ORIGINAL ARTICLE

Managed care in the USA: history and structure

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At the turn of the twentieth century, health care in the United States, as in the rest of the world, was a commodity: you could buy it and enjoy it if you could pay for it. The poor went hungry or received some care at municipal, governmental or charity soup kitchens. In the 1920s, liberal reforms in Western Europe, probably in response to the Communist revolution in Russia, led to state supported universal health coverage. Pressure started building in the US to adopt a similar reform. However, the American Medical Association (AMA), considering a state-run system tantamount to 'communist revolution', was opposed to this. But, a group of physicians fearing government-mandated reforms established Blue Cross, an insurance company to pay for hospital costs and Blue Shield, to pay for physician services (1). Over the next 20 years, this grew into the private indemnity insurance, fee-for-service (FFS) system that paid for a lion's share of health care expenditure for the middle class. Tax incentives encouraged all mid- and large corporations to provide free health insurance to their workers and their dependents as a benefit of employment.

In mid 1960s the Great Society program of President Johnson created Medicare to pay for the health care of the elderly and Medicaid to pay for the poor. As a result, spending by federal, state and local government accounted for 46% of total health expenditure (2). So long as hospital and physician charges were reasonable, either the insurance company or the government paid up. Under the Hill-Burton Act of 1946 and its amendment in 1975, hospitals that accepted federal funds had to provide care for every one, particularly the poor (3). Over three decades health care changed from a commodity to an entitlement. Before the days of third party coverage, the cost of health care restrained excessive consumption. Although organised medicine opposed Medicare and Medicaid vehemently, hospitals and physicians reaped a bonanza. As third party payers covered any charges considered 'usual and customary', there was rapid growth in the number of hospital beds. Patients on their part expected everything done because the direct cost to them was small. As a consequence, health care expenditure almost doubled from 7.1% of GDP in 1970 to 13.9% in 1999 (4).

The health care debate in the US in the 1970s focused on the twin problems of the double digit health care inflation and lack of insurance coverage for the working poor and their families. Those who worked for small businesses that did not provide health insurance benefits, part-time, contract and temporary workers or those self-employed with income too low to afford private insurance, were left out. Ironically the unemployed were covered under Medicaid. Despite the colossal amounts being spent on health care, national public health indices such as life expectancy, infant mortality rate etc., showed that the US lagged behind most industrialized nations while outpacing every one else in total health care expenditure, utilisation of hospital beds and pharmaceuticals and high tab procedures (5). In this environment, the Kaiser Permanante Foundation in California showed that health maintenance organisations (HMOs), developed primarily to enhance health care quality, could check the rising costs by reducing inappropriate utilisation of hospitals and physicians while improving preventive measures such as vaccinations, screening for breast and colon cancer etc.

In early 1970s, in an environment of rising prices, President Nixon signed into law a bill promoting widespread Health Maintenance Organisations (HMOs) with the ostensible goal of improving care with preventive measures. While the original model was meant to improve quality, the intent now was primarily to reduce costs. The next significant step followed the election of President Reagan who signed the 1983 budget reconciliation act. This included a provision granting immunity to HMOs, now directly providing health care unlike insurance companies that just paid for care, from most malpractice law suits. At the same time, the government initiated a push for close scrutiny of hospital admissions and continued stay and the need for hospitalisation for most surgical procedures. Regional Professional Standards Review Organisations (PSROs) established minimum standards for admission. Each hospital had to establish a Utilisation Review (UR) Committee to assess their physicians' use of laboratory, radiology and other resources. The PSROs sent teams to the hospital to review the admissions and continued stay. Those judged inappropriate were denied reimbursement. Now a physician could justify an admission only if the patient was very sick (temperature > 102° F, BP <80/60 or > 180/120, Respirations > 30/min etc.), or the physician was planning to make the patient very sick (major surgery, aggressive chemotherapy, etc.). Hospitals quickly emptied out and many acute care facilities closed or drastically reduced in-patient beds, converting the freed space into out-patient, same-day surgery units or into intermediate and chronic care facilities. In a turbulent decade, with aggressive marketing of lower priced HMO-type coverage and the rising costs of FFS plans, most employers eliminated FFS coverage and offered their employees only a variety of HMO options.

Health care inflation now seemed to be under control and the next major issue was universal health care. Mr. Clinton in 1992, in one of the earliest initiatives of his presidency, appointed his wife to head a commission to develop proposals for expanding health care coverage. The Clinton plan (6) proposed universal health care coverage, expanding the range of services including preventive care, patient rights protection, nominal co-payments for services and pharmaceuticals, elimination of life-time limit on coverage characteristic of most FFS plans, guaranteed equality of premiums and portability of coverage. It gave the worker and not the corporation the choice of selecting coverage. But big business and organized medicine successfully campaigned to block its passage. The extreme complexity of the final 1000+ page report, concerns about how this expanded coverage would be paid for and the antipathy of business to any plan that they perceived as restricting their actions while expanding the role of government, were reasons enough. Corporate America launched a media blitz reminiscent of the 'Willie Horton' campaign of candidate George Bush. The campaign aimed to generate fear in the public emphasizing the weak points of another universal health model, namely the National Health Service of Britain. The TV ads hammered at long waiting times for procedures, lack of choice about physicians and denial of expensive treatments. It worked so well that Universal health coverage was not even in the platform of the Democratic Party in the 1996 and 2000 campaigns. However some elements of the Clinton plan were adopted as separate bills over the next eight years including children's health insurance program

(CHIP) that extends coverage to millions of previously uninsured children, health insurance portability and accountability (HIPAA) and many patient rights provisions. Prescription drug coverage is currently being debated and is likely to be adopted (7). In the absence of legislative direction and debate for universal health care, market forces took over and went about implementing what was recognized by all as essential: cost controls. Managed care seemed to be the best alternative at the time to achieve this (8).

What is managed care?

Managed care combines financing and delivery of health care in a single entity with the aim of improving quality of care while controlling costs. In the traditional system, the employer pays a fixed premium to an insurance company. A patient with insurance coverage can go to any physician or hospital and the insurance company pays 80% of the charges and the patient the rest. In Managed Care, the employer negotiates with a Managed Care Organisation (MCO) to provide for the health needs of their employees and their families. The MCO hires physicians, or contracts with physicians to provide care. It also owns or contracts with hospitals. A patient covered by an MCO may receive care from only those physicians/hospitals on the MCO's list. The intent of the MCO is to reduce demand for health care and at the same time to reduce the cost of care.

To reduce demand, a gate-keeper, usually a nurse, screens the patient's complaint and approves or denies access to a general physician who is expected to handle a far greater range of services than under the FFS system. A patient may consult a specialist only after a referral from the general physician (9). Patients may use only plan physicians and hospitals. Emergency room visits are discouraged by denying payment for 'inappropriate' use. Hospitalisations require pre-certification and many procedures require mandatory second opinion. Pharmaceutical cost containment is achieved by a restricted formulary (10). MCOs use case managers, usually nurses, to oversee care of high cost chronic diseases such as asthma, congestive heart failure and diabetes. Credentialing of physicians by MCOs extends beyond verification of training and certification to review of practice patterns, use of diagnostic tests, rates of subspecialty referrals etc. A system of incentives and penalties based on utilisation review 'encourages' physicians to regulate their use of tests, procedures, and specialty consultations (11, 12). Before laws prohibiting their use, many MCOs included 'gag rules' which restricted physicians to discussing only MCO-sanctioned treatments. Physicians are required to follow specific protocols limiting their clinical autonomy and are monitored for their compliance with practice guidelines. An MCO may also transfer some of the risk to the physician through a capitation arrangement under which the physician is expected to provide total care irrespective of the resources/effort required. This system came to be called 'managed care' as every aspect of medical care is managed.

To reduce costs, MCOs recruit younger healthier patients ('cherry-picking'), negotiate lower charges from hospitals and pharmaceutical companies and force physicians to accept lower fees. Costs are also shifted aggressively to other payers such as the Veterans Hospital Administration, and other insurers.

Types of managed care

Managed care plans include: Health Maintenance Organisations (HMOs), Preferred Provider Organisations (PPOs), Exclusive Provider Organisations (EPOs) and Point of Service (POS) plans. Although there are important differences between the different types of managed care plans, there are similarities as well. All managed care plans involve an arrangement between the insurer and a selected network of health care providers (doctors, hospitals, etc.). All offer policyholders significant financial incentives to use the providers in that network. There are usually specific standards for selecting providers and formal steps to ensure that quality care is delivered (13).

HMO members pay a fixed monthly fee in return for which they receive comprehensive medical services, from office visits to hospitalisation and surgery. There are no co-payments. However, HMO members must receive their medical treatment only from physicians and facilities within the HMO network. When a person joins an HMO, he chooses a network primary care physician (PCP) who is the first contact for all medical care needs. The PCP provides all general medical care and must be consulted before a member can see a specialist.

A PPO is a group of doctors and/or hospitals that provides medical service at discounted rates and may set up utilisation control programs to help reduce the cost of medical care. Members are not required to sign up with a PCP. Rather than prepaying for medical care, PPO members pay for services as they are rendered. A co-payment is required and the member may consult out-of-plan facilities at a higher co-payment. A Point of Service (POS) plan combines characteristics of the HMO and the PPO. Like an HMO, members pay no deductible and usually only a minimal co-payment when a healthcare provider within the network is involved. However, the member must choose a primary care physician who is responsible for all referrals within the POS network. If the insured opts to go outside the network, POS coverage functions more like a PPO. She/he may be subject to an annual deductible (around $300 for an individual or $600 for a family), and the co-payment may be a substantial percentage of the physician's charges (usually 30-40%). An EPO is similar to PPO but the physicians consulted must be part of the plan.

Conclusion

Historically, health care had been a commodity. Progressive forces or enlightened self interest saw its transformation into a right. The marketplace of American style laissez faire capitalism responded by driving up prices. When health care became almost unaffordable, Big Business stepped in and imposed its brand of rationing called 'Managed Care'. In future articles, we will assess the efficacy of managed care and the impact of corporate management on health care ethics.

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