

The Rise and Decline of Managed Care

What Comes Next?

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The Evolution of Managed Care in North Carolina

IN THE EARLY 1980s, the traditional role of the health insurance industry was to provide a standard array of insurance options, and to administer those programs through claims review and payment. Employers who purchased coverage for their workers typically did not expect anything more of their carriers. However, during this time there was mounting evidence, both nationally and in North Carolina, that the use of hospitals varied significantly from one geographic area to another.¹⁻³ Patients in high use areas were not just spending more days in the hospital; they were spending more money for their healthcare. And, increasingly, analysis was showing that most of the variation was due to physician practice patterns, rather than differences in population demographics, health status, or underlying risk factors. Employers who had employees in multiple NC locations began questioning their greater financial outlays to cover employees in the high utilization locations, and wondered what additional benefits they and their employees gained for the extra expense. This led to the obvious question: How much could be saved if it were possible to reduce utilization in the high use communities?

Though employers were increasingly concerned about their insurance costs, they were uncertain about how to ensure their employees were obtaining only the care they needed. In response, Blue Cross Blue Shield of North Carolina (BCBSNC), in partnership with a textile employer in western North Carolina, pilot tested a Pre-Admission Certification (PAC) program.⁴ This began in January 1983 and was the first such program in North Carolina. Its objectives were to encourage outpatient alternatives where appropriate, to discourage weekend admissions, and to provide prior approval for payment of needed inpatient care.

Results of the pilot were immediate and dramatic. During the first year, hospital days per 1000 persons declined 36 percent, representing a reduction in costs to the employer and employees of \$545,000 on a benefit program of \$1.6 million. Another 26% reduction in days per 1000 occurred in year 2. By 1985 the success story of this pilot was widely known and most major NC employers were requesting to be included in the program.⁵ Even groups in communities that traditionally had lower utilization rates enjoyed savings of 15-20% through a PAC program.

Shortly after the BCBSNC PAC program gained momentum, other insurance companies in North Carolina followed suit. *Pre-admission* programs expanded to be *admission* certification programs, requiring approval for emergency and maternity admissions within 24 hours after admission. The next enhancement was *length of stay review*, to determine how many days were approved for reimbursement once an admission was certified. *Case management* was introduced to manage inpatient care and expedite discharge planning for the more complex cases. And *prior approval* programs for costly procedures such as MRIs were developed to ensure that procedures ordered by physicians were medically necessary. All of these programs were a marked departure from the traditional role of health insurers, but were designed to meet the growing cost consciousness of the competitive employer market.

Collectively these programs were designed to manage the care ordered by physicians and provided to patients. While in the decade of the 1980s these were not referred to as “managed care programs”, they clearly were the beginnings of managed care, as we know it today.

Managed care is broadly defined as “Systems and techniques used to control the use of healthcare services. [It] Includes a review of medical necessity, incentives to use certain providers, and case management. [And it includes]

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Table 1. North Carolina licensed HMOs, 1997

1. Aetna Health Plans of the Carolinas, Inc.
2. Aetna U.S. Healthcare of the Carolinas, Inc.
3. Atlantic Health Plans Inc.
4. Blue Cross Blue Shield of North Carolina Line of Business HMO
5. Carolina Summit Healthcare, Inc.
6. CIGNA Healthcare of North Carolina, Inc.
7. Community Choice of North Carolina, Inc.
8. Doctors Health Plan, Inc.
9. Generations Family Health Plan
10. Health Maintenance of North Carolina
11. Healthsource North Carolina, Inc.
12. Kaiser Foundation Health Plan of North Carolina
13. Kanawha Healthcare, Inc.
14. Maxicare North Carolina, Inc.
15. Optimum Choice of the Carolinas, Inc.
16. PARTNERS National Health Plans of North Carolina, Inc.
17. Personal Care Plan of NC, Inc.
18. Principal Health Care of the Carolinas, Inc.
19. Provident Health Care Plan Inc. of North Carolina
20. Prudential Health Care Plan, Inc.
21. Qualchoice of North Carolina, Inc.
22. The Wellness Plan of North Carolina, Inc.
23. United HealthCare of North Carolina, Inc.
24. WellPath Select, Inc.

The body of clinical, financial and organizational activities designed to ensure the provision of appropriate healthcare services in a cost-efficient manner. ...[Managed care is] Any system of health payment or delivery arrangements where the plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.⁵ Components of managed care were developed and incorporated incrementally into many health insurance programs in North Carolina during the 1980s and early 1990s.

As the full complement of managed care components were pulled together the resulting health insurance programs became products that were licensed as Health Maintenance Organizations (HMOs). These included traditional HMO products where coverage was limited to network providers, as well as Point of Service (POS) products that allowed greater access to providers out of the network. Most all products



Figure 1. North Carolina HMOs licensed by the NC Department of Insurance. Source: NC Department of Insurance.

included a gatekeeper arrangement for seeking primary care, and gaining referral access to specialists. During the 1980s there were ten HMOs licensed in North Carolina by the NC Department of Insurance. Subscriber enrollment, though, remained low throughout the decade.⁶

North Carolina Enrollment Peaks in 1998

The number of licensed HMOs grew in the 1990s with a flurry of activity between 1994 and 1997.⁷ As shown in Figure 1, the number of licensed HMOs peaked at twenty-four in 1997. Table 1 lists the HMOs licensed to operate in 1997. The offerings were a mix of North Carolina-based health insurance companies, national companies entering the North Carolina HMO market, hospital-based HMOs and physician group initiated HMOs. While all held HMO licenses to operate, they were at vastly different stages of evolution and readiness for the HMO functions of managing provider networks, marketing, and managing care.

From the peak of 24 HMOs in 1997, the subsequent five years can be characterized as a period of shakedown and reorganization. Some HMOs never made it through the development phase and closed before enrolling members. Others found the HMO business to be not what they expected and closed or sold. Still others were fully functional, though not profitable, and chose to leave the state or sell. Because of multiple financial, marketing, and other factors, mergers, consolidations and closings have resulted in only fourteen HMOs maintaining a license at the end of 2001 (see Table 2). The corresponding number licensed at the end of 2002, when reported in 2003, will remain at 14. However, of the 14 licensed HMOs, only 10 have members, and eight are actively marketing.⁸ This is due to the merger of Coventry with WellPath, the merger of Partners with BCBSNC, and the cessation of NC marketing operations by Prudential, QualChoice, and Doctors.

While the number of HMO licenses was at its maximum

in 1997, the membership peaked the following year. As seen in Figure 2, fully insured HMO subscribers numbered 1,183,845, or 17% of the population, in 1998.⁹ However, market penetration varied widely by geography, exceeding 25% in two urban areas—the Triangle and the Triad—and reaching only 9% in the non-metropolitan areas.¹⁰ North Carolina HMO membership began to slide in 1999, and we have now seen three consecutive years of decreases. Membership in 2001 was 1,050,263.⁸ This North Carolina trend mirrors the national experience as well. National enrollment peaked in 1998, and HMO enrollment dropped a half-million subscribers in the first six months of 1999.¹¹ Subsequent declines have continued as subscribers move to less restrictive insurance programs.

The slate of players in the HMO game has made a dramatic shift in recent years – by 2001 the 1,050,263 HMO members are concentrated in only a handful of HMOs (Figure 3). Just four companies—UnitedHealthCare, CIGNA, BCBSNC, and WellPath Select—account for a full 92% of the state’s membership. The remaining players in the market have small enrollments ranging from 1,781 to 19,540 members in each HMO.

Hope for Managed Care Collides with Reality

From the beginnings of managed care there were high hopes it would transform the financing and delivery of healthcare for the better. Patients would have insurance coverage that would encourage the use of outpatient services when appropriate. When inpatient care was contemplated, medical necessity checks would assure it was warranted based on best practices. Case managers in the managed care plans would work collaboratively with patients’ physicians and hospital personnel to assist in timely delivery of services and discharge planning. Patients needing home care would have this arranged seamlessly by the case managers. The use of expensive technology and complex procedures would require prior approval by managed care nurses and medical directors to see that standard need criteria were met. The emphasis in the

Table 2. Licensed HMOs and membership in 2001

CompanyName	Enrollment as of 12/31/01	Marketing in NC 11/30/02
Aetna US Healthcare of the Carolinas, Inc.	19,540	yes
Blue Cross Blue Shield of North Carolina Line of Business HMO	169,904	yes
CIGNA HealthCare of North Carolina, Inc.	227,383	yes
Coventry Health Care of the Carolinas, Inc.	23,026	no
Doctors Health Plan, Inc.	7,603	no
FirstCarolinaCare, Inc.	6,193	yes
One Health Plan of North Carolina, Inc.	1,781	yes
Optimum Choice of the Carolinas, Inc.	10,696	yes
Partners National Health Plans of NC, Inc.	220,811	Medicare only
Prudential Health Care Plan, Inc.	11,508	no
QualChoice of North Carolina, Inc.	26,166	no
UnitedHealthCare of North Carolina, Inc.	292,040	yes
WellPath Select, Inc	33,612	yes
Total	1,050,263	

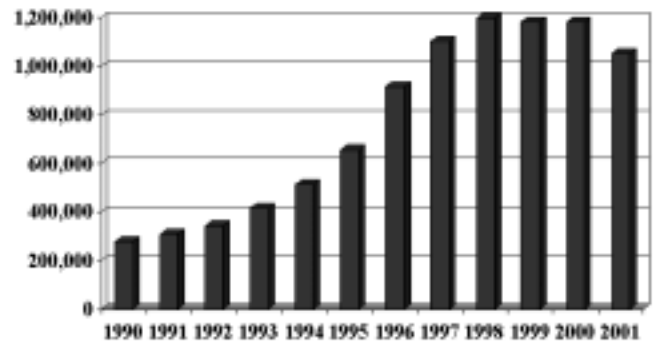


Figure 2. North Carolina HMO enrollment. Source: NC Department of Insurance.

components of managing care was for better coordination of services for individual patients and improved continuity of care. Reducing unnecessary procedures and inpatient days of care would result in cost savings to the patient, and reduce the rate of increase in health insurance premiums. These high expectations were met with, at best, mixed results.

Components of managed care generally fall into two categories: programs that manage price and those that man-

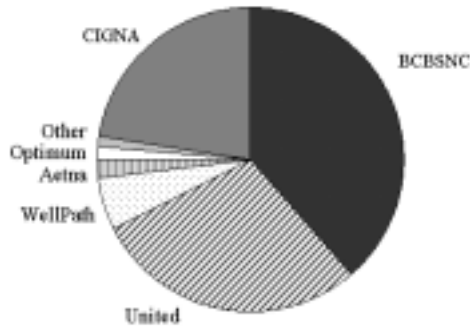


Figure 3. HMO enrollment in HMOs actively marketed in 2002 (12/31/01 enrollment)

age utilization. It was intuitively easier for insurance companies to control the unit price of a service than to manage utilization. Consequently, that was the primary focus, at least early on, of managed care companies. Insurance companies that had been reimbursing physicians on a fee-for-service basis, with an automatic escalator clause such as a “usual, customary, and reasonable” (UCR) method, changed to a fee schedule—either proprietary, insurance company-specific fee schedules, or a variation of Medicare’s resource-based relative value scale (RBRVS). Other options for physician reimbursement were capitation, usually a monthly fee per patient under the physician’s care. Hospital reimbursement was changed from charge-based reimbursement to a variety of prospective payment methods: per diems, case rates and diagnostic related group (DRG) fixed prices. The new methods had the advantage of increased predictability in the unit price of services. Unit price increases were generally negotiated in advance between the provider and the managed care company.

Managing utilization proved to be more challenging than changing reimbursement methods and contracts. The success of early pre-admission and admission certification programs has been noted above. These were the easy programs, with quick and significant results. The sentinel effect of requiring approval for inpatient reimbursement changed practice patterns quickly, and the use of outpatient services was substituted. Utilization management that moved beyond changing the *location of care*, and questioning physician decisions on *what care to give*, was more difficult. Disease management programs, in which managed care companies partner with patient and physician to help manage cost effective, appropriate care, have not grown as rapidly as was hoped. While such programs were once prevalent for conditions like diabetes, asthma, and high-risk pregnancy, few others have been developed on a widespread basis.

Another expectation for managed care was to improve the flow of information to the provider community, to both individual physicians and hospitals. One level of information reporting encompassed basic physician practice characteris-

tics, including such measures as number of visits per patient, referral rates to specialists, average number of tests ordered, average number of drugs prescribed, and hospital admission rates. An individual physician’s rates were compared to a peer group, often other physicians in the same specialty, and perhaps by region. Most large HMOs in North Carolina distributed physician reports cards with such variables as these. At a more complex level, some physician report cards adjusted for the case mix of the doctor’s population and illness level. Some reporting has also been done on a disease specific basis. This may take the form of comparing one physician’s diabetic population to standards of care that have been developed by a national body of experts. This type of profiling is to take advantage of the growing field of *evidence-based medicine*, in which standards of care are developed based on best treatment outcomes.

What Happened to Derail the Managed Care Train?

Implementing the vision of managed care proved to be more difficult than anticipated, and managed care companies made their share of mistakes. It required a new business approach to change the reimbursement contracts with providers. Managed care companies assembled teams of professional contract negotiators, most with MBAs, to re-negotiate reimbursement arrangements. What had historically been characterized as a collegial interaction where insurer and provider would sit down annually and assess what each needed was now a business negotiation where there would be a winner and a loser. And the larger entity, the managed care company, was often perceived to be the winner. In the early years of the new contracts, price increases were contained with some degree of success. Then a wave of provider consolidation ensued which resulted in a strengthening of provider negotiating power. This has changed the nature of the negotiations, and the outcomes as well. Providers making greater demands for higher reimbursement to make up for multiple years of modest or no gains spurred a resumption of cost increases.

Managing utilization through insurance programs ran into problems as well. Programs that steered patients to the least costly setting with cost sharing and prior approvals were successful in changing patterns of utilization in North Carolina. But managing inpatient care through insurance company nurses, located at the insurance company or sometimes on site at the larger hospitals, was more difficult and costly. It required gathering extensive clinical information beyond what is needed for claims adjudication. It also required more specialized medical knowledge than was usually available in the managed care company. And the patient’s physician often considered this level of involvement by the insurance company as intrusion.

Information sharing with providers in a way that was useful and meaningful proved to be more complex than envisioned. A model for physician practice profiling was developed in North Carolina using multiple measures: cost of care, use of services, effectiveness of care, outcome measures and member satisfaction.¹² Challenges existed in both the calculation of these measures and the education of physicians to interpret and use the reports. Most physicians are convinced that their patient population is sicker than their peers', and consequently their out-of-line statistics are justified. For some physicians this is accurate, and the challenge is to figure out which ones truly have a sicker population. Statistical adjustment techniques were often used, but none are perfect. And many physicians do not have a large enough population base to use these techniques properly. To pool an individual's results with his/her physician group, there is a tendency to assume the aberrant results are due to a colleague. While strides have been made in North Carolina in profiling utilization of physician services, physicians can understandably argue that we have a ways to go to make such tools useful.

Insurance company involvement in managing care complicated the practice of medicine with multiple levels of approval and oversight. The physician office has borne the brunt of the increasingly complicated nature of health insurance. No longer is it a matter of determining eligibility and billing the appropriate insurance company. Each managed care company has its own forms, policies, procedures, phone numbers for certification and approval, and benefit restrictions. There has been little attempt in North Carolina at standardization and simplification. Consequently, physician office staffing has had to increase and specialize to handle the workload.¹³⁻¹⁵ In a 2002 survey of physicians by the North Carolina Medical Society, 87% reported that HMOs and managed care requirements had increased the cost of running their practice.¹⁶ But most of all physicians did not like the principle of third party payers questioning their clinical decisions. There was resentment that insurance companies with no personal knowledge of their patients were interfering with the practice of medicine. The sanctity of the doctor-patient relationship seemed threatened, and there was uncertainty about the role physicians would play in the new managed care environment.¹⁷⁻²⁰

Some components of managed care were troublesome to consumers as well. Programs that steer patients to the least costly setting for care are mostly seamless to the patients, and not problematic. However, other components of managed care cause consumer dissatisfaction: gatekeepers, restricted networks of physicians and prior approval for selected procedures. Patients value the freedom to choose any doctor they wish and to go directly to specialists without permission from their primary care doctor. An insurance company denying reimbursement for a test or procedure that the physician recommends is also a patient irritant. Early discharge following delivery, limits on coverage for emergency room visits,

and denying care to a nearby specialist not in the provider network exacerbate the dislike for managed care.

The local and national media fueled the anti-managed care sentiment. Vignettes of care denied by a managed care company, sometimes for treatment of life-threatening conditions, made for good news stories.^{21,22} There was a noticeable absence of balance in the stories such as the medical consequence of providing inappropriate, unnecessary care. Only rarely has there been news coverage of managed care's emphasis on preventive care such as immunizations, mammograms, smoking cessation, and weight control.²³

In spite of the negative coverage and its ferocity, many individual consumers remain satisfied with their managed care plan. HMOs are required by law to hire an independent contractor to conduct a satisfaction survey of their subscribers on an annual basis. On a scale of 0 to 10, with 0 being the worst, subscribers are asked to rate their overall satisfaction with their healthcare plan. For the most recent reporting year (2001) for the largest 11 reporting HMOs in North Carolina, nine had respectably high satisfaction scores, with at least 85% of their adults rating the plan 5-10.²⁴ While the satisfaction scores reflect reasonable satisfaction, there is no comparison available to satisfaction levels of subscribers in non-managed care benefit plans. There is no law requiring their measurement.

The Response to the Backlash Against Managed Care

Managed care companies responded to the dislike of their products in a variety of ways. The first sign of change was the removal of gatekeeper requirements, allowing subscribers to go directly to specialists without a primary care referral. Open-access HMOs were seen as more user-friendly, and they put decision-making authority back in the hands of the consumer. Most North Carolina HMOs made this change in 2000 or soon thereafter.²⁵ Managed care companies also responded by designing and promoting Preferred Provider Organizations (PPOs) as an alternative to HMOs. These usually offered a broader network of providers to choose from, which addressed consumer dissatisfaction with limited choice of physicians. PPOs also appealed to employers because their benefit design allowed greater cost shifting to employees. So while PPOs were marketed in the early 1990s as a first step towards HMOs, more recently they have become the health insurance plan of choice for those unhappy with HMOs.²⁶ PPOs are the fastest growing type of insurance coverage in the private market.

The North Carolina legislature also heard the cries of dissatisfaction over managed care, and responded with several pieces of legislation. The first was a requirement that managed care companies allow a minimum 48-hour hospital stay following a delivery. There were mandates for insurance

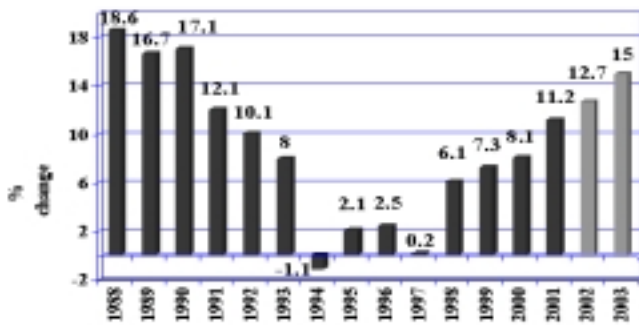


Figure 4. Trends in healthcare costs. Source: Mercer/Foster Higgins National Survey

benefits for breast reconstruction surgery after mastectomies, and coverage for visits to emergency rooms for conditions that a layperson would consider an emergency. And HMOs could no longer require a subscriber to travel a long distance for care that is available nearby.²⁷ After several years of debate, the North Carolina legislature also passed a patients' bill of rights, allowing patients to sue their HMO.²⁸ However without federal legislation this has limited applicability to employer-sponsored health insurance plans.

The bottom line of the changes to move away from the negative aspects of managed care – removal of gatekeepers, broader networks of physicians, PPOs, legislative mandates for benefits, and the right to sue – all add up to more costly healthcare, and in turn, more expensive health insurance. A fuller range of benefits and providers does not come without a price. Nationally, the financial benefits of managed care appear to diminish in 1998, the year enrollment peaked (Figure 4). In that year the average rate of increase in private insurance premiums was 6.1% following four years of modest or no inflation. The annual rate of increase continues to climb, reaching 12.7% in 2001. The estimate for 2003 is 15%. In North Carolina the rates of increase are steeper. In 1999 North Carolina experienced a 9.9% increase, the largest of any state.²⁹ This was followed by a 12% increase in 2000 and 13.5% increase in 2001.^{30,31} North Carolina employers are expecting a third year of double-digit rate increases in 2002, and for HMOs the average rate of increase has reached 27%.³² Since the insurance plans offered in recent years have increasingly larger cost sharing, the rates of increase in the premiums are an underestimate of the actual cost inflation of healthcare services.

Insurance Products Today – But Is It Really an HMO?

By 2002 all of the major insurers in North Carolina marketed open-access health insurance products. Open access can refer to HMO products as well as POS and PPO products. Some

open-access plans are marketed aggressively in ad campaigns that compare themselves to the less desired products requiring the use of a physician gatekeeper. Network products, those requiring the use of contracting providers to receive the most favorable reimbursement rate, are still widely available, though not as aggressively marketed.

The HMOs that are marketed today do not look quite like those of yesterday. Though they are network products, most of them have very extensive networks, to allow greater choice of physicians. And if the HMO product requires the use of a gatekeeper physician, the hassle of changing one's primary care physician is a thing of the past. For most HMOs, one can change primary care physicians for any member of the family instantaneously through the plan's web site. Prior approval requirements for many tests and procedures have diminished, and in some HMOs, care management has been refocused on fewer subscribers with specific chronic conditions. Some insurance plans continue to offer disease management programs to employers who wish to purchase them, though others have retreated from any further development. Those that are still used typically include programs for diabetes, heart disease, asthma, and low back pain.

A perusal of health insurance company websites reflects the new focus on the empowerment of the subscriber.³³ There is a noticeable lack of emphasis that these managed care companies will intrusively manage your care. The focus is on the ease of using their products to obtain the care that you need. These sites contain descriptions of how an individual's health insurance program works, how to find a physician close to home, and how to change primary care physicians. The most noticeable difference in what is being provided to subscribers on-line is a host of health and medical information to educate and assist members in caring for themselves. This information is presented by disease category in the case of illness, or by age and gender for wellness information. Health insurance plans either develop this information on their own, or link to other web sites. The clear intent of this effort is the empowerment of individuals to self-educate and make better choices about their care.

The number of actively marketing HMOs in North Carolina has plummeted and enrollment is declining. Yet as referenced earlier, member satisfaction scores are high. No doubt that is due to the new look and feel of these products, and the changes that HMOs have made. Heavy-handed care management is gone. The business of managing the use of healthcare services has moved to a different page, though the name, HMO, has stayed the same.

So what has been accomplished with managed care in North Carolina and where are we today? The number of HMOs is now down to a handful, and membership is declining. Residents of many counties in the state no longer have access to any HMO, let alone a choice. PPOs are the product preferred by many, with wider physician networks

and freedom to seek care outside of a gatekeeper. Yet some of the components of managed care remain imbedded in these new products. Care management practices have changed utilization patterns, with care increasingly delivered in outpatient settings, as evidenced by a decade of decline in North Carolina hospital occupancy rates.³⁴ Such changes in physician practice patterns are likely to stick, and we won't see a return to inpatient care, for example, for minor surgery.

What Is the Next Chapter in Health Insurance?

As premiums continue to rise and employers increasingly shift cost to their employees, both employers and employees are seeking solutions to the spiraling expense. But what will the solutions be? Paul Ginsberg, a noted health policy expert recently assessed where we are:

"The situation in 2001 resembles that in the early 1990s, especially in terms of costs. But some differences do not bode well for the health system or consumers. One such difference is that the easy gains from managed care have already been exhausted. ... Another critical difference is the absence of a vision for an improved health system. In the early 1990s, many people shared a vision that managed care and integrated delivery would improve care. I cannot identify any comparable vision today."³⁵

In the absence of a vision, though, something will happen. *PPO benefit plans* may become the norm as one option, with escalating cost shifted to employees. Or managed care plans and *HMOs* may become attractive again when the open access and wide provider networks of PPOs price themselves beyond what subscribers can afford. Another alternative is a *defined contribution benefit plan*, which would be a change in type of insurance plan offered by the employer.

PPO benefit plans are fast becoming the benefit plan of choice in North Carolina. To address steep premium increases, greater cost sharing has become the norm. In particular, most pharmacy benefits have changed to three tiers, usually with the smallest co-pay for generics, a moderate co-pay for less expensive brand name drugs, and the highest co-pay for the most expensive brand name or drugs where a generic substitution is available. Insurance plans experienced one-time savings from making this switch, following a return to an underlying rate of inflation from 15-25%. Now that this change in benefits has been made, there has been little else that is successful in reducing prescription drug costs, and benefit managers are resorting to raising all three co-pay amounts.

Empowering employees to make decisions on their drugs, which has financial implications for out-of-pocket expense, is a model that some believe can and should be replicated for other benefits. For instance, if there are two

hospitals in a community included in the PPO network, and one is more expensive than the other, a benefit can be offered requiring the subscriber to pay more out of pocket when admitted to the costlier hospital. This model can be used for physician services as well. Theoretically, under such a benefit structure, a subscriber would have a significantly variable out-of-pocket expense which would be under their control based on personal choice of providers. Reports of such coverage elsewhere in the country are evident, with at least one North Carolina insurance company considering this type of coverage.³⁶ So-called empowerment of employees is an interesting concept, but is dependent on employees having a choice of hospitals and physicians. In a state where the vast majority of counties have no more than one hospital, and limited choice of physician groups, the applicability and potential success appear limited.

Another alternative for next steps in health insurance is a possible return to managed care and HMOs. Given the degree of dissatisfaction expressed by employees over limited provider networks, gatekeepers, and prior approvals, it doesn't seem likely that employers would force employees back into these plans. However, two things have changed since the peak of HMO membership. HMOs have dropped many of the characteristics that were unappealing to consumers, making them look much more like PPOs. These new plans maybe more palatable, though they may not have the cost advantage that they once did. The second change is the economy: In the current slowdown, the quality of health insurance may not be an employer's primary concern, nor is it as important for retaining employees. Employers focused on staying in business may not have the incentive to provide full health coverage that is economical to their employees.

A discussion of alternatives in health insurance would not be complete without acknowledging medical savings accounts (MSAs). These have been around for a number of years, though with limited enrollment. MSAs are made up of a catastrophic insurance policy, coupled with a tax-favored account from which individuals can pay noncovered medical expense. The employer and employee usually fund this account jointly. Proponents of this approach argue that it empowers individuals to control cost through their judicious use of services. Opponents believe there maybe a one-time cost advantage if large numbers of individuals switch, but the underlying rate of inflation in healthcare will remain unchanged.³⁷

Defined Contribution Benefit Programs Could Be the Next Wave

Defined contribution programs represent a shift in employer level of commitment to providing for health insurance. Rather than assuming responsibility for covering the cost of reasonably comprehensive coverage, employers make a con-

tribution towards the employee's choice of coverage. Employers are weary of the annual increases in their health insurance costs, and the accompanying decisions on how to manage them. They are increasingly interested in managing health insurance the same way many handle their pension benefits, by contributing a fixed sum per employee, and thus the name "defined contribution." The employee chooses a set of benefits appropriate for his or her family's needs. At one stage of a family's life one may choose to cover in vitro fertilization, and at a later stage, eye glasses. The employee would make up the premium difference not covered by the fixed employer contribution. The employer's fixed contribution would not necessarily escalate from year to year.

A number of national surveys indicate significant employer interest in defined contribution benefit plans. The Healthcast 2010 report, a survey of US healthcare leaders conducted by PriceWaterhouseCoopers in 1999 found that 62% expect employers will move to defined-contribution plans by 2010. Additionally, 58% believed that Medicare would do the same as a cost containment measure. A Booz-Allen & Hamilton survey of Fortune magazine's "100 Best Companies to Work For" found "all but a few were anticipating a shift to defined-contribution systems, which would save them millions of dollars in administrative costs by taking them [employers] out of the selection and retailing process."³⁸ A clear advantage of the defined-contribution plan to employers is that it limits their liability and establishes predictability of their financial outlays for healthcare from year to year. The advantage to employees is that it gives them more control in choosing coverage that makes sense at each stage of life; the disadvantage to employees is that they will be burdened with an increasing share of healthcare costs.

As employers hold the line on the level of contributions they are willing or able to make, and as premium costs rise 12%-15% a year, it will not be long before employee cost sharing is substantial.

Employers Drove the Shift to Managed Care. Will Consumers Drive the Next Change?

Giving employees more choices—and hopefully cost-effective ones—in providers, treatment options, and preventive care is laudable. And many employees and subscribers will take on this challenge armed with the right information. To expect that such personal empowerment, though, will stem double-digit healthcare cost increases, is to misunderstand the driving forces that are increasing costs. The major cost drivers are technology, drug development, and drug marketing—none of which is under the control of the individual consumer. Once an individual enters the healthcare system, he or she has little control over the plethora of tests and procedures that are ordered and undertaken.

In the apparent absence of any market counter-forces

constraining the major drivers of healthcare costs, we can expect the escalation to continue. It is likely that some employers who now provide health insurance will be priced out of the market, thus increasing the number of uninsured. With increasing levels of cost sharing, whether it is through defined contribution programs, PPOs, or even HMOs with cost sharing, there will likely be more under-insured. The uncertainty is how employers in North Carolina will react to the current round of cost increases. In the early 1990s they responded by promoting and supporting managed care. If their response this time is to embrace defined-contribution programs, or to continue increasing the out-of-pocket cost sharing on PPO plans, the question becomes, how will employees/consumers respond. What will consumers do when the out-of-pocket expense becomes unbearable? What kind of change will they want? And what will the consumer be willing to give up to have more affordable coverage? It is possible that the consumer will drive the next change in health insurance, and what that will look like remains to be seen.

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