6	24.5	0.0	0.0	6
Miami	2.3	60.6	35.8	24.4	6
Northern NJ	2.1	27.9	5.9	69.8	8
Orange County (CA)	2.9	61.2	33.0	17.5	10
Phoenix	3.5	23.8	29.9	46.6	10
Seattle	2.4	20.5	12.3	16.9	10
Syracuse	0.7	15.9	0.0	31.3	9

SOURCE: InterStudy *Competitive Edge*, using data from January 2003.

NOTES: MSA is metropolitan statistical area, using the new U.S. Census Bureau definitions as of 6 June 2003. HMO is health maintenance organization.

^a Includes third-party administrators (TPAs) and preferred provider organizations (PPOs).

beneficiaries. In each of these plans we attempted to interview the chief executive officer (CEO), medical director, marketing executive, network development executive, utilization management director, and pharmacy benefit administrator. To ensure adequate coverage of the major health plan competitors, we interviewed executives at up to two additional health plans in each community, including major preferred provider organization (PPO) plans, as well as one or more third-party administrators (TPAs) for self-insured employers.

Health plan interviews asked about changes in the design and operation of health insurance products and about the rationale and perceived impact of these changes. In this paper we focus specifically on health plans' approaches to cost containment, including utilization management processes, disease and case management programs, provider contracting and network development strategies, and benefit design and cost-sharing arrangements. To confirm and expand upon this information, we also inquired about health plans' cost and care management approaches during interviews with employers, benefit consultants, insurance brokers, hospitals, and physician organizations. Data from each interview were coded, extracted, and analyzed using text analysis software. Interview responses were analyzed both within and across the twelve communities to examine how the use of cost containment approaches varies across health plans and local markets. In this paper we give primary focus to information obtained during the fourth round of CTS site visits conducted in 2002–03, and we compare this information with that obtained and reported in previous rounds of the study.⁹

Results

After discontinuing or relaxing many managed cost containment tools during 2000 and 2001, sizable numbers of health plans have refined and refocused these approaches during the past two years in an effort to moderate the recent growth in health care costs and use. Refinements included selective reintroduction of

utilization management techniques; expanded investments in disease and case management programs; and development of restricted provider networks and new provider incentive programs designed to encourage efficient clinical practice. Although far from being adopted universally, these changes were pursued by some of the largest, most visible insurers in the communities studied, perhaps providing a preview of what is to come. Although these leading health plans are using more than just higher cost sharing to constrain premium growth, relatively few expect that their current approaches will have large near-term effects on cost trends.

■ **Utilization management.** Health plans in six of the twelve study communities reintroduced prior authorization requirements for selected services after having eliminated these requirements (Exhibit 2). In northern New Jersey, for example, Aetna eliminated prior authorization requirements for approximately fifty inpatient and outpatient services in its HMO and PPO products during 2000–01 but reinstated many of them during 2002–03 after experiencing sharp increases in health care use. Similarly, Excellus BlueCross BlueShield in Syracuse reinstated prior authorization requirements for specialist referrals within its HMO product after finding that referral rates increased markedly when these requirements were eliminated during 2002. These health plans noted that although many services subject to prior authorization are rarely denied, the requirements often discourage requests for services that are not considered medically necessary. However, health plans in five communities continued to eliminate prior authorization requirements for hospitalizations, noting that inpatient care was less likely than other types of services to be discretionary.

In reintroducing prior authorization requirements, health plans have targeted those services that offer little or no clinical benefit while being careful not to reduce access to potentially beneficial services. In many cases, the new prior authorization requirements were less restrictive than those the plans had used previously. In Seattle, for example, Regence

EXHIBIT 2 Health Plans Reporting Changes In Utilization Management Processes Since 2001

Type of change	Plans (N = 56) ^a	Communities (N = 12)
Prior authorization requirements		
Hospitalizations		
Increased use	5	4
Decreased use	5	4
Outpatient services/procedures		
Increased use	5	4
Decreased use	0	0
Specialist referrals		
Increased use	4	3
Decreased use	1	1
Prescription drugs		
Increased use	7	4
Decreased use	0	0
Concurrent review processes		
Increased use	7	5
Decreased use	2	2
Retrospective review and provider profiling		
Increased use	15	9
Decreased use	2	2

SOURCE: Authors' analysis of data from the Community Tracking Study, 2000–01 and 2002–03.

^a Excludes third-party administrators (TPAs).

BlueShield adopted a policy requiring prior authorization only after a patient has exceeded an established utilization threshold, such as a third magnetic resonance imaging (MRI) scan or a tenth chiropractor visit. This policy was adopted for both its HMO and PPO products. In several other markets, health plans have replaced prior authorization requirements with more lenient notification policies that oblige patients or their physicians, or both, to advise the plan of an impending procedure or service to receive full coverage. These plans provide partial coverage for the designated services if advance notification is not received.

Health plans in five communities have stepped up their efforts to review hospital stays concurrently in an effort to reduce lengths-of-stay and eliminate unnecessary diagnostic tests and procedures received in the hospital (Exhibit 2). Some plans recently have begun to station utilization review nurses in frequently used hospitals to monitor patient care, while other plans have adopted new telephone-based review procedures in an effort to

cover more hospitals with fewer staff. In Miami, for example, Blue Cross and Blue Shield of Florida reintroduced an in-hospital concurrent review program in 2002 after finding that the hospitalist program it had created to replace concurrent review did not reduce unnecessary hospital days and costs.

Although most plans historically have used concurrent review processes only in HMOs, several plans introduced these approaches into their PPOs in 2002–03, as these products have become more popular and costly. One plan moved from in-person to telephone-based concurrent review specifically to begin using it in its PPO hospital network, which was much larger than the HMO network in which in-person reviews had been used. In an effort to reduce the administrative costs of conducting concurrent reviews, some health plans have adopted processes for reviewing inpatient cases only after stays have exceeded an established outlier threshold based on the patient's diagnosis and severity. Additionally, several plans have begun to use concurrent re-

view processes in non-hospital-based settings such as skilled nursing and rehabilitation facilities and for ongoing outpatient services such as physical, occupational, and speech therapy. Plans noted the steady growth in spending for these services as the primary rationale for these changes.

Health plans in nine communities have introduced or expanded initiatives for reviewing health care claims retrospectively and profiling providers based on indicators of health care use and quality. These plans varied widely in the types of providers profiled, the measures of use and quality reviewed, and the ways in which this information is used. A large Seattle insurer, for example, recently introduced a claims review system to detect targeted instances of inappropriate care delivered by hospitals and physicians in both its HMO and PPO products so that the plan could follow up with problematic providers and, in some cases, withhold payment for the services. In Greenville, a health plan began collecting comparative data on physician use and costs to use as part of its contract negotiations, while a Lansing health plan introduced a system for profiling physicians in its HMO using Health Plan Employer Data and Information Set (HEDIS) measures of quality and providing comparative feedback reports to encourage improvements. Many of these plans reported making sizable investments in their information systems during 2002–03 to support retrospective review and profiling applications.

Unlike the trends observed for some prior authorization and utilization review requirements, we saw no resurgence in the use of primary care gatekeeping requirements among plans in the study communities. During 2000–01 health plans increasingly moved away from these requirements by introducing open-access HMOs and PPOs as alternatives to traditional gatekeeper HMOs. Enrollment in these open-access products continued to grow during 2002–03, but most health plans retained their gatekeeper HMO products as lower-cost insurance options.

■ Disease and case management.

Health plans continued to expand disease and

case management programs in 2002–03 in an effort to improve care and reduce costs for patients with chronic and complex health conditions. Plans in at least half of the study communities added new disease management programs during this period, while many other plans took steps to expand participation in their existing programs (Exhibit 3). A Lansing health plan, for example, recently added programs for osteoporosis and back pain to its array of offerings that already included programs for congestive heart failure, asthma, diabetes, and depression. Other plans have made existing disease management programs available to more members. For example, health plans in Seattle and Greenville previously offered disease management only in their HMOs but recently began offering these programs to their PPO members as well.

Health plans have begun to move beyond traditional disease management to more targeted approaches that seek to identify and address the health care needs of high-risk patients who are likely to generate high health care costs.¹⁰ Unlike traditional disease management, these approaches focus on managing the health care needs of high-risk patients through intensive and customized case management, instead of emphasizing standardized, disease-specific interventions that apply to an entire population of members. Health plans in nine communities have adopted intensive case management programs combined with “predictive modeling” applications that use health care claims data and health risk assessments to identify members with utilization patterns or complex health conditions that suggest they are likely to generate sizable health care costs in the future. Most of these plans implemented such programs in both HMOs and PPOs. By identifying high-risk members prospectively, these plans expect to lower future health care costs through avoiding delays in receipt of needed health care, coordinating health care delivery and eliminating redundant care, and encouraging member self-management of health conditions.

Many plans have introduced intensive case management and predictive modeling applica-

EXHIBIT 3 Health Plans Reporting Changes In Other Cost Containment And Care Management Approaches Since 2001

Type of change	Plans (N = 56) ^a	Communities (N = 12)
Disease management programs		
Increased use	15	6
Decreased use	2	2
Intensive/complex case management programs		
Increased use	18	9
Decreased use	0	0
Provider networks		
Developed limited-network product	4	3
Developed tiered-network product	9	6
Provider incentives		
Introduced financial incentive program	15	7
Introduced nonfinancial incentive program	2	2
Eliminated incentive program	2	2
Benefit design and cost sharing		
Increased deductible and copayment levels	35	12
Introduced deductible HMO product	2	2
Introduced coinsurance options	5	3
Introduced consumer-directed health plan	30	11

SOURCE: Authors' analysis of data from the Community Tracking Study, 2000–01 and 2002–03.

NOTE: HMO is health maintenance organization.

^a Excludes third-party administrators (TPAs).

tions alongside their traditional disease management programs. These plans view member-focused case management programs as “filling in the gaps” by serving members with complex conditions and health care needs that are not addressed by existing treatment protocols and standardized care plans. However, other health plans have adopted intensive case management as an alternative to traditional disease management programs that are viewed as ineffective or of benefit to limited numbers of members. In Seattle, Regence Blue Shield discontinued most of its disease management programs—including programs for diabetes, asthma, and cardiovascular disease—in 2002 and replaced them with an intensive case management program linked to predictive modeling. Similarly, in Miami, UnitedHealthcare chose to emphasize intensive case management rather than disease management in its Medicare+Choice plan because of the large number of members who have multiple health conditions that would not be addressed by a single disease management program.

■ **Network design and provider contracting.** In contrast to the emphasis placed on broad and inclusive provider networks in previous years, some health plans have begun to experiment with new products that restrict provider choice in order to achieve cost savings. Health plans in Syracuse, Orange County, and Miami introduced new PPO and exclusive provider organization (EPO) products in 2002–03 that offer a more limited choice of hospitals and physicians than is available in the standard PPO and HMO products in these markets. One Orange County plan, for example, expected to include only about half of its contracted physicians and hospitals in its new PPO product under development and expected to sell this product for 10–15 percent less than its standard PPO product.

Similarly, health plans in at least half of the communities have begun to experiment with tiered provider networks, which group providers into tiers based on measures of the cost of care they deliver and then encourage patients to choose providers in the lower-cost

tiers through reduced cost sharing.¹¹ In Orange County and Boston, plans have developed tiered networks for hospitals only, while in Seattle and Miami, plans have included both physicians and hospitals in the tiers. However, most plans have experienced considerable operational difficulties with these products, including methodological challenges in differentiating providers based on cost measures and resistance from large hospitals and medical groups. In Cleveland and Indianapolis, several hospitals have preemptively negotiated contract language that precludes these types of products, and in other markets large hospital systems have threatened to drop out of the network altogether unless they are placed in preferred tiers. Moreover, both providers and employers have expressed concern that quality of care typically is not considered when forming tiers—a limitation that some health plans have begun to address. Most of the tiered-network products launched to date exclude relatively few providers from the preferred tiers and therefore offer relatively modest savings over traditional, single-network products. Moreover, enrollment in these products has been light in most communities.

We found no evidence of a resurgence in the use of capitated payment arrangements for providers in the study communities. Some health plans previously had used these arrangements in HMOs to encourage providers to reduce health care use and costs, but they were scaled back or abandoned in many communities during 2000 and 2001 as a result of provider resistance and the growing demand for open-access products.¹² Since that time, plans in many communities have moved to fee-for-service (FFS)-based payment systems for both HMO and open-access products, with a few exceptions. Some plans continue to use capitated payments with physician organizations that have developed the infrastructure to operate successfully under this form of payment—an occurrence observed more frequently in Orange County than in the other study communities. Moreover, health plans in several communities continue to use capitated provider payment systems only in their

Medicaid and Medicare HMOs, noting that such cost containment arrangements allow the products to remain financially viable.

Although the use of capitation remains limited, health plans in most of the study communities have begun to experiment with new incentive payment systems designed to reward providers for the quality and efficiency of care they deliver. Fifteen plans in seven communities have introduced new financial incentives for physicians and hospitals that are based on measures of quality and efficiency (Exhibit 3). Health plans in Seattle, Syracuse, and Orange County began piloting programs that encourage physicians to prescribe lower-cost generic drugs rather than brand-name drugs and offer them a percentage of the cost savings that result. In Lansing, one plan began offering hospitals higher payments in exchange for reducing medication errors and achieving other patient-safety standards, while another plan introduced physician incentives tied to HEDIS quality measures. Similar HEDIS-based incentive programs were launched by plans in Boston, Northern New Jersey, and Orange County during 2002–03.

Some plans viewed these new financial incentives as replacements for capitated provider payment methods that had been used previously in HMOs.¹³ Whereas capitation was used primarily as a cost containment strategy, these new incentives are being used to address both cost and quality issues. Moreover, some plans have begun to introduce these types of incentives not only in HMO networks but also in much larger PPOs. For example, Blue Cross of California introduced an incentive payment and recognition program for its 15,000 PPO network physicians based on measures of quality in chronic illness care and efficiency in generic prescribing.

■ Benefit design and cost sharing.

Nearly all of the health plans we studied reported increasing consumer cost-sharing requirements during 2002–03 in an effort to control escalating premium costs. Continuing a trend noted in 2000–01, plans have increased copayment and deductible levels, added deductibles to HMOs that previously offered

first-dollar coverage, and introduced coinsurance into both HMOs and PPOs that previously offered fixed-dollar copayments.¹⁴ In Seattle, Group Health Cooperative of Puget Sound departed from its long-standing tradition of offering only HMOs with first-dollar coverage by introducing a deductible HMO in 2002 with annual deductible options ranging from \$200 to \$500 for individuals. This product reportedly offered a premium 10–15 percent below the plan's standard HMO, thereby helping the plan compete with lower-price PPOs in the market. Similarly, a large plan in Miami introduced an EPO in 2002 that included coinsurance rates of 20–30 percent for most services rather than the \$10 and \$20 copayments common in other products, reportedly allowing the plan to offer a premium 15–20 percent below those of its closest competitors. The growing popularity of this product prompted several other Miami health plans to develop similar coinsurance products.

Additionally, health plans in all but one of the study communities introduced variants of consumer-directed plans during 2002–03 to give employers additional options for premium savings. These products provide members some first-dollar coverage for health expenses through member-directed spending accounts or other mechanisms, and they require expenses to be paid out of pocket once this coverage is exhausted until an established spending threshold (or deductible) is reached. Most of these products use a PPO provider network as their platform and function like a traditional PPO once the spending threshold is met.

Health plans indicate that consumer-directed products offer employers lower premiums than traditional HMOs and PPOs by shifting more costs to consumers and encouraging consumers to be more economical in their patterns of service use. Nevertheless, employers' interest in consumer-directed products has remained tepid in most markets, and enrollment has been modest, with some exceptions. In Seattle, Regence Blue Shield's new product attracted considerable attention among small businesses and the state's subsidized health insurance program because of

premiums 10–15 percent below those of traditional PPOs and a design that offers full coverage for an initial set of routine services including office visits, diagnostic and laboratory services, and preventive care. Nevertheless, many employers remained skeptical that these products could offer sizable cost savings without substantial reductions in the benefits offered to employees.

Discussion

Recent increases in health care use and costs have prompted health plans to revisit some of the cost containment strategies that were discontinued or relaxed in the wake of the managed care backlash. Health plans re-instituted selected cost controls during 2002–03, although in many cases these controls are less stringent than those employed before the backlash. Health plans have also begun to apply these controls in a broader range of health insurance products, recognizing that HMOs now serve only a small segment of the market in most communities. Collectively, these developments suggest that at least some of the concepts and tools of managed care remain viable in the current health insurance marketplace.

Although these tools' viability appears secure, many health plans, employers, and other stakeholders question their ability to alter future health care cost trends. Although health plans continued to invest in disease and case management programs during 2002–03, most report relatively limited evidence of cost savings.¹⁵ For many plans, these programs need to operate for longer periods of time and achieve higher rates of membership participation before sizable cost savings could be expected. Most of the tiered-network products launched to date offer only modest price advantages over traditional products because relatively few providers are excluded from the preferred tiers. Moreover, enrollment in these products has remained low in most markets, which indicates that their near-term effects on health care costs will be limited. Many of the provider incentive programs adopted to date cover only selected providers and offer relatively modest financial rewards, which sug-

gests that the incentives may not be sufficiently strong or widespread to induce large-scale changes in clinical practice.

Because most health plans are still relatively early in their experience with disease management, tiered networks, and provider incentive systems, the effects of these arrangements on health care costs will depend on how they mature and evolve over time. If tiered networks become more selective and better able to target cost-effective providers, they could begin to place downward pressure on costs. Similarly, the savings from disease management programs and provider incentive systems may increase over time as they reach larger numbers of eligible patients and providers. The success of all of these approaches will hinge in part on health plans' ability to gain the acceptance and cooperation of physicians and other providers. In the wake of the managed care backlash, most plans remain cautious about imposing new requirements and constraints on hospitals and physicians. Moreover, health plans lack the bargaining power to impose such requirements on the large, consolidated health care providers that have emerged in many markets. Instead, plans are focusing on improving provider relationships through better communication and smoother business transactions. Whether these activities will lead to increased provider engagement in cost containment and care management activities remains to be seen.

Employers' and consumers' interest in cost containment approaches is also essential for their success, and such interest may grow over time if health insurance premiums continue to rise rapidly. Because health plans' current approaches place relatively few limits on health care choices, consumers and employers may find them preferable to more restrictive managed care tools. If so, these approaches could become increasingly important features of health plan design and have moderating effects

on health care costs.

Nevertheless, current approaches do little to address the most powerful driver of long-term cost growth: advancements in medical technology.¹⁶ This casts doubt on the extent to which they can truly contain costs. The array of administrative controls and financial incentives in use in 2002–03 lacked the sensitivity and specificity required to differentiate alternative treatment options based on their clinical effectiveness and steer both providers and patients toward the most cost-effective options. Addressing these gaps would require much more aggressive efforts to evaluate new technologies prior to making decisions about coverage, and much more intricate and differentiated systems of incentives for both providers and patients.¹⁷ Developing and implementing such a comprehensive evaluation and incentive system would likely

require policy action at the federal, state, or local levels, since individual health plans would likely face intractable technological challenges and provider resistance. Without such approaches, the long-term cost growth experienced during the past four decades appears likely to continue unabated.

In the absence of more systematic approaches to cost containment, health plans have continued to develop products and options that allow employers to buy down their premiums through higher consumer cost sharing. Because patients faced with higher cost sharing tend to cut back on both discretionary and needed care, these responses may contribute to reduced access to care and, ultimately, poorer health outcomes, particularly for seriously ill and low-income populations.¹⁸ If cost sharing continues to increase, consumers may begin to demand products with more cost containment and care management features, particularly those such as tiered networks that offer consumers a trade-off between costs and choice of providers. These possibilities under-

“In the wake of the managed care backlash, most plans remain cautious about imposing new requirements and constraints on hospitals and physicians.”

score the need for continued efforts to refine and improve such features of health plan design, even if employers appear more focused on cost sharing than cost containment.

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 This research was conducted as part of the Community Tracking Study at the Center for Studying Health System Change and was funded by the Robert Wood Johnson Foundation.

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