

HOW CARE IS MANAGED:

A Descriptive Study of Current and Future Trends in Care and Cost Management Practices Under Private Sector Employee Benefit Plans

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Introduction

The rapid growth in managed care during the past two decades has been fueled largely by the shift in employment-based health insurance from traditional indemnity and service benefit health plans to more tightly managed and structured arrangements. This trend is evident among both public and private employers of all sizes and in all geographic areas.

Originally, employers flocked to managed care organizations (MCOs) because they appeared to offer an important set of fiscal and health care outcomes, specifically:

- lowering employer costs by reducing waste and inefficiency;
- improving the quality of patient care by creating a more efficient and responsive delivery system that focused on preventive services and chronic care management, thus reducing the need for more costly acute care interventions; and
- reshaping the marketplace by empowering purchasers and by encouraging competition among health plans based on a variety of considerations, including quality and cost.

Many employers viewed managed care as a promising new approach to an old dilemma: how best to provide affordable high quality health insurance to employees as a tool to attract and retain the most talented and productive workers. Yet the very features that set managed care apart from traditional indemnity arrangements may have

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undermined its power to deliver on its promises, compelling MCOs to rethink their approach to cost and quality issues based on marketplace responses.

Managed care promised to lower costs and improve quality through the use of such mechanisms as: (1) limiting patients to obtaining care from a select group of physicians through MCO contracts with single physicians or groups of physicians; (2) limiting access to specialized services or physicians, through various gatekeeping mechanisms; (3) employing utilization review in its various forms, including prospective, concurrent and retrospective review, and (4) providing incentives (both financial and other) to physicians to provide care consistent with specified practice guidelines and clinical protocols.

However, there is little evidence in the literature to help purchasers or policymakers evaluate whether these initial practices of managed care actually achieved their goals. Furthermore, although recent articles in the trade press have highlighted several other types of cost and care management techniques in use today, such as medical case management and disease management, it is unclear whether current industry practice reflects a refinement and augmentation of the classic care management techniques or their abandonment.

In the fall of 2001, the United States Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Center for Health Services Research and Policy in the School of Public Health and Health Services, The George Washington University Medical Center, to undertake a descriptive study of the current and future trends in cost and care management techniques used in the employment-based health insurance marketplace. The purpose of this study was to identify and report on (1) the cost and care management techniques currently in use in the private sector by health plans and employers, and (2) what, in the view of experts, were the likely future trends. The research team was asked to perform this descriptive study by interviewing experts in field. As part of the study, the Center was also asked to conduct a review of the literature concerning current cost and care management approaches used by managed care plans and employers in the private sector, with a focus on non-peer reviewed articles in trade journals and the popular press. Since the focus of this study was private sector purchasers, we were asked to exclude literature regarding cost and care management techniques used in the Medicaid and Medicare programs.

Study Methods

To conduct this descriptive study, researchers at the Center interviewed approximately twenty-four (24) experts in both employer-sponsored health insurance and cost and care management approaches. Although the experts interviewed were drawn from a more extensive list of experts that was jointly developed by researchers and the project staff at ASPE, prospective interviewees were assured that their names and affiliations would be treated as confidential and that their comments and observations would not be attributed to them in the final report or in subsequent discussions with the project staff at ASPE.⁶

⁶ This project was approved by The George Washington University Institutional Review Board, No. U020211ER.

Using a predetermined set of discussion topics and related questions, in a series of structured interviews conducted primarily during the first half of 2002, researchers at the Center interviewed a cross section of experts to gain an understanding of which case and care management techniques were important components of employer-sponsored health coverage. The list of topics and questions developed in consultation with ASPE project staff was furnished prior to each interview to the interviewee, so that the experts had the option of inviting other members of their organization to participate in the interview. Although the information sought was the same for all of the experts, each interview was tailored slightly to reflect the specialized expertise of the interview subject. In several instances, the interview included more than one representative of an organization, although for purposes of the study, the interview was treated as a single interview, even when several individuals were part of the discussion. For the most part, interviews were conducted by telephone. Where possible, however, interviews were conducted in person. We interviewed representatives across a broad spectrum of organizations, including large employers, purchasing coalitions, attorneys who assist employers in designing or choosing employee health plans, labor unions, employee benefits and human resources consultants, managed care organizations and health plans, clinical practice experts, physicians, specialty vendors, organizations that specialize in developing and promoting standards to evaluate health care quality, academics, and other health policy experts. Although the interviews focused on the specific topics and questions that had been furnished in advance to the experts, many of the experts raised additional issues with us and, where relevant, we have tried to capture that information in this report.

The draft report was submitted in December, 2002 and after receiving comments from the ASPE staff, the final report was submitted in March, 2004. Although the text of the report was revised, the literature review has not been updated.

Because this study is descriptive, not analytic, we note at the outset that the opinions expressed in this report reflect those of the experts we interviewed, not the opinions of the researchers at the Center.

Summary of Findings

Literature Review

The literature review (Attachment 1) focused on articles published in the past five years which could give policymakers insight into the changing nature of care management techniques in the private sector employer-sponsored health plan market. During the period surveyed, there was very little discussion in the literature of private-sector use of the care management techniques which the Center was asked to examine. For instance, although there were articles discussing the trend toward health plans that provide more open access and fewer gate-keeping restrictions, we found no discussion regarding the effect of this trend on physician contracts or any change in utilization management techniques. The most widely discussed care management technique found in the literature was implementation of disease management programs, with some discussion also of medical case management programs. Rather than a specific

discussion of the cost and care management techniques we were asked to examine, most of the literature surveyed during the period in question addressed these topics only indirectly through broader discussions of the following trends in health care and health care delivery:

- **Recent steep increases in the cost of health insurance premiums** have reinforced employers' purchasing behavior that focuses on cost as the principal factor driving health plan selection.
- **Consumer backlash** has resulted in a retreat by purchasers and plans from the most restrictive managed care practices, as many employers were unwilling to continue purchasing products that made their employees unhappy.
- **Diminishing variation among managed care plan types** has occurred because of the movement by managed care plans toward less restrictive approaches to access to care in reaction to consumer and purchaser complaints. The literature suggests that during the past few years there has been substantial blurring of the distinctions among health maintenance organizations (HMOs), point-of-service (POS) plans and preferred provider organizations (PPOs). There was no evidence from the literature that particular care management techniques were more or less likely to be used by a certain type of managed care plan.
- **Consolidation in the marketplace** has resulted in decreased plan choice among insurance carriers and health plans for employers and their employees.
- **Increased cost-sharing for employees and their families through higher premiums, co-payments and deductibles, as well as multi-tier pharmaceutical pricing schemes** have been the typical employer responses to rising health care costs.
- **Emerging interest in a "defined contribution" health plan model, including the use of "personal care accounts" (PCAs) or "health reimbursement arrangements" (HRAs)** has been another employer response to rising health care costs.
- **The adoption or consideration of medical case management or disease management programs by some large employers, particularly for chronic diseases**, reflects those employers' belief that these programs will ultimately improve the health of their employees and reduce employer costs. This belief was expressed despite the absence of literature reflecting a rigorous examination of the actual effect of existing programs on health outcomes or employer costs. According to the experts we interviewed, these programs typically include the use of nurse/administrators, clinical treatment protocols, and various evaluative tools (such as consumer satisfaction surveys) in support of patient monitoring and feedback.

- **A continuing lack of consensus around the acceptable measures of quality or evidence of its practice** exists, despite employers' expressed goals to provide high-quality/low-cost health care, there is some evidence in the literature that employers and health plans are reluctant to adopt certain care management techniques that they perceive will be resisted by their employees unless these techniques can be shown to improve the quality of care that patients receive.

Interviews with Experts

The findings from our interviews with experts were generally consistent with the trends identified through the literature review and consistent among the experts themselves.

In summary, our findings were:

- **Generally, employer decision-making regarding the health care plans offered to employees is driven by cost considerations.** According to the experts, costs are rising so quickly that purchasers do not have the ability to focus on anything but cost. However, the majority of the experts we interviewed did not believe that even if costs were stable or rising more slowly, a majority of employers would consider care management a priority. The experts who felt this way pointed to the fact that, in evaluating competing health plans, employers almost never inquire about care management techniques used by the plans. And several experts observed that when employers did ask about care management, their interest was in how much money the programs had saved, rather than evidence of health outcomes improvement. The experts pointed to one group of employers that appeared to take factors other than cost into consideration: employers involved in the Leapfrog Group (discussed below).
- **Lack of data on the effect of various care management techniques on health outcomes as well as employer costs were consistently cited as the reasons that care management techniques are not more widely considered or utilized by providers, health plans, or employers.** Even the experts who believe that, once health care costs stabilize again, employers will be more likely to consider including care management practices in their health plan design decisions, said that in the interim, better data regarding the clinical and cost effectiveness of various care management techniques must be developed or employers will not take them seriously.
- **Both in the literature and in our interviews, the experts generally did not differentiate between care management and cost management techniques,** because they said that all care management techniques are linked to cost management. As one consultant noted, the use of the term “care management” was a convention that he had adopted since his clients did not want their employees to think that changes in the company’s employer-sponsored health plan were being made to save money, but rather to improve

care. However, for purposes of this report, we will use the term “care management” to denote interventions that affect access to and delivery of care and “cost management,” to denote interventions that relate to price controls, or payment or insurance approaches.

- **One notable group of large employers with self-insured employee health plans – the Leapfrog Group – has been working to include consideration of certain patient safety practices in their own purchasing decisions and to encourage other purchasers to do so as well.** Founded in late 2000, the Leapfrog Group is attempting to identify best practices among health care providers (particularly hospitals), encourage reporting using standardized quality measures and influence care management practices of plans and providers. Although the Leapfrog Group’s activities have been publicized in the trade and popular press and most of the experts we interviewed spoke positively about their efforts, the experts also pointed out that currently very few other employers appear to be following their lead. The literature also identified several other value-based health care purchasing coalitions in which large employers have been involved (such as the Pacific Group on Health (PGH) and the Minnesota Buyers Health Care Action Group (BHCAG)),⁷ but few of the experts mentioned these organizations in our interviews as leaders in the type of practices described above, although the Leapfrog Group was consistently mentioned by the experts.
- **Instead of looking to care management techniques, including medical case management for expensive or complicated cases, to reduce or stabilize health care costs, most employers have responded to escalating health care costs by shifting some or all of the increased costs to their employees and their families.**
- **Other employers are considering major structural changes to their employee health benefit plans, such as dropping subsidies for family coverage, limiting or eliminating retiree medical coverage, and/or studying various defined contribution approaches to replace or supplement their current health plans.**
- **Managed care plans stress that care management will ultimately improve the quality of care patients receive and will reduce employer costs, although they agree with the other experts who point out that little data currently exist to support those beliefs.** However, some of the experts who were interviewed contrasted this belief with the observation that, at least currently, in practice most employers appear to have little interest in care management techniques to achieve either of those results.
- **Experts report a clear movement away from traditional care management techniques (e.g., gatekeepers, pre-certification) among commercial**

⁷ See, for example, “Value Purchasers In Health Care: Seven Case Studies,” a report issued in September 2001 by the Milbank Memorial Fund (available on the Fund’s website at: www.milbank.org/reports/2001ValuePurchasers/011001valuepurchasers.html).

managed care plans as a reaction to the backlash from employers and their employees in response to the more restrictive practices that limited access to providers and services. However, the primary care management techniques described by the experts as currently in use (such as disease management) are directed toward influencing patient, rather than provider, behavior.

- **Disease management programs were cited by many of the experts as a care management technique with potential to improve care, but the experts said that the widely varying descriptions of what constitutes a disease management program and the lack of consensus regarding evidence that these programs actually achieve their goals have hampered their adoption.**
- **Based on the interviews, employers and health plans both regard medical case management as an effective care management technique that has the potential to save employers money and improve patient care, although the experts said that there does not appear to be empirical data to confirm this belief.**
- **Employers and health plans say that effective tools or techniques to change physician behavior currently do not exist; according to the experts, these tools would be an essential component of any successful care management strategy.** However, when asked to give examples of such techniques, the experts generally indicated that the problem was more complex than simply developing new mechanisms. Instead, they said that it is difficult to influence physician behavior without adequate information systems to collect and analyze the data at the physician or group practice level concerning the efficacy of care and cost management techniques.
- **Physicians believe that care management programs, such as disease management programs, are more likely to be successful when the practice guidelines or clinical protocols to be used in the program are developed by the physicians themselves, rather than imposed by health plans or employers.**
- **Some managed care plans have adopted physician profiling and other mechanisms to measure physician compliance with evidence-based practice guidelines and protocols, although the ways that health plans use this information vary substantially and few incentives are given to physicians to comply with the guidelines and protocols.**

Discussion of Findings

Description of Care Management Practices Currently In Use

Based on our review of the literature and interviews with experts, we identified a number of care management practices that are currently in use. In addition, we asked

the experts how widely used these practices were in the private-sector employer-sponsored health plan marketplace and to what extent they believed these practices would continue in the future. Finally, we asked them to identify any new care management practices that they thought might emerge in the future.

We also asked follow-up questions regarding how these care management practices were developed and implemented. For example, we asked whether care management practices were specifically described in contracts between the plan sponsors and health plans or contracts between health plans and their network providers. The experts agreed that general care management practices were not described in contracts, but a few of the experts said that occasionally certain clinical protocols could be found in provider manuals or instructions to network physicians issued by hospitals or health plans. These experts noted that the manuals were typically directed at physicians for use with Medicaid patients but, if physicians were required or encouraged to use such protocols, it would likely have an impact on private patients since most physicians would probably not have different practice patterns for treating their private patients than their patients enrolled in public programs.

The conclusion of the experts that care management practices were not generally enforced through contracts was reinforced when we examined the limited data base on state employee benefit plan contracts with managed care organizations (MCOs) that the Center established several years ago. Although this report pertains only to private sector employee health benefit plans, a review of the Center's database of state Medicaid contracts with MCOs and of MCO/physician contracts also yielded no evidence of contractual provisions relating to the use of specific care management techniques.

Moreover, the development of care management techniques by MCOs did not seem to be influenced by existing accreditation standards, but rather was a function of internal MCO priorities and studies. One expert representing a MCO said that the accreditation standards might have been a factor, but he could not recall any explicit discussion of them as their internal working group performed periodic review of existing care management procedures.

The care management techniques that were identified in the literature and by the experts included:

- (1) Utilization management tools;
- (2) Practice guidelines and clinical protocols, including physician profiling;
- (3) Disease management programs;
- (4) Incentives or penalties for physicians;
- (5) Cost shifting.

Utilization management tools

Utilization management tools include pre-authorization requirements for some or all services, concurrent review, retrospective review, discharge planning and follow-up and case management.

The experts said that most employer-sponsored health plans included some pre-authorization requirements, particularly for in-patient hospitalization and behavioral

health services (mental health and substance abuse), although widespread use of pre-authorization for most treatments and services has been abandoned in recent years, in large part due to the consumer backlash against tightly managed care practices.

Several of the employee benefit plan consultants noted that although the majority of employer health plans still have them, pre-authorization requirements for in-patient care and behavioral health services were not as prevalent as they had been in the past. Many saw this in part as a consequence of the new claims and appeals regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA) that became effective for health plans recently.⁸ Under the new regulations, benefit claims and appeals must be decided within a much shorter time frame if they are “pre-service” claims (i.e., claims that require pre-authorization before treatment can be given). Notwithstanding the apparent decline in the prevalence of pre-authorization requirements, the experts agreed that pre-authorization for certain expensive treatments will continue to be a viable care management tool in the future.

According to the experts, many private sector health plans still require referrals for most specialty care, except for pediatric and obstetric and/or gynecological care.

Several of the experts indicated that some employer-sponsored health plans also use concurrent review (a practice in which the need for continued care is evaluated periodically once care has begun) in connection with in-patient hospitalization care. Others said that it is also used at times in connection with behavioral health benefits. Most of the experts indicated that concurrent review implementation has become more tightly controlled than it used to be with many HMOs requiring the treating physician to call for authorization of additional hospitalization for their patients on a day-by-day basis, rather than the HMO authorizing treatment for a specific period of time, based on the nature of the treatment the patient was to receive. One expert representing doctors described this as “overkill rather than sensible care management,” citing an example of a heart transplant patient whose HMO only authorized a two-day hospital stay (including the day of the surgery itself) and then required the surgeon to seek authorization each day for the next day’s stay. However, the experts generally agreed that monitoring utilization of care was an extremely important tool for care management, but on this issue, most went further to say that employers see monitoring utilization as primarily a cost management device. For that reason, the experts believe that some form of concurrent review will continue to be part of employer health plan design.

With respect to retrospective review, the experts agreed that this was not an effective care management technique because telling a patient after he or she had already had obtained treatment that the service was unnecessary only shifted the cost to the patient and did not substantially deter physicians from performing unnecessary tests or procedures in the future. However, one expert disagreed with the latter conclusion, noting that most physicians have limited ability to bill and collect the full payment from patients and therefore might be more likely to consider payment issues when ordering expensive tests in the future. As a practical matter, observed one of the experts,

⁸ Group health plans must comply with the new rules for claims filed on or after the first day of the first plan year beginning on or after July 1, 2002, but not later than January 1, 2003. 66 Fed. Reg. 35886 (July 9, 2001).

retrospective review was more closely associated with a fee-for-service system and has limited relevance in the current marketplace to care management.

All of the experts said that discharge planning by hospitals and follow-up visiting nursing services for a short period of time were frequently part of employer-sponsored health plans.

Medical case management (particularly regarding expensive or complicated cases) was identified as one of the primary tools for care management that is widely used and generally perceived as effective by employers. Although several experts indicated that some anecdotal evidence exists that case management in these situations results in quantifiable cost savings for employers, none furnished us with data to support that conclusion.

As described by the experts, medical case management takes a variety of forms. It generally involves a coordinated program in which a team of professionals, usually at least a nurse and a social worker, work with a patient, the patient's family, the treating physician, and the employer-sponsored health plan to develop a plan of care for both in-patient and out-patient follow-up care. Sometimes this includes the use of alternative treatment modalities (e.g., home dialysis, rather than facility-based treatment) that are not normally covered under the employer's health plan but which may be more effective in treating the underlying illness or injury as well as less costly. In some cases, medical case management may involve negotiation with health care institutions regarding placement of a patient, treatment and billing rates. It may also include coordination with Medicaid or Medicare for patients who are eligible for those programs and identification and assistance in securing other non-health benefits through community-based social services programs.

Medical case management is usually listed in the description of the benefits provided under the employer's health plan, but it is rarely described in any detail, since it varies from patient to patient. Because there are generally no explicit financial or other incentives for either patients or physicians to use it, the experts said that most often it is triggered automatically once a patient has been identified as needing a costly or complicated treatment (such as care following a heart attack, stroke or premature birth or some type of organ transplant).

Although the experts agreed that medical case management is a fairly common practice among employer-sponsored health plans, one employee benefits consultant observed that to the extent an employer does not include some form of medical case management in its own plan design, the employer may be forced to do so if the employer-sponsored health plan is self-insured and the employer seeks to purchase stop-loss insurance, since those carriers often require employers to have medical case management programs as a risk management tool. This consultant also said that some stop-loss insurance carriers require employers either to purchase bundled coverage (i.e., coverage that includes not only the insurance product itself but also a case management program offered through a subsidiary or partner of the stop-loss carrier) or to pay a higher premium for the stop-loss coverage. The experts believe this care management tool will continue to grow in importance for employer-sponsored health plans.

Practice Guidelines and Clinical Protocols; Physician Profiling

The experts were divided on how widespread the current use of practice guidelines and clinical protocols was. However, there was agreement that the development and dissemination of such care management tools was necessary and should be encouraged by employers and other purchasers, as long as these guidelines and protocols were evidence-based and represented consensus standards. Representatives of doctors also said that it was important that doctors be involved from the beginning in the development of these standards, otherwise it was unlikely that they would be voluntarily accepted and used.

Experts involved in designing or running employer-sponsored health plans said that the plans themselves rarely, if ever, required the use of practice guidelines or clinical protocols. However, experts representing the managed care industry indicated that most MCOs used some type of practice guidelines and/or clinical protocols at least in connection with certain conditions. The experts representing doctors said that although a number of health plans are beginning to encourage doctors in their networks to conform to certain practice guidelines and clinical protocols, this was not a very widespread custom. They said that even when such tools had been available, doctors had been offered few incentives, financial or otherwise, to use them and so they generally did not.

One of the managed care plan representatives said that his plan was using evidence-based practice guidelines and clinical protocols in one geographic area to profile physician behavior. Ultimately, the plan's long-range goal was to determine whether patient health outcomes could be improved by encouraging greater consistency of physician treatment for certain medical conditions. However, the managed care plan's more immediate goal was to better understand whether the practice patterns of their network physicians were consistent with evidence-based practice guidelines and to develop practice pattern profiles of the physicians in its network so that the MCO could better evaluate them.

The example the expert gave was an examination of whether physicians routinely prescribed beta blockers to patients who had suffered heart attacks. He said that the plan first distributed the protocol and information about its usefulness to all doctors in the plan's network and held seminars to educate the doctors about the use of beta blockers for cardiac patients (he noted that the attendance at these programs was extremely low). In addition, the plan offered additional educational information on-line. The plan told the doctors that it was going to track their adherence to the guidelines over a period of time and then was going to share the results of that tracking with each of the doctors individually. The expert said that performance of the majority of doctors appeared to conform with the guidelines, although it was unclear whether that was as a result of the efforts of the MCO or whether the doctors' actual practice patterns conformed to the guideline for some other reason. The MCO originally planned to contact the doctors whose practice pattern seemed at odds with the guideline and thereafter personally encourage treatment more consistent with the guidelines. Eventually all the plan did was to send each of the network physicians a letter enclosing the graph illustrating the behavior of all network physicians and indicating where the particular doctor's practice pattern fell in relation to others. No other contact or follow-

up was made. The expert was unsure as to why the original plan had been abandoned but speculated that without specific follow-up, the doctors whose performance deviated from the norm would likely have little incentive to change that behavior.

Some of the experts believed that if more data were collected on physician practice patterns and if consensus could be developed on reliable techniques to analyze the data, this might be a useful care management tool in the future.

Disease Management Programs

Disease management programs are a widely discussed care management practice in the literature, although it is unclear how widely used they are. Moreover, all of the experts we interviewed considered them important care management tools for employers and health plans, both currently and in the future. Yet, there does not appear to be a common definition or description of what exactly a disease management program is. Nearly all the experts we interviewed who described these programs in any detail had a somewhat different concept. Drawing from the literature and our interviews, however, a few common elements of these programs can be identified. It is also clear that there are many variations in the way these programs are structured.

Disease management programs typically involve structured care management arrangements that combine patient education, treatment, monitoring and follow-up for patients with one or more chronic medical problems, such as diabetes, asthma, hypertension, congestive heart disease or high cholesterol. Sometimes they are directed at or also include patients who want to improve their health through behavioral changes, such as smoking cessation programs. Often they include instruction on self-care (including self-medication) and nutrition and counseling by specially trained nurses and other health professionals.

One of the employee benefit experts who counsels employers said that, depending on the type of program, employers will sometimes provide financial incentives for their employees to participate in disease management programs, such as a premium discount for employees who attend smoking cessation clinics or cholesterol screening and treatment programs. However, this expert also pointed out that employers cannot condition financial incentives on an employee's performance in the program (i.e., lowering his cholesterol by 100 points), but only on the employee's participation in the program without violating the rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibiting discrimination against individuals based on a health-related factor.⁹

According to the experts advising employers, disease management programs may be structured either as part of the employer's group health plan or as a separately-offered benefit. In some cases, disease management programs are offered by the MCO in which the employee has enrolled. Alternatively, the employer may separately contract with an MCO or other specialty vendor to offer a disease management program to all employees.

⁹ Parallel statutory requirements are found in § 702 of the Employee Retirement Income Security Act of 1974 (ERISA), § 2702 of the Public Health Service Act, and § 9802 of the Internal Revenue Code.

In addition, a few of the experts indicated that the current structure and operation of disease management programs is under evaluation by employers and some practices may have to be revised in the future because of uncertainty regarding how the medical privacy rules promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will affect the use and disclosure of protected health information (PHI) of current and future participants in the programs.

Some of the experts noted that that disease management programs are commonly marketed to employers as initiatives that can lead to both improved health outcomes for employees and greater worker productivity. However, these experts also indicated that evidence of these results is limited and anecdotal and that more structured research is necessary to determine whether the additional cost of implementing disease management programs is justified by measurable results in improving health outcomes and productivity.

Incentives or penalties for physicians

All of the experts we interviewed indicated that financial incentives for physicians were no longer very common, except possibly in staff and group model HMOs, and, despite a period of considerable activity in the mid-to-late 1990's, the experts were divided as to how much even those plans were currently using them.

Nearly all of the experts noted that capitation of physicians and other forms of down-streaming of financial risk seem to have been abandoned by most health plans, except within certain integrated health care networks, which many noted, were quite limited in number. Some of the experts explained that this decline was likely attributable to a combination of factors, including the reluctance of many physician groups to accept financial risk after observing the relatively quick descent into bankruptcy of some capitated physician-hospital organizations (PHOs), and the current trend toward more open delivery networks and less restrictive health plans, which made financial risk-sharing by physicians more difficult to structure because care was more difficult to manage.

Several of the experts believed it was unlikely that financial incentives would be used as an important care management tool in the future, but a few experts disagreed.

Cost shifting

Cost shifting to employees was a practice repeatedly highlighted in the literature and raised by the experts in nearly every interview we conducted. However, the experts were divided as to whether shifting costs to employees should be considered a care management technique as well as a cost management mechanism for employers. A few of the experts believed that cost shifting is part of care management because when employees have more of a financial stake in payment issues, they are less likely to demand unnecessary care. But most of the experts said that cost shifting had nothing to do with care management because patients do not have the ability in today's marketplace to make informed decisions about whether and to what extent a

particular treatment or service is necessary nor do patients know how to evaluate the skill and efficiency of the providers in their network.

Both the experts and the literature catalogued a variety of cost-shifting techniques currently in use by employers, including increasing the employee's share of the premium, increasing co-payments and deductibles, and imposing annual or lifetime caps on coverage generally or on particular benefits offered (such as limiting enrollees to coverage for one organ transplant or capping the amount of coverage for all organ transplants to \$10,000). In addition, some employers are moving to restructure their health plans by reducing or eliminating employer subsidies for family coverage, eliminating retiree medical coverage, or moving to a defined contribution approach.

According to the experts, many employers are considering offering their employees a restructured health plan that establishes overall limits on the employer's promise to finance health care for its employees. These plans, often called "consumer-driven" or "defined contribution" health plans, are discussed in more detail later in this report. In brief, however, they typically combine a high deductible health plan with some type of cash account to which employers, employees, or both, contribute and from which employees can pay medical expenses not otherwise covered under the plan (such as the employee's share of the premium, co-payment or deductible amounts, or payments for non-covered services, such as hearing aids or eyeglasses). Some of the experts described these arrangements as not only a way for the employer to better manage its health care costs by circumscribing its ongoing financial obligations, but as a mechanism to encourage patients to be better consumers of health care. Other experts were skeptical that patients were currently equipped to make the kind of health care decisions that would improve their care, because reliable data regarding the effectiveness of most types of treatment or physician performance was not currently available to most consumers.

Balancing Care and Cost Management Approaches in an Environment of Rising Costs

The past decade has seen a substantial growth in the adoption of managed care plans among employers providing health benefits for their employees. But just as quickly as they moved in, employers are now moving out of tightly structured managed care arrangements into more loosely managed programs.

Some of the largest managed care plans have restructured their administrative approaches and eliminated many of the gatekeeping and pre-authorization requirements for certain outpatient services. Experts attribute these changes to a combination of factors, including employee dissatisfaction with the barriers to access that are an integral part of the managed care structure, the threat of Federal legislation curbing some of those practices and mandating more patient choice and access, and the lack of empirical evidence that these tightly managed programs actually save employers money.

One employer representative noted that because managed care plans had not been able to demonstrate that requiring employees to comply with strict gatekeeping procedures to receive care actually saved employers money or improved patient care, it seemed pointless to continue to purchase health care coverage that only evoked employee dissatisfaction and complaints.

As a result of the marketplace pressures to relax many of the most restrictive managed care administrative procedures, the distinctions between the primary types of MCOs have become blurred. Even staff and group model HMOs today offer products in which access to a network of outside providers is available, thus moving closer to a POS or PPO model. The representatives of health plans acknowledged this trend and the influence that employee dissatisfaction has had on the structure of service delivery.

However, health plan representatives expressed just as much frustration as employer representatives about the lack of data to demonstrate positive effects of care management mechanisms, such as the use of a primary care provider as a gatekeeper/coordinator of care, on health care outcomes or employer cost. Several health plan representatives argued that use of these techniques was an important improvement over the traditional indemnity insurance system; yet at the same time they lamented that in the quest for short-term savings to offset increasing health care costs, employers seemed unwilling to stick with this type of approach long enough to allow health plans to gather the data to prove its merits.

As one employee benefits consultant described it, employers are always searching for the “silver bullet” that will deliver quality health care while generating demonstrable bottom-line savings for the company. Another consultant described the propensity of employers to seek short-term gains from the use of particular care management techniques as the inevitable result of applying “a bottom-line mentality” to health care expenditures, rather than regarding health care costs as a long-term investment in their workforce.

Cost Drives Employer Purchasing

Regardless of their background or their position in the current health care system, the experts agreed that employer decision-making regarding the health care plans offered to employees is primarily driven by cost considerations. They stated that until there is greater consensus on how to measure other factors, such as quality, and the tools are available to accomplish that measurement, employers will of necessity focus on cost considerations to judge competing health care products.

Even representatives of employer purchasing coalitions that had been formed in part to facilitate the ability of employers collectively to look beyond cost in their health insurance purchasing, said that they had been unable to stimulate employer interest in even the most rudimentary quality measures, such as consumer satisfaction surveys and hospital report cards. Purchasing coalition representatives noted that access to these tools is not uniformly available, especially those tools that analyze the performance of individual physicians. Even when employers do have access to this information, their ability to select coverage based on the performance of the health plan’s provider network is limited. Complicating factors include the fact that in many geographic areas, there is little obvious difference between the networks of competing health plans – most local doctors and hospitals are part of all of the networks.

In addition, the mechanisms that health plans use to influence and measure physician behavior are not apparent to the purchaser, nor in many cases emphasized in

the promotional activities or literature of the health plan. Some health plan representatives expressed reluctance to promote or advertise some of their care management programs, particularly those aimed at patients with chronic conditions, in large part because they are apprehensive that adverse selection will result.

According to those interviewed, this reliance on cost rather than care management is particularly acute for small employers. Small employers frequently rely on insurance agents and brokers in choosing health plans and invariably the advice they get is cost-based. The experts consistently reported that neither employers nor their insurance agents or brokers inquire about quality or care management issues unless the health plans under consideration emphasize care management features in their promotional materials. Even then the question invariably is, “How much extra will having a plan like this cost?” Moreover, as the experts pointed out, employer interest in these features quickly subsides unless demonstrable short-term savings can be guaranteed.

One physician who is also a small employer remarked that, while he appreciates the helpful service that insurance brokers and agents provide in assisting small employers to find affordable coverage, he is concerned about the significant influence they have over employer selection. He noted that brokers often recommended health plans to maximize their commissions, promoting plans with larger commissions over others, regardless of the quality of the plan or the appropriateness of the benefit structure to the employer’s workforce. He suggested that any public education program focused on encouraging employers to look at factors other than cost in their purchasing decisions must also target insurance brokers and agents or it will have little impact on the small group market.

The Leapfrog Group: An Employer-Driven Evidence-Based Effort to Reward Provider Performance

Most of the experts we interviewed pointed to the members of the Leapfrog Group as the most prominent group of employers who have tried to create a climate in which cost is not the only element in the health insurance purchasing decision. The Leapfrog Group, founded by a small group of large employers in 2000, is currently composed of more than 150 public and private organizations representing more than 34 million Americans.

By focusing on the need to establish patient safety standards against which to judge provider behavior, experts believe that the Leapfrog Group is laying the groundwork for a broader examination of care management and its relationship to quality and cost. They pointed to the Group’s focus on reducing medical errors in hospitals as an example of an approach that could have a noticeable impact. Consistent with the recent report by the Institute of Medicine, *To Err is Human*,¹⁰ the Group believes that preventable medical errors are both harming patients and driving up costs. Therefore, it has adopted a strategy to identify and financially reward hospitals that establish higher standards for patient safety by directing patients and other

¹⁰ Kohn LT, Corrigan JM, Donaldson MS (eds): *To Err is Human: Building a Safer Health System: a report from the Committee on Quality of Healthcare in America*, Institute of Medicine, National Academy of Sciences, National Academy Press, Washington, DC, 1999.

purchasers to them. The Leapfrog Group has adopted three patient safety standards for hospitals, established a web survey for hospitals to report compliance with these standards, and has made this information publicly available on its website (www.leapfroggroup.org). Eventually, the Group hopes to be able to develop comparable standards to evaluate patient safety in ambulatory care settings, but the experts believe that this goal is still several years away.

Representatives of both health plans and large employers indicated that they are waiting to see if the Leapfrog Group's efforts to document and encourage hospital compliance with these patient safety standards are successful and if it can be demonstrated that these standards impact patient care and costs. The experts suggested that if the Leapfrog Group can produce such results, it might encourage other employers to follow their example and use information regarding adherence to patient safety practices and perhaps other performance standards in their purchasing strategies.

Employer Responses to Rising Costs

Both the literature and our interviews with experts highlighted a growing consensus among employers that there are no adequate ways to manage their costs over the long-term, because so many of the drivers of health care cost are outside of their control. Instead of looking to care management techniques to reduce or stabilize health care costs, the experts reported that most employers seem to be looking to two principal mechanisms to manage their costs:

- (1) within the model of traditional employer-sponsored health insurance, shifting some or all of the increased costs to their employees, including considering structural changes to employee health benefit plans, such as dropping subsidies for family coverage, limiting or eliminating retiree medical coverage, and
- (2) moving away from more traditional models of employer-sponsored health plan coverage in favor of various defined contribution approaches.

Cost-Shifting within a Traditional Employer-Sponsored Insurance Model

Nearly all the experts we interviewed reported that most employers have responded to rising health care costs by adopting or considering adoption of various mechanisms to shift all or part of their health care cost increases to their employees and families. A recent article in *Health Affairs* confirms this trend. The authors reported that from 2001 to 2002, the average employee contribution for single coverage grew by 27 percent.¹¹

However, even in some of the instances in which cost-shifting was the primary focus of employers, some attention seemed to have been paid to care management issues. This was particularly evident in the way the programs were structured, though

¹¹ Gabel J, Levitt L, Holve E, et al., Job-Based Health Benefits in 2002: Some Important Trends. *Health Affairs*. 2002;21:143-51.

several of the experts noted that the implications of these structural changes for influencing patient behavior may not have been anticipated by employers.

For instance, employers, employee benefit consultants and health plans reported that virtually all employer-sponsored health plans have formularies limiting the number and types of prescription drugs covered by the plan. The experts indicated that the use of three-tier co-payments for outpatient prescription drug benefits was now common. One specialty vendor noted an emerging trend toward a four-tier approach, with the fourth tier including “lifestyle drugs,” paid for entirely by the employee but at a rate reflecting the bulk purchasing discounts that the pharmacy benefit manager (PBM) could obtain. In addition to saving employers money, this approach also encourages patients (and perhaps their doctors) to use less costly but equally effective generic drugs when available.

Several of the health plan experts also mentioned the widespread use of tiered hospital networks, where the patient’s reimbursement rate varied based on the facility at which care is obtained. The experts reported variations on how the tiers are structured, based in part on what data is available concerning hospital performance and whether hospitals have agreed to negotiated rates. For example, employer-sponsored health plans generally establish a two-tiered approach with one reimbursement rate if the patient has obtained services at a network facility and a lesser rate if the patient has used a non-network facility. One employee benefit consultant described a three-tier plan that a number of his clients have adopted in which the reimbursement rate would be increased if the patient used a designated center of excellence or other high-volume specialty facility. However, this expert pointed out that a major limitation on greater use of this type of approach was the absence of data in some geographic areas regarding the performance of these facilities in comparison to other facilities in the area that may not be so well known.

Movement Toward “Defined Contribution” Approaches

The latest object of the “never-ending search by employers for the silver bullet” (as one employee benefit consultant characterized it) is a defined contribution health plan model, including the use of “personal care accounts” (PCAs) or “health reimbursement arrangements” (HRAs). Employers and vendors generally refer to these arrangements as “consumer-driven health plans,” although many of the experts we interviewed suggested that use of this name was more of a marketing device rather than a description of the true nature of the product. However, the literature refers to them as both “defined contribution” and “consumer-driven” health plans.

Every expert that we interviewed identified this coverage model as an important trend (either current or future) and indicated that although the number of employers that have adopted one of the new defined contribution products is relatively small, that number is expected to grow in the future, particularly since the Department of the Treasury and the Internal Revenue Service clarified some of the tax issues surrounding these arrangements in guidance issued in June, 2002.¹² However, there was

¹² Treasury and IRS have issued two types of guidance on health reimbursement arrangements (HRAs): Notice 2002-45 which generally sets out the rules applicable to HRAs and Revenue Ruling 2002-41 which establishes a safe harbor for applying the rules to two specific situations.

disagreement among the experts as to whether this trend was positive or negative with respect to the effect on employer costs. Even among the experts who supported defined contribution approaches to providing health care as a cost management tool (regardless of their impact on care management), there was no consensus as to whether the various defined contribution products would save employers money.

The trade literature in particular contained many articles regarding the projected trend toward a more individually-based insurance market and various defined contribution approaches under consideration by employers. Most of the articles on defined contribution health plans were promotional in nature, written by consultants and representatives of health plans who are actively marketing these arrangements to employers. Articles describing these arrangements in the peer-reviewed literature have only begun to appear in the past couple of years.¹³

Based on the literature and our interviews with experts, however, it appears that there are a number of products on the market that capitalize on the emerging employer interest in defined contribution plans. A few employee benefits consultants reported that a small number of employers had replaced their existing defined benefit health plans with the new product, but most employers were currently offering employees a choice between existing, more traditional health insurance plans and the new defined-contribution type products.¹⁴

Typically, this approach is accomplished through offering some type of an individual reimbursement account in conjunction with a high-deductible or tiered health plan. These accounts often operate in a similar fashion to the way current tax-favored flexible spending accounts (FSAs) operate. For example, the employee can use the account to pay for certain designated health care expenses, such as medical services that are excluded under the employer-sponsored plan. The experts familiar with these products said that although all employers provide some type of health insurance in addition to the accounts, most employers offer employees a choice of either a catastrophic or more comprehensive major medical plan (with varying employee premiums reflecting their choice) to supplement the account balance.¹⁵ Usually these programs provide web-based consumer information to allow employees to evaluate the health plan offerings.

Taken together, the Notice and the Revenue Ruling describe the conditions under which an employer may establish an HRA that provides non-taxable benefits.

¹³ See, for example, Christianson, J.B., Parente, S.T., & Taylor, R. (2002). Defined-Contribution Health Insurance Products: Development and Prospects. *Health Affairs*, 21(1), 49-64.

¹⁴ According to several of the experts that were interviewed, such choice could likely lead to adverse selection within the traditional health insurance plans. If younger, healthier employees opt for the defined contribution-type product because of the lower premium costs and increased flexibility it provides, the average cost of enrollees in the traditional product would rise, reflecting an older group of individuals with higher anticipated health care costs. As the cost of enrollment in the traditional product increases as a result, even more employees will choose to disenroll in the traditional product in favor of the defined contribution product. In the long run, these experts believe that adverse selection will result in increasingly higher costs for enrollees in traditional health insurance products, which could reduce the likelihood that the employer would offer them.

¹⁵ Some of these defined contribution products are similar in structure to Medical Savings Accounts (MSAs). Under the Internal Revenue Code, certain individuals and employers may establish MSAs that consist of a high-deductible health plan in conjunction with a cash account from which medical expenses can be paid.

According to the experts we interviewed, the structure of many of the current products is similar. The employer “deposits” a predetermined amount into each employee’s account (as a practical matter, this usually is only a “notational” or bookkeeping account – no actual money is transferred). The balance in the account can be used by employees for routine care; unused amounts roll forward from year-to-year. Generally, there is a financial gap between the total amount in the employee’s account and the point at which the employer coverage takes over. Employees are responsible for all the health care expenses incurred in the gap, although some employers pay for all preventive care expenses and do not require employees to tap their individual accounts for those expenses.

For example, an employer might contribute \$1,000 per year to each employee’s PCA or HRA for payment of all non-taxable medical expenses the employee incurs during the year.¹⁶ In addition, the employer may provide a comprehensive medical plan with a \$3,000 annual deductible. If the employee has medical expenses of \$2,500, he or she may draw down the full \$1,000 from the PCA and supplement that amount with an additional \$1,500 from his or her own resources. The employer plan would not be activated until the employee has incurred an additional \$500 in unreimbursed expenses, since the plan’s deductible is \$3,000.

Some of the experts we interviewed observed that defined contribution health plans were primarily a means to shift costs to employees. These experts do not believe they serve as care management tools. They expressed concern that, as currently structured, defined contribution products put employees and their families at risk for a greater share of medical expenses without giving them the tools necessary to make better health care choices. To illustrate this point, several experts said that under the typical defined contribution health plan product, employees or families with medical bills that exceed the amount in the PCA or HRA but whose expenses had not yet reached the point where the employer health plan would be activated, would be responsible for 100% of the health care expenses falling into that gap. The experts expressed concern that rather than providing an incentive to patients or to providers to encourage more effective care management, this structure would increase the likelihood that employees who could not afford to pay for treatment would defer necessary care. These experts were concerned that defined contribution arrangements would create financial disincentives to obtaining primary care, preventive services and specialty treatment that were necessary but fell within the out-of-pocket obligation of the employee and his or her family.

On the other hand, many employee benefit consultants and some employer representatives were enthusiastic about these arrangements. Most said that they were optimistic that they would enable employers to better manage their health care costs. A few also noted that plans could be structured to encourage certain care management practices, such as allowing the individual to obtain preventive care services whenever necessary, even if the individual or family deductible had not been met. Some experts believe that giving consumers access to more information regarding providers and health outcomes will result in more thoughtful selection and use of the health care

¹⁶ An employer is likely to limit medical expenses paid from these health accounts to non-taxable benefits (such as those defined as medical benefits in section 213(d) of the Internal Revenue Code) to limit the possibility that employees would have to report reimbursements from the accounts as income for the year.

system and physician services, although they too were concerned that there was not currently enough useful consumer information available about provider performance to enable consumers to make intelligent and informed choices.

Experts involved in designing systems to gather and report such information tended to be more skeptical that the kind of information that consumers would need to make informed choices about providers (which experts said was a significant feature of defined contribution plans currently being marketed) would be available in the near future. One quality management and consumer information specialist described these efforts as in their “infancy” stage and when asked whether he would expect sufficiently reliable comparable information to become available in the next ten years, he said it was “possible” that hospital performance measures might be widely available, but “doubtful” that such information would be available for individual physicians, except for certain discrete geographic markets.

Many Health Plans Look to Care Management as Potential Solution to Rising Costs

In contrast to the apparent lack of interest that most employers have in care management techniques, many health plans have invested varying amounts of resources in analyzing and experimenting with different care management techniques as tools to address quality and cost issues.

The primary objective of our interviews was to identify the types of care management activities that health plans and private sector employers currently use. We asked each of the experts the extent to which they rely on certain traditional managed care approaches to influencing patient and provider behavior, such as (1) requiring patients to select a primary care physician as a focal point for care coordination, (2) permitting visits to specialists only after referral from a primary care physician, (3) requiring pre-authorization for inpatient hospitalization, access to inpatient or outpatient mental health or substance abuse services, or certain other outpatient services (such as vision care), and (4) concurrent utilization review.

The experts report a movement away from some of these care management techniques, such as the use of pre-authorization for outpatient procedures, but retention of others, such as the use of PCPs and pre-authorization for inpatient hospital admissions. They characterized these changes as a reaction to the backlash from employers and their employees as a result of the more restrictive practices that limited access to providers and services. Some large health plans now allow self-referrals for routine preventive services or to certain specialists, such as pediatricians and obstetricians/gynecologists. Others have instituted procedures for standing referrals (typically for a limited period of time) to specialists of various types for patients with chronic conditions, such as asthma, or for those patients who need follow up for a particular illness, such as cancer. Several health plan representatives pointed out that these changes have been made voluntarily, rather than as a result of externally imposed requirements.

Another factor that health plan experts cited as being key in the decision to impose less restrictive access to specialists rules is the lack of empirical evidence demonstrating that more restrictive approaches have been successful in reducing costs.

Experts felt that in part this might be due to the current market climate in which such rules are not strictly enough enforced to make a difference. Some experts noted that there was no any evidence that eliminating requirements for referrals to specialists would result in substantially increased costs, although the data on that point was quite limited.¹⁷ Perhaps more significantly, in the view of a few employee benefit consultants and health plan representatives, there is a lack of data to show that these rules improve care.

Experts representing employers, employee benefit consultants and health plans identified two types of care management activities that they believe have the potential to improve clinical outcomes while reducing employer cost: disease management programs and large case medical management programs. Labor union and other consumer representatives agreed that these approaches deserved additional consideration. The literature reflects this interest as well, particularly in disease management programs.

According to the experts we interviewed, a number of large and some medium-sized employers have launched disease management programs, primarily focused on improving patient self-care for specific medical conditions such as diabetes, asthma, high blood pressure, or high cholesterol. One health plan expert described these programs as a shift in focus from managing care for all toward a focus on better management of care for certain high-risk individuals. Some employers have integrated disease management activities into their health plan; others have carved out these activities and contracted them out to a specialty vendor. According to the experts we interviewed, the primary characteristics of disease management programs were both generalized and specific patient education coupled with individual follow-up (usually by a nurse or other health professional) and written reminders to assure compliance with a mutually agreed upon self-management plan. In addition, the experts said that financial incentives to patients to participate in the programs were also important. Experts mentioned that disease management programs should also include financial incentives to physicians to provide follow-up care, although several experts said that such an approach was less feasible in PPOs, than in staff and group model HMOs.

When asked why these programs were not more widely used, interviewees across-the-board stated that lack of evidence that these programs actually achieve their cost management goals or improve clinical outcomes has hampered their adoption.

As discussed earlier in the paper, there is some evidence from the interviews that both employers and health plans regard “large case” medical case management (individualized programs consisting of a plan of medical care and coordinated treatment for expensive or complicated cases) as a more effective care management technique

¹⁷ Many experts cited an article that appeared in the *New England Journal of Medicine* in 2001 describing the effects of lifting this restriction on a large HMO in Massachusetts. In the article, a group of researchers described the results of a study that found that there was little evidence of changed behavior on the part of adult patients enrolled in the Harvard Vanguard Medical Associates, a large, capitated, multispecialty group practice, in the first 18 months in which the gatekeeping requirement was eliminated. Ferris TG, Chang Y, Blumenthal D and Pearson SD, Leaving Gatekeeping Behind – Effects of Opening Access to Specialists for Adults in a Health Maintenance Organization, *N Engl J Med* 2001; 345:1312-7.

than disease management. These experts assume that medical case management saves employers money and can improve patient care, although there does not appear to be empirical data to confirm this belief. Most of the experts said that medical case management programs, particularly those focused on hospital discharge planning and follow-up care, are widely used care management tools, particularly among large employers with self-insured health plans and managed care plans. A recent *Health Affairs* article reinforces the experts' observations regarding this trend.¹⁸

Affecting Care and Cost Management Through Changes in Provider Behavior

Neither employers nor health plans feel that effective tools currently exist to change provider behavior, which they believe is an essential component of any successful cost and care management strategy. Except in staff and group model HMOs, health plans report that they generally exercise limited control over the practice patterns of the physicians within their networks. Some provide clinical practice guidelines or protocols to physicians, but adherence to these standards, although encouraged, varies among physicians and is generally not required to be documented.

A few health plan experts indicated that some evidence exists that hospitals are beginning to use financial incentives to encourage adherence to evidence-based clinical guidelines or protocols, but that practice does not seem to be widespread. The literature suggests, and some of the experts confirmed, that physicians have regained some of the bargaining leverage that they had lost to managed care plans during the early 1990s.¹⁹ As a result, in many communities, most physicians participate in most, if not all, of the networks in their geographic areas. The experts said that because of this phenomenon, financial incentives offered by one hospital or one MCO do not appear to have much influence over physician behavior.

We asked the interviewees whether some health plans incorporated references to clinical practice guidelines or protocols (not always evidence-based) into their contracts with doctors, so that they became part of the contractual standard of care for treating patients. None of the experts we interviewed had personally encountered this practice, although several remarked they had heard some discussion about it. In fact, nearly all said that physician contracts typically were silent regarding practice procedures or care management approaches that doctors were expected to follow.

According to the experts we interviewed, some hospitals and managed care plans have adopted physician profiling techniques and other mechanisms to measure physician compliance with evidence-based practice guidelines and protocols. However, experts reported that hospitals and health plans use this information in substantially different ways. Experts indicated that, in some settings, physician-specific information is passed on to the physicians who are then encouraged to review their performance in comparison to their peers, but no formal mechanism is established to follow-up with physicians whose profiles indicate substantial variance from the norm. Other experts

¹⁸ Felt-Lisk S, Mays GP, Back to the Drawing Board: New Directions in Health Plan's Care Management Strategies. *Health Affairs*: 2002;21:210-217.

¹⁹ Draper, D. A., Hurley, R. E., Lesser, C. S., & Strunk, B. C. (2002). The Changing Face of Managed Care; Managed Care Plans Face the Challenge of Satisfying Marketplace Preferences for Less Restrictive Care While Holding Down Costs. *Health Affairs*, 21(1), 11-23.

described settings in which hospitals or health plans actually worked with physicians to determine the reasons for variation and developed mechanisms in a cooperative fashion to improve physician performance. Still other experts described how data collected through physician profiling activity were used by the hospital or managed care plan in determining whether or not to review a physician's contract and in compensation negotiations with individual physicians or groups of physicians.

Doctors often have a very different view of the usefulness or reliability of some of the care management activities that hospitals or health plans have undertaken. Tension between managed care plans and physicians was evident through several of the interviews. According to the representatives of doctors and hospitals we interviewed, the information obtained through profiling activities in most instances was simply sent to the doctors and not discussed with them. Both the physician and health plan experts agreed that often the health plans did not take the time to work with individual doctors to improve their performance. Doctors were expected to review and analyze the data themselves and, if necessary, conform to "arbitrary standards of conduct" (as one expert representing doctors characterized them). Some physicians criticized managed care plans for using these profiling techniques in evaluating physician performance, noting that many of the systems failed to take into consideration the relative seriousness of the patient's condition or other complicating factors.

Managed care plan experts were divided in their response to this criticism. On one hand, several experts acknowledged that their provider profiling systems were "works in progress" and agreed that more coordinated effort with providers would be helpful to make profiling data more useful to both providers and plans. On the other hand, a few health plan experts said that some doctors were more willing to criticize the profiling system than examine why their treatment patterns varied from the norm. On balance, however, the health plan experts agreed that greater input from physicians in the development and assessment stages of provider profiling system development could improve both acceptance of the system and its operation.

Experts representing doctors we interviewed emphasized that as a general matter, care management techniques, such as disease management programs, are more likely to be successful when the practice guidelines or clinical protocols to be used are developed by the doctors themselves (or in concert with health plans), rather than imposed by health plans or employers. Although most managed care plan representatives agreed that cooperative development of practice guidelines or clinical protocols might be advantageous, a few insisted that use of "objective criteria," such as the guidelines developed by Milliman and Robertson, to measure physician behavior would result in less variation among hospitals and health plans.

Another recent article in *Health Affairs* based on data collected through the latest Community Tracking Study (CTS) conducted by the Center for Studying Health System Change in Washington, DC described various quality improvement activities undertaken by hospitals and medical groups, including the techniques used to select physicians, quality-related payment arrangements, and care management programs.²⁰ This study

²⁰ Devers K, Quality Improvements by Providers: Market Developments Hinder Progress. *Health Affairs*:2002;21:201-09.

reinforces the information we received through our interviews with experts representing health plans and physicians, although, as noted above, at times their perspectives appeared to be at odds.

Lack of Data on the Effectiveness of Care Management Activities Is Seen as the Primary Barrier to Adoption

Lack of data that can be used to assess the effectiveness or cost savings generated by care management techniques was consistently cited by the experts we interviewed as the primary reason that care management techniques are not more widely considered or utilized by physicians, health plans or employers. The literature also reflects this concern.

Experts stated that although employers continue to search for high-quality/low-cost health care, the lack of consensus around acceptable measures of quality or evidence of its practice appears to have impeded progress. Experts involved with developing tools for employers and other purchasers to assess quality acknowledge the difficulty of their task, yet they remain optimistic that eventually most employers will recognize that assessing the competence and effectiveness of physicians is a necessary part of the purchasing decision. However, these experts also stated that until physician information is standardized, reliable and publicly available, employers and consumers cannot be expected to consider the use of this information essential to their purchasing decision-making.

One expert on quality standards observed that there are many self-serving evaluation tools being offered to consumers and purchasers in the marketplace today, but their lack of reliability undermines the process of measuring quality. He noted that the fundamental building blocks of a successful system for assessing quality should include standard evidence-based performance measures, publicly available reports regarding the performance and compliance of physicians with these performance measures, information systems that support a national health information infrastructure, and payment and reimbursement policies that reward the more efficient physicians and those who are providing quality care. When asked whether he thought we could accomplish these tasks in ten years, he replied that he hoped that by then we would have created a health care culture of excellence that values and rewards quality care. He was less hopeful that the infrastructure to support such a system would also be in place in ten years.

Conclusion

The major findings from our interviews can be simply stated. In the view of the experts:

- For the vast majority of employers, cost drives purchasing decisions.
- Current care management techniques have not been empirically demonstrated to improve patient care or reduce employer costs; employers are unlikely to rely on them to evaluate health insurance options.

- A few techniques, such as medical case management and disease management, may be effective, but insufficient data and research exists to demonstrate their effectiveness.
- In the absence of this type of data, most employers are turning to cost-shifting to cope with escalating health care costs. Some are moving away from traditional defined benefit models of employer-provided insurance and toward a defined-contribution model.
- Some private sector employer purchasers are interested to varying degrees in exploring care management as a cost-management technique if the efficacy of care management can be demonstrated through the creation of tools to measure the effectiveness of care management and models of evidence-based care can be tested.

Many of the newer care management techniques that experts highlighted and discussed with us are in early stages of development. As yet, according to the experts, none appears to have shown strong enough promise to overcome the cost concerns of employers as they make purchasing decisions. And if projections of continued steep increases in employer health care costs prove correct, the experts believe that for the foreseeable future any efforts to encourage employers to broaden their purchasing considerations to include a greater emphasis on care management are not likely to succeed.

Yet there is a sense among some of the experts that given sufficient time and research, a case could be made that certain types of care management such as medical case management and disease management are effective in improving patient outcomes and reducing employer costs. Most experts believe that the current lack of data is a significant obstacle that must first be overcome before most employers will take these approaches seriously.

Both the literature and our interviews identified the growing belief among employers that there may be only two principal ways for employers to manage health care costs with any degree of success: (1) shifting increased costs to employees and dependents (which some experts believe may ultimately increase the ranks of the uninsured and decrease coverage), and (2) moving away from the current structure of employer-sponsored group health plans into a individually-based insurance system where the consumer decides how much and what type of health insurance he or she wants and can afford (the experts we interviewed disagreed whether this was feasible or desirable).

When asked to predict future trends in care management, many of the experts thought that in ten years we would still be exploring the same approaches to care management as those being considered today, including disease management, medical case management, tiered reimbursement approaches and cost-shifting. Among those experts who looked to defined contribution approaches as the wave of the future for employer-sponsored health plans, there was little optimism that this trend would result in any significant reduction in overall health costs. Most experts believed that employers would continue to reduce their health care costs in the future by cost-shifting to employees, rather than by using traditional care management techniques. And with the decline or abandonment of many of the care management techniques directed at

providers that were discussed in the literature in the 1997-2001 period, the experts believe that the current managed care system offers substantially less opportunity for managing either care or costs.

The experts expect that one of the most difficult and important tasks America will face in the future is to keep health care costs under control. But even if costs could be kept on a relatively even keel in the future, most of the experts believe that the development of widely accepted care management approaches as cost-management tools will not occur in the next ten years because the necessary infrastructure to collect data to evaluate the effectiveness of efforts to manage care or control costs does not currently exist. Every expert we interviewed identified this lack of data and the infrastructure to collect it as a critical shortcoming in our current system. A few experts observed that despite its importance, development of a reliable system to collect and analyze data on the potential benefits of various approaches on care and cost management does not seem to be a priority for the future for either the private or public sectors; others pointed to the efforts of the Leapfrog Group and other purchaser-provider collaborations as possible opportunities to demonstrate the efficacy of care management approaches.

In particular, many of the experts identified the effectiveness of disease management programs as an important area for future research. However, they noted that one of the difficulties researchers will have in evaluating these programs is a lack of consensus in the marketplace around the definition of disease management and the structure of the programs. According to the experts, extensive variation that currently exists is likely to complicate objective analysis of these programs.

Without adequate data about this or any of the other care management approaches, the experts believe it will be difficult for researchers to draw any useful conclusions about their effectiveness and for models of evidence-based care to be developed to test these approaches. Although identifying viable cost and care management techniques and measuring their effectiveness will be difficult, the experts we interviewed all agreed that this was a critically important goal worth pursuing.

ATTACHMENT 1

Review of the Literature

How Care is Managed: Care and Cost Management Practices Under Private Sector Employee Plans

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Introduction

In conjunction with the descriptive study of the current trends in cost and care management techniques used in the employment-based health insurance marketplace, the Center for Health Services Research and Policy was asked to conduct a review of the literature related to this topic. The purpose of this review was to identify and track information about the changing nature and structure of managed care utilization management techniques and provider reimbursement strategies.

This literature review identifies information published in a variety of publications during the past five years on current trends in care and cost management techniques in the private health insurance market. Specifically, we reviewed articles from peer-reviewed journals committed to documenting significant health system change (such as *Health Affairs*) that are widely read among health policy and health services researchers and other health professionals. We also reviewed articles from relevant trade publications since they generally report industry trends more rapidly than scholarly research journals. Finally, we have also included select newspaper reports to identify care and cost management issues that are considered most important to the general public.

We found considerable consistency across these very different formats in terms of the key messages communicated and the care and cost management trends that were

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identified as most prevalent and likely to continue in the future. Most of the literature reviewed addresses the following trends in health care:

- Recent steep increases in the cost of managed care health insurance premiums.
- A retreat from the most restrictive managed care practices.
- Less variation among managed care plan types such as HMO, PPO, and POS plans.
- Decreased plan choice among insurance carriers for beneficiaries.
- Increased cost sharing by beneficiaries in the form of higher copayments, premiums, and deductibles as well as multi-level pharmaceutical pricing schemes.
- A resurgent interest in the “defined contribution” plan model.
- A continuing discussion about the trade-offs between high quality/low cost health care with no consensus on acceptable measures of quality or evidence of its practice.

Peer-reviewed Publications

Focusing on trends in care management, provider compensation and employer cost-management techniques, we searched for articles that document the range of changes that have swept through employer-sponsored health insurance coverage in the past few years and the likely changes that are expected to occur over the coming five-to ten-year period.²⁵

We found numerous articles that address the rapid proliferation of managed care plans throughout the 1990s and the extent to which employers have offered, encouraged, or required employees to enroll in a variety of managed care arrangements. Although it is not our intention to catalogue this vast literature on managed care, it should be noted that the majority of articles found tend to address issues related to quality of care, access to care, cost, or some combination of the three, and tend to focus on consumers’ experience with managed care. We found relatively few such articles that specifically address these changes from a system and insurance product perspective.

In a recent article published in *Health Affairs*, researchers examined employer strategies for controlling health insurance costs and changes in employer contribution

²⁵ Search terms included “managed care, employee benefits trends, health care benefits, disease management, insurance market, managed care, carve out, health insurance, insurance coverage, disease management, insurance benefits, care management, case management, integrated delivery systems.”

strategies during the past two years.²⁶ Based on data from the Community Tracking Study (CTS),²⁷ the authors note that overall, few large employers had increased the share of the premium paid by employees or changed their contribution strategies. Instead, they were attempting to reduce health insurance costs and their administrative burden by increasing an employee's financial stake in providing for his or her own health care, through such techniques as reducing the level of employer subsidy for spousal or dependent coverage or providing financial bonuses to employees who accepted coverage under their spouses' health plan.

Prevalent cost management trends in use today include increasing employee co-payments and deductibles, increasing retiree's out of pocket expenses (or dropping retiree coverage altogether), and targeting pharmaceutical benefits through the use of various mechanisms, such as three-tiered schemes, preauthorization requirements for expensive drugs, and excluding some drugs altogether (i.e., Viagra, Claritin, and oral contraceptives). Although employers expressed interest in defined contribution plans, only a limited number had adopted such plans.

Trude, et al, note that future trends are difficult to discern because "for all but the largest employers, planning tends to be pragmatic with decisions made year to year, contract to contract." Furthermore, changes in employer benefits may be a product of specific circumstances in the local labor market rather than reflections of general trends.

Kuttner provides a comprehensive review of recent trends in employer-sponsored health insurance in a *New England Journal of Medicine* Health Policy Report published in 1999.²⁸ His observations are echoed in many of the other articles covered in this review and include:

- Huge shifts to managed care and away from indemnity plans during the 1990s.
- Significant cost-shifting from employers to employees involving increased premium shares, co-payments, and deductibles; and availability and cost of family coverage and other benefits such as prescription, dental and mental health.
- A decline in the percentage of nonelderly employees who receive their health insurance from their employer over the period 1987 to 1997.
- A decline in the "take-up" rate among workers during that same period (1987 – 1996) in which slightly more employers offered health insurance to their employees.

²⁶ S. Trude, J.B. Christianson, C.S. Lesser, C. Watts and A.M. Benoit. Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes. *Health Affairs* 2002; 66-75.

²⁷ The Community Tracking Study site visits occurred between June 2000 and March 2001 in twelve communities randomly chosen to provide representation of national trends. The study targeted small and large employers and consisted of interviews with local representatives of large and small employers.

²⁸ R. Kuttner. The American Health Care System: Employer-Sponsored Health Coverage. *New England Journal of Medicine* 1999; 248-52.

- A return to high rates of growth in premium costs after several years of flat to modest increases.

Marquis and Long also address many of these same issues in their analyses of findings from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Tracking Survey, which provides information at the establishment level on businesses in the continental United States, stratified by geographic area and size of the establishment.²⁹ In an article published in *Health Affairs* in 2001,³⁰ the authors take issue with Kuttner's contention that employees' share of medical costs increased over the 1993-1997 period. Instead, Marquis and Long attribute the change in relative payments to more generous coverage for large medical expenses over that time period.³¹ They note an increase in the percentage of enrollees with mental health, prescription drug, dental and vision coverage, which contributed to higher average plan benefit values. They also report that a majority of large employers use information on quality of care when choosing health plan offerings, although they do not indicate the extent to which these employers use this information in relation to other information about costs of care.

Marquis and Long found little evidence that managed competition practices were in play, even among employers who offered a choice of plans. In 1997, about one-quarter of establishments offering a choice of plans contributed a fixed dollar amount for single coverage to all health insurance plans, and another third of those plans paid a fixed percentage. According to the authors, large employers were more likely than small employers to require that employees pay at least a part of the cost difference if they chose a more expensive plan. Among large employers, only 36 percent had a fixed-dollar contribution policy in 1997. Few employers provided information to help employees compare quality and other performance indicators across plan choices.

According to a study by LoSasso, et al, few employers based purchasing decisions on quality and other plan indicators not explicitly related to cost.³² Using data from two surveys of business-coalition members and a national survey of employer-

²⁹ The RWJF survey oversampled businesses in the sixty communities followed by the Community Tracking Study and in twelve states with significant small group rating reforms. For a description of the survey and its methodology; see: 1997 Employer Health Insurance Survey: Final Methodological Report (Research Triangle Park, N.C.: Research Triangle Institute 1998); and P. Kemper et al. The Design of the Community Tracking Study: A Longitudinal Study of Health System Change and Its Effects on People, *Inquiry* 1996; 195-208.

³⁰ M.S. Marquis and S.H. Long. Prevalence of Selected Employer Health Insurance Purchasing Strategies in 1997: How Many Employers Are Following the Leaders Example? *Health Affairs* 2001; 220-230.

³¹ The authors point out that as employees moved into lower cost managed care plans, cost sharing for small expenditures in HMOs and PPOs increased. Thus, there were shifts within out-of-pocket costs but not an overall increase in the average employees' costs, at least during the 1993-1997 period.

³² A.T. LoSasso, L. Perloff, J. Schield, J.J. Murphy, J.D. Morimer, P.P. Budetti. Beyond Cost: 'Responsible Purchasing' of Managed Care by Employers. *Health Affairs* 1999; 212-223.

sponsored health plans,³³ the authors found that firms generally relied more on traditional “bottom-line” measures rather than on “responsible purchasing information” when selecting health plans. The authors define responsible purchasing information as access and geographic coverage, a focus on prevention and wellness programs, member satisfaction and physician turnover, NCQA or other accreditation, chronic disease management expertise, and ability to provide HEDIS reports. While nearly all firms report that they bear some responsibility for assessing the quality of the plans that they offer, few use these factors as key drivers in their decision-making concerning plan selection. Consideration of these factors was higher, however, among purchasing coalition members.

There was very little evidence in the literature that accreditation standards, particularly those regarding care management techniques, such as analysis of quality information, influence an employer’s purchasing practices. The use of quality information in making contracting decisions is addressed in a study by Maxwell, Temin and Watts, who surveyed Fortune 500 companies on their health care purchasing practices.³⁴ The authors found that 83 percent of Fortune 500 firms reported that they considered quality in the selection of health carriers, yet only about half required all of their plans to be NCQA accredited. Furthermore, 32 percent reported that they set specific standards for clinical quality in their contractual arrangements. Yet nearly all of these companies (93 percent) have reduced the number of contracting carriers as a cost management measure. The authors state that in their interviews with respondents, corporate executives considered “dropping carriers” as “an effective method of curtailing the rate of premium increases.”³⁵

Aetna chief executive officer Richard L. Huber offers his insights about changes in the industry in an interview conducted by James Robinson and published in *Health Affairs*.³⁶ According to Huber, several trends are apparent in employer-sponsored health coverage:

- A shift to using fewer carriers, in response to employers’ needs for greater “simplification and efficiency.”³⁷
- A predicted move to a defined-contribution system over the next five to ten years.
- A blurring across traditional plan categories such as HMOs, PPOs, and POS plans to produce a “spectrum of products.”³⁸

³³ The authors used data from a 1997 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans and data from two surveys they designed and administered to The Midwest Business Group of Health and the Washington Business Group on Health.

³⁴ J. Maxwell, P. Temin, C. Watts. Corporate Health Care Purchasing Among Fortune 500 Firms: The Nation’s Largest Employers Have Exacted All of the Savings They Can from Aggressive Purchasing and Switching Employees to Managed Care. What Will Their Next Move Be: *Health Affairs* 2001; 181-188.

³⁵ Ibid, p. 184.

³⁶ J. Robinson. At the Helm of an Insurance Giant: Aetna’s Richard L. Huber. *Health Affairs* 1999; 89-99.

³⁷ Ibid, p. 89.

- The recognition that the “two ends of the spectrum, the pure indemnity plan and the staff-model HMO, are too extreme for the population.”³⁹
- A trend toward opening up the utilization review process and toward managing costs by placing more decision-making into the hands of consumers.
- The availability of new insurance products for the group or individual markets with a base level of coverage and varying levels of benefits based on consumer preferences.
- An increasing reliance on direct-to-consumer information and information that relies heavily on use of the internet.
- Greater investment in information technology and the ability to use patient-level data for clinical improvement and quality initiatives, both at the patient and population levels.

As plans have begun to move away from tighter management practices, new care and cost management mechanisms designed to provide efficient care have begun to emerge. Chief among these are efforts to develop clinical standards of care and implement disease specific management techniques. Holland, for example, in a 1995 article in the *Journal of Outcomes Management*,⁴⁰ states: “In a competitive marketplace, clinical standards have become the mainstay of health plans’ medical policies; these, in turn, drive utilization management activities.”⁴¹

Holland’s conclusion follows his assessment of the failure of a host of other targeted efforts to control health care costs via utilization management. In his words:

Traditionally, health plans have sought to control volume in a number of ways. Retrospective review of care after it has been provided is both costly and difficult, and it rarely returns true cost savings. Provider profiling is likewise often ineffective, since smaller health plans may not have enough utilization across their network to gain meaningful data over time. For those plans large enough to gather sufficient data, provider profiling has generally focused on counting health care events and tabulating costs. They have only recently moved to profiling utilization patterns and quality. Preauthorization programs are administratively burdensome and viewed as a hassle by providers, but continue to be an essential tool for controlling admission rates and days of care... Meanwhile, disease management programs, though popular, focus only on small select groups of patients that traditionally use large volumes of medical services.⁴²

³⁸ Ibid, p. 90.

³⁹ Ibid.

⁴⁰ S.K. Holland. Clinical Standards, Critical Pathways, and Managed Care. *The Journal of Outcomes Management* 1995; 10-11.

⁴¹ Ibid, p. 11.

⁴² Ibid, p. 10.

Despite Holland's embrace of clinical standards, more recent literature suggests that such standards have not resulted in meaningful change across a wide set of practice settings or disease states. The results have been disappointing, since the development of practice guidelines and clinical standards was an attempt to bring scientific rigor to the delivery of care and to eliminate variation across patient encounters in which there was an evidentiary basis for a specific standard of care.⁴³ In the area of diabetes, congestive heart failure, asthma, depression, back pain and a number of other chronic conditions, practice guidelines were developed to guide busy clinicians toward the most appropriate care for patients. The literature on efforts to change clinical behaviors, however, shows that almost all approaches work at least some of the time, but none works all the time.⁴⁴

As noted previously, Richard Huber, in an interview with *Health Affairs*, predicts the move to a defined contribution system over the coming decade.⁴⁵ Defined contribution plans "respond to employers' desire to reduce their involvement in managing health benefits and shift more decision making to employees,"⁴⁶ according to another article in *Health Affairs*. Although the authors note that the "defined-contribution health insurance product is itself ambiguous," many of today's defined contribution plans share the following characteristics:

- "A portion of the employer's contribution toward employee's health benefits is placed in an account from which the employee purchases services with tax-advantaged dollars."⁴⁷
- A portion of the employer's contribution is also used to purchase major medical or "wrap-around" insurance.
- Employees are responsible for, if necessary, those health services costs that fall between the health spending account monies and the insurance coverage.
- The internet is used in some fashion to assist employees with their health care purchasing needs.⁴⁸

Although the authors report that defined contribution plans had made little impact at the end of 2000, by mid 2001, defined contribution plans had reported contracts with "several major employers for the upcoming benefit period."⁴⁹ The authors believe that future prospects for defined contribution plans rest on conditions in

⁴³ G. Anderson. Implementing Practice Guidelines. *Canadian Medical Association Journal* 1993; 753-755.

⁴⁴ L. Wyszewlanski, L.A. Green. Strategies for Changing Clinicians' Practice Patterns: A New Perspective. *Journal of Family Practice* 2000; 461-464.

⁴⁵ J. Robinson. At the Helm of an Insurance Giant: Aetna's Richard L. Huber. *Health Affairs* 1999; 89-99.

⁴⁶ S. Christianson, S.T. Parente, and R. Taylor. Defined-Contribution Health Insurance Products: Development and Prospects. *Health Affairs* 2002: 49-64.

⁴⁷ Ibid, 51.

⁴⁸ Ibid.

⁴⁹ Ibid, 62.

the labor market and the economy; but ultimately, “long-term prospects for employers’ interest in defined contribution plans ... will depend on their ability to induce consumers to play an active role in containing health care costs, an object that, while laudable, has yet to be achieved.”⁵⁰

In an article published in the *Journal of the American Medical Association*, James C. Robinson examines the ascendancy of the American consumer as the key decision maker in healthcare. The retreat of insurers, physicians, and employers from active and direct involvement in the design of health care benefit packages (an involvement which had been encouraged by managed care in the past) coupled with resistance to large scale federal government involvement in health insurance has spurred the growing role of the consumer.⁵¹

While Robinson does not question employers’ continued commitment to funding health insurance and pension plans, their role has increasingly become more supportive of the consumer through the provision of “decision-support tools” and financial subsidies and less involved in the actual decision making process. As employers move to a less “paternalistic” role, “information and incentives will replace paternalism and control as the primary instruments of corporate health policy.”⁵²

Robinson observes that physicians are returning to a more comfortable patient advocacy role. Health insurers are also redefining their role. “Heretofore, managed care organizations rarely have managed care but mostly have managed costs.” Robinson predicts that “henceforth, they will not even manage costs but only analyze, explain, and pass those costs on to the consumer.”⁵³ As noted in the report, this observation was confirmed by the experts we interviewed.

Trade Publications and Other Journals

Trade publications and other journals aimed at healthcare executives, doctors, and other professionals were consistent with peer-reviewed journals in terms of the prevalent trends in managed care highlighted. In our review, we focused on articles found in *Business & Health*, *Managed Care Magazine*, and *Managed Healthcare Executive* related to trends in care and cost management techniques utilized in managed care insurance benefits. We also searched the *Business and Management Practices* data base for other publications that addressed the changing nature of managed care insurance over the past five years.

One of the most frequently addressed topics is that of disease management. Disease management appears to hold promise among many health professionals and is cited frequently in trade publications and non-reviewed journals as the next frontier for cost-conscious, high-quality care for selected high-cost and high-utilization plan enrollees. According to The Disease Management Purchasing Consortium & Advisory Council, the “\$340 million disease management industry is one of the fastest-growing

⁵⁰ Ibid.

⁵¹ J.C. Robinson. The End of Managed Care. *Journal of the American Medical Association* 2001: 2622-2628.

⁵² Ibid, p. 2627.

⁵³ Ibid, p. 2634.

investments in health care.”⁵⁴ *Managed Care* has published several articles on disease management and its value for health plans and enrollees alike. According to Wolf and Maljanian, there are three main components of disease management:

- A knowledge base that defines the natural history and economic structure of a disease for each particular juncture in the disease process and includes guidelines regarding the care to be provided, by whom, and in what setting;
- A health care delivery system of partnerships between primary care providers, subspecialists, social organizations, and others that provide coordinated care throughout the disease process, breaking down the traditional barriers that fragment the health care system; and
- A continuous-improvement process that measures and evaluates clinical, financial, satisfaction and health-status outcomes; refines treatment standards; and continuously ensures the highest quality of care.⁵⁵

Disease management programs have gained popularity in part on the strength of the business proposition and their potential for a positive return on investment – careful management of chronically ill enrollees avoids costly hospitalizations and emergency room care. The programs, which rely heavily on pre- and post-measures of both the use of health services and the burden of disease, are suited to outcomes measurement. Critical to this measurement, however, is the identification of a base line for the costs associated with the patients who need to be covered. The base line can become the source of contentious disagreement between disease management companies and employer purchasers, and even within the disease management industry itself.⁵⁶ These issues remain largely unresolved, even as more health plans begin to offer disease management services as an in-house or contractual service.

Many of the other articles reviewed focused on the changing nature of managed care plans and the insurance market and the growing costs of health insurance. In an exploration of the former, Michael Dalzell notes three trends in health insurance design, driven by the search for cost saving efficiencies in the health care market.⁵⁷

- *Cost shifting.* According to Mark Weinberg, President of WellPoint Health Network, consumers have been “insulated ... from the real cost of care.” “As people were being desensitized to cost, they weren’t absorbing managed care’s lessons about prevention and resource use.”⁵⁸ New plans for small groups and the individual market are variations of defined contribution plans in which consumers choose health care packages based on the amount of money they are

⁵⁴ Anonymous. Snapshot of a Growth Industry. *Managed Care* 2001; www.managedcaremag.com.

⁵⁵ S.A. Wolf, R. Maljanian. Attention to Detail Crucial in Designing a DM Program. *Managed Care* 2001; www.managedcaremag.com.

⁵⁶ J. Carroll. Health Plans Demand Proof that DM Saves Them Money. *Managed Care* 2000; www.managedcaremag.com.

⁵⁷ M. Dalzell. Where Will Health Plans Find the Next Generation of Savings? *Managed Care* 2001; www.managedcaremag.com.

⁵⁸ Ibid.

willing to spend a month on health care. Generally, the higher the premiums the more extensive the coverage.

- *Paperless health care.* Web-based technology has stimulated the growth of e-health sites in attempts to cut down on administrative costs. These sites offer a variety of services, ranging from allowing consumers to change primary care physicians to allowing them to customize their benefit packages.
- *Care enhancement.* “Built on the core principles of [disease management]” but promising to “go beyond,”⁵⁹ care enhancement takes a more holistic approach to health care, looking at the beneficiary’s comprehensive health care needs, as opposed to disease specific needs, and encourages beneficiaries to participate in managing their care, in efforts to produce better outcomes.

In an interview with *Business & Health* magazine, Helen Darling, President of the Washington Business Group on Health, echoes Dalzell’s findings on recent trends⁶⁰ in managed health insurance. Darling also shares the belief that consumers have been largely insulated from the costs of their health care because employers have absorbed a disproportionate share of these costs over the past five years. Newer plans employers are purchasing tend to place more emphasis on consumer participation. Additionally, according to Darling, efforts to save money through disease management programs, cost shifting, and e-health efforts involve consumers more fully in their health care, financially and otherwise.

Newspapers and Other Sources

We reviewed articles from major U.S. newspapers over the past five years, selecting those articles that best represented what was being reported overall. We found that those trends in managed health insurance reported in current newspaper articles were fairly consistent with those found in other sources, though they placed greater emphasis on issues considered most important to consumers, particularly cost. Many of the newspaper reports also tend to be largely anecdotal. Issue areas prevalent in newspapers include:

- The growing costs of health care.
- Cost shifting to the consumer.
- The move away from restrictive managed care practices, the growing popularity of PPOs, and the blurring of the differences between different types of managed care plans.
- Diminishing health plan choice for consumers in the private health insurance market.

⁵⁹ Ibid.

⁶⁰ G. Muirhead. New Choices for Employees. *Business & Health* 2001; www.businessandhealth.com.

The majority of the reviewed articles found in all regions of the country, regardless of their national or local circulation, focus on the growing costs of health care in the U.S. and the repercussions of such costs for consumer premiums and employer contributions alike.⁶¹ Cost shifting is explored in somewhat more depth in a few papers, including *The New York Times* and the *Los Angeles Times*. Both also take a closer look at trends in managed health insurance, all of which are noted previously in this paper (rising premiums, higher deductibles, reduced retiree benefits, increased co-payments, increased hospital deductibles, three-tiered or multi-level drug pricing, and the increased use of disease management programs).⁶²

We also have reviewed the reports on managed care contracting practices and the evolving health system prepared by national research organizations, such as The Center for Studying Health Systems Change (CHSC) and a national initiative of The Robert Wood Johnson Foundation, Changes in Health Care Financing and Organization (HCFO). These reports are also consistent with the previously described findings.

Among the care management issues that have received special attention by both the CHSC and HCFO are issues that affect physician payment practices.

For example, CHSC's work in documenting changes in provider reimbursement and contracting is substantial. In a June 2001 Issue Brief, Strunk, et al, describe a shift in the balance of power that has occurred from health plans to providers.⁶³ The authors attribute this shift to several factors, including purchaser and consumer demand for broader choice of providers, the development of inpatient capacity constraints among certain well-regarded hospitals, serious financial pressures on providers because of low reimbursement rates, and greater sophistication in managed care contracting and tactics.

Similarly, HCFO sponsored a small invitational conference in 2000 on physician payment that was described in their December 2000 issue of *HCFO News & Progress*.⁶⁴ One of the papers commissioned for that meeting was a literature review by Peter R. Kongstvedt, MD and HCFO associate Kathryn Martin. Although they found the literature "fairly thin," they concluded that physician opinion regarding capitation is largely

⁶¹ See, for example, R. Brownstein. A New Worry About an Old Concern: Health Care. *Los Angeles Times*, January 7, 2002; C1; T. Fong. Health-care premiums for employers go up in '02; 15%-to-20% Increases Likely in S.C. County. *The San Diego Union-Tribune*, November 1, 2001; C1; M. Perrault. Costs of Benefits Up. Colorado Companies Report 13.8% Increase to Cover. Amid Rising Rates and Changing Coverage, It's Time to Cast Your Ballot for the Right Health Care Plan. *The Washington Post*. November 7, 2000; Z12.

⁶² Ibid; B. Carey, C. Ornstein and R.A. Rosenblatt. Open Enrollment; Open Questions; Selecting the Right Health Plan is no Simple Task. Complicating things further are big price increases, instability among plans and a delay in legislative action on managed care reforms. *Los Angeles Times*. November 24, 2001; S1.

⁶³ B.C. Strunk, K.J. Devers, and R.E. Hurley. Health Plan-Provider Showdowns on the Rise. *Center for Studying Health System Change Issue Brief* 2001; 1-4.

⁶⁴ *Health Care Financing & Organization News & Progress* December 2000; The Power of Physician Payment: Designing Incentives in a New Era; 1-10.

negative and that it is unclear whether financial incentives have any effect on physician behavior. This conclusion is consistent with the views of the experts we interviewed.

In its 2000 Annual Report, CHSC's President, Paul Ginsburg, writes that the backlash against managed care and the increased emphasis on consumer empowerment through wider provider choice have created barriers to the growth of an integrated delivery insurance product and to efforts to improve care management through the use of quality improvement techniques or provider financial incentives. As Ginsburg notes:

Integrated delivery had offered the hope of accountability for the quality of care provided to an enrolled population. The movement away from integrated delivery systems and capitated payment of provider organizations – aspects of the retreat from managed care – is removing a potential platform for providers to improve quality. Integrated delivery systems were seen as improving quality through the use of evidence-based medicine applied to the needs of a defined population.⁶⁵

Moreover, without capitated payment systems, Ginsburg believes that providers are less likely to become involved in care management or quality improvement activities because the financial incentives to pursue them under the current payments systems are perverse. For instance, programs to reduce patients' length of stay actually result in a reduced bottom line for the hospital.

Conclusion

We found consistency across all types of literature on current trends in care and cost management in the private managed care health insurance market, the majority of which appear to be driven by cost management concerns. Employers, no longer willing or able to absorb the growing cost of health care insurance, are increasingly shifting costs onto the consumer in the form of higher copayments, deductibles and premiums; reduction of retiree benefits; and three-tiered pharmaceutical payment plans. At the same time, the literature indicates that the use of many other more traditional care management techniques, such as utilization review, gatekeeping, pre-authorization, and provider financial incentives is diminishing. Under development, however, are data bases and research intended to help explore the efficacy of such care management and cost management strategies as disease management, medical case management and value-based purchasing by "activist" employer/purchasers.

⁶⁵ P.B. Ginsburg (2001). *President's Essay: Danger Signs Ahead* (HSC Annual Report 2001). Washington, DC; Center for Studying Health System Change; page 6.

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