

combine a high-deductible insurance plan with a tax-sheltered health savings account. By 2006, some 4 percent of insured workers were covered by such arrangements.

In the past year, the Commission has reached settlement with five groups of physicians for allegedly colluding to raise consumers' costs. . . . The alleged conduct I have described is naked price fixing, plain and simple.

—Timothy J. Muris, Chairman, Federal Trade Commission, Chicago,
November 7, 2002

The 1980s through the mid-2000s has been a roller coaster of successes and failures for managed care and private health insurance more generally. Much of this can be summarized by examining the trends in health insurance premiums over the period. Figure 1-2 tells the story. In the late 1980s, premiums for employer-sponsored health insurance were increasing at 18 percent per year, much faster than general inflation. The rates of increase declined precipitously over the first half of the 1990s. So much so that, by 1996, premium increases were virtually nonexistent and well below inflation. In real terms, health insurance premiums had declined! Premiums began to increase again in the latter half of the 1990s, peaked in 2003, but were still increasing at about 7.7 percent in 2006, more than twice the rate of inflation.

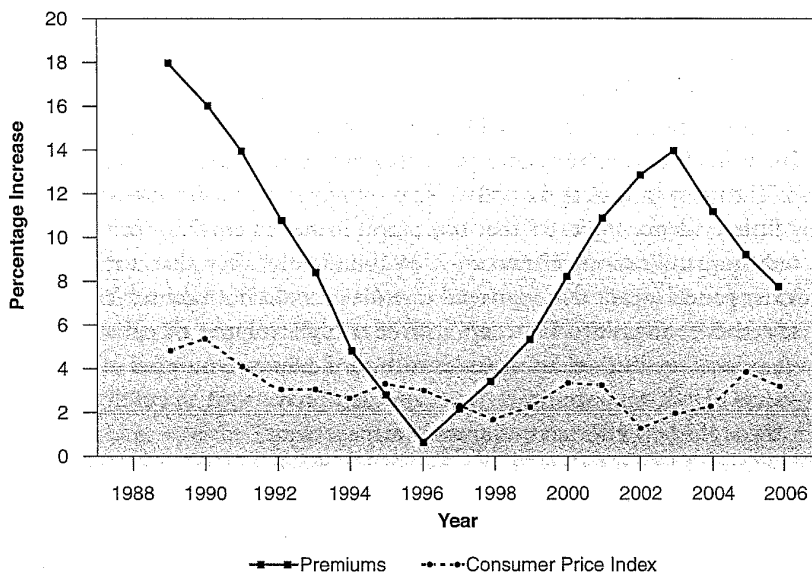


FIGURE 1-2
Percentage Increase in Health Insurance Premiums

SOURCE: Data from Jensen et al. (1997), Gabel et al. (2005), and Fronstin (2006).

What happened? As we will discuss in considerable depth later in the book, the first half of the 1990s can be characterized as the success of selective contracting by managed care plans. By entering into contracts with only some providers in a local market, the plans were able to negotiate lower prices. When there were more hospitals, for example, HMOs and PPOs were able to get lower prices. Two things happened subsequently, and their relative importance has yet to be fully identified.

First, providers began to consolidate. A handful of hospitals closed; many more joined hospital systems. Physicians joined somewhat larger medical groups but also entered into joint marketing arrangements. These actions arguably had the effect of reducing competition in local provider markets and reducing the ability of managed care plans to negotiate lower prices. Indeed, the federal government has obtained court decisions breaking up some physician marketing arrangements and has continued to challenge hospital mergers. In 2004 the Federal Trade Commission and the Department of Justice jointly issued a report *Improving Healthcare: A Dose of Competition*.

Second, there was a backlash against managed care plans precipitated by providers and consumers. In addition to selective contracting, managed care plans have used a variety of utilization management techniques to try to control utilization. These include preadmission certification and concurrent review of hospital admissions, and “gatekeeper” primary care providers who limit access to specialists. Managed care plans were also accused of preventing physicians from discussing more costly treatment alternatives and forcing new mothers and other patients to leave the hospital before it was medically prudent.

The upshot of this was that consumers wanted access to a greater choice of providers as a way of assuring themselves of better care, if needed. As a result, narrow-panel HMOs expanded to allow greater choice, and PPOs, with their much broader provider panels, became the preferred plan type. The irony in this, as we will see in a subsequent chapter, is that remarkably little evidence indicates that utilization management has been effective in reducing utilization. However, it is abundantly clear that the broader provider panels meant that managed care plans could not take full advantage of selective contracting. We cannot trade a high volume of patients for a lower price if we can’t channel patients toward a limited number of selected providers. Thus, managed care plans appear to have shot themselves in the foot through their efforts at utilization management.

Currently, attention in the health insurance industry is focused on consumer-driven health plans (CDHPs). These plans combine a high-deductible health insurance product with a tax-sheltered health savings account (HSA). The intent is to encourage individual healthcare consumers to become more prudent purchasers of healthcare by making them see a bigger share of the cost of routine health services. As we saw in Table 1-1, 4 percent of insured workers were in such plans in 2006.

The future will likely see the emergence of “new managed care.” New managed care will look a lot like old managed care except that utilization management will be gone. Utilization management often did not work, and it alienated consumers. Instead, new managed care will return to its roots of aggressive selective contracting. Some merger of the CDHP concept and new managed care is also expected because managed care plans are in a better position to negotiate lower provider prices than are individual consumers. But more on all of this after we discuss the current state of the industry and understand the demand for insurance and the challenges insurers face.

Chapter Summary

- Private health insurance in the United States began as efforts by hospital and physician providers to deal with the revenue consequences of the Great Depression.
- The forerunners of managed care plans emerged at the same time as conventional insurance but were subject to serious challenge by physicians, who were concerned about the potential loss of income from the inability to price-discriminate among patients with different demands for care.
- The growth of health insurance over the middle of the 20th century was spurred primarily by the tax-exempt status of employer-sponsored health insurance. Wage and price controls during World War II, the rise of labor unions, and the declaration of health insurance as a proper focus of collective bargaining were other key factors.
- Commercial insurers were successful in the insurance market because they introduced experience rating, which allowed them to offer lower-priced coverage to groups with lower expected claims experience. The rest of the industry followed suit.
- The enactment of Medicare in 1965 expanded insurance coverage to older Americans. The current Medicare program reflects the nature of private health insurance in the 1960s. The allowable cost reimbursement system, largely borrowed from the provider-designed Blue Cross and Blue Shield plans, entrenched cost-based reimbursement for 20 years.
- The passage of the Employee Retirement Income Security Act (ERISA) in 1974 led to the growth of self-insured employer health plans and all but assured competition in the risk-bearing segment of the conventional insurance market.
- The growth of managed care in the 1980s and 1990s was the result of the introduction of selective contracting as a response to growing healthcare costs. Selective contracting introduced price competition into healthcare markets.

- The 1990s and 2000s saw consolidation among healthcare providers and a backlash against the utilization management of managed care plans. Both actions undercut the ability of managed care plans to selectively contract.
- Consumer-driven health plans offering a high-deductible insurance plan and a tax-sheltered health spending account were emerging in the mid-2000s.

Discussion Questions

1. How might the history of U.S. healthcare been different if single-hospital plans rather than all-hospital plans had been the model Blue Cross adopted?
2. In what ways did insurance undercut physician income opportunities? Overall, how has health insurance affected the demand for physician and hospital services?
3. How might tax policy toward employer-sponsored health insurance affect the extent of coverage employers offer?
4. What features of a PPO have contributed to its rise as the predominant form of managed care for insured workers?