The Metamorphosis of Managed Care: Implications for Health Reform Internationally

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Many writers suggest that managed care had a brief life and that we are now in a post-managed care era. Yet managed care has had a long history and continues to thrive. Writers also often assume that managed care is a fixed entity, or focus on its tools, rather than the context in which it operates and the functions it performs. They overlook that managed care has evolved and neglect to examine the role that it plays in the health system.[1]

This article argues that private actors and the state have used managed care tools to promote diverse goals. These include the following: increasing access to medical care; restricting physician entrepreneurialism; challenging professional control over the medical economy; curbing medical spending; managing medical practice and markets; furthering the growth of medical markets and private insurance; promoting for-profit medical facilities and insurers; earning bounties for reducing medical expenditures; and reducing governmental responsibility for, and oversight of, medical care. Struggles over these competing goals spurred the metamorphosis of managed care internationally.

To help illustrate these conflicts and changes in managed care, this article explores two related themes. First, it examines how managed care transformed physicians' conflicts of interests and responses to them. Second, it examines how managed care altered the opportunities for patients/ medical consumers to use exit and voice to spur change. Patient and consumer voice, I contend, is a neglected means to help manage medical care, organizations and public policy.

The growth of managed care was in part a response to conflicts of interest arising from physician entrepreneurship, payment incentives, and professional control over the medical market. Medical consumers used early forms of managed care, called prepaid group practice (PPGP), as an alternative to physician entrepreneurial practice, which had raised the cost of medical services and impeded the growth of insurance. Later, policymakers and payers used health maintenance organizations (HMOs) to end incentives that created physicians' conflicts of interest or to oversee physician choices that were compromised by their conflicts of interest. They had some success, but as HMOs and other forms of managed care evolved, they created new conflicts of interest.

Dissatisfied individuals, Albert Hirschman writes, have two main means to effect change. They can *exit*, namely purchase from alternative suppliers or leave an organization. Alternatively, they can use their *voice*, that is, complain, protest, or engage in political activity.[2] Prior to managed care, individuals could employ exit by switching providers freely, an option that rewarded physicians who catered to their patients. However, most patients had limited options. They could only choose from self-employed physicians in an uncoordinated medical system, what Charles Weller calls "guild free-choice."[3] Individuals had less ability to effect change through voice, by complaining or participating in governance. The growth of managed care limited the ability of patients to exit, but did not correspondingly increase opportunities to exercise voice within MCOs. However, voice exercised through the political process led to increased governmental oversight of MCOs and accelerated their transformation.

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Managed care's trajectory is briefly summarized. From 1930 to 1966, PPGPs were used to increase access to medical care and as an alternative to entrepreneurial private practice, but constituted a minor part of the medical economy. The enactment of Medicare and Medicaid in 1965 and the rise in health care spending led policymakers to seek ways to control costs. By 1973, policy leaders turned to PPGP, renamed HMOs, in order to control spending.

After 1975, policymakers promoted markets, investor-owned medical firms, and commercialization. HMO enrollment, then overwhelmingly in not-for-profit entities, shifted into for-profit firms. Managed care was transformed from a reform movement into a market-driven industry. Since 1980, HMO ownership consolidated, and managed care and indemnity insurance each became more like the other. In place of having distinct models of medical finance and organization, a continuum of arrangements emerged — referred to as managed care organizations (MCOs) — that differed from each other in degree. Within the framework of managed care, variations in finance and organization proliferated.

Some economists urged the development of an economy based on *managed competition*, i.e., regulated MCOs competing over price and quality, rather than by selecting low risk patients or offering different benefits. This idea influenced the health reforms spearheaded by President Bill Clinton in 1993, but his proposal and managed competition were never adopted. Instead, MCOs became bounty hunters who reaped profits by cutting spending, in part by reducing medical services and provider payment.

These changes precipitated a political backlash by consumers and providers, and led to legislation which regulated MCOs, in short, public management. Many writers viewed these changes as the end of managed care. Actually, it stimulated transformations already underway. As part of this change, MCOs that preclude exit were replaced by MCOs that allow patients to use providers outside the network when they make additional co-payments.

Subsequently, President George W. Bush proposed the use of MCOs to change Medicare from a program that offered defined benefits into one that offered a defined financial contribution that each beneficiary could use toward the purchase of medical benefits through an MCO. That would have relieved the federal government for responsibility for ensuring that patients received needed services and for the cost of medical care; it would have granted private firms greater control over medical policy and sifted financial liability to each Medicare beneficiary.

Managed care became an export. Some nations with national health insurance (NHI) used it to oversee providers, others to privatize public sector medical facilities.

I. Medicine's Political Economy, 1930-1973

1930-1966: Increasing Access, Changing Incentives, and Creating New Organizations

Traditional private practice was rife with financial conflicts of interest.[4] Self-employed practitioners were entrepreneurs who bore the risk of financial loss and reaped profits from their medical practice. In addition, fee-for-service payment encouraged physicians to increase medical services they supply. Physicians' interest in selling services compromises their independent judgment in assessing patients' needs, prescribing therapy, and overseeing patient care.[5] Physician's entrepreneurial opportunities were restricted prior to insurance, however, because many people lacked means to pay physicians.

Although patients could choose their physicians and hospitals, they lacked information to make informed choices. Professional ethics restricted advertising prices or other matters and hardly any evaluations of physicians and hospitals were public. Furthermore, from the 1930s until 1960, a doctor shortage reduced patient choice. In addition, switching physicians often requires severing a long-standing relationship. Patients with a chronic illness are often reluctant to switch providers because they want someone familiar with their history.[6] Thus, many patients endured problems and reserved exit as a last resort.

Patients had even more difficulty exercising effective voice. Physician Jay Katz described the patient-physician relationship as a *silent world*.[7] Physicians were paternalistic and did not elicit patients' views or participation in decisions. Medical and social norms encouraged patients to play a passive sick role, depend on doctors, and not raise questions.[8] Nor did patients have opportunities for voice on medical matters outside of the patient-doctor relationship. Patients did not view themselves as consumers or perceive themselves as having common quality problems stemming from the way medicine was organized.[9] Thus, patients rarely formed organized groups to assert their interests. They lacked institutions to amplify their individual voices.

The organization of medical care also impeded consumers from expressing their voice. There was no single entity responsible for coordinating or overseeing health care to which consumers could complain. Patients received medical care through a decentralized and fragmented delivery system. Patients could complain of egregious conduct to state licensing boards, but

these boards had limited powers and usually focused their discipline on doctors who had been convicted of criminal offenses or were impaired by alcohol or drug use.[10] Courts provided a forum for patients injured by medical malpractice, but this was a very limited and costly form of consumer voice.[11]

Managed care emerged at the early 20th century when the United States lacked private and public health insurance.[12] Commercial insurers maintained that medical risk could not be insured. They could not accurately price insurance based on population-wide statistics, they said, because individuals who needed medical care were more likely to purchase insurance than average, a phenomena they called *adverse selection*.[13] Furthermore, insurers said that being insured created a *moral hazard*. It induced individuals to increase their use of medical services because they do not bear the cost, and because physicians can prescribe services to boost their income without budget constraints. Proposals for public insurance also faced obstacles. The organized medical profession opposed NHI — fearing that the state would control physician payment and medical practice. It opposed many private insurance arrangements and lay-directed medical practice that employed physicians for the same reason.[14]

As a result of organized medicine's opposition, it often required a combination of concerted consumer voice and exit to spur the formation of PPGPs.

The absence of commercial and public medical insurance set the stage for the emergence of two forms of voluntary not-for-profit insurance in the 1930s. The model that became dominant — Blue Cross hospital and Blue Shield physician insurance (referred to as the Blues) — supplied medical benefits through independent hospitals and self-employed physicians. The Blues did not exclude any individual from purchasing insurance based on their medical condition or risk, a practice they called *open enrollment*. Everyone paid the same premium, a policy they called *community rating*. Initially, Blue Cross supplied medical services, but soon it reimbursed patients for about 80 percent of their medical expenses. In effect, the Blues became indemnity insurers.

The Blues constituted a reform movement backed by laymen.[15] Communities formed not-for-profit organizations to finance medical services because commercial firms and the state did not. Consumer voice resonated, however, because hospitals helped create the Blues to supply stable financing and because the Blues accommodated organized medicine's interests.[16] They included virtually all providers, let them decide what services to supply, and allowed providers to bill patients the difference between their charges and the amount they reimbursed. The Blues did not challenge organized medicine's authority over practice and deferred to it on issues of economics and policy. Although they expanded access to medical care, by neglecting oversight, the Blues spurred conflicts of interest from physician entrepreneurship and fee-for-service payment. However, physicians could boost their income by recommending and supplying services because the Blues did not manage physician incentives, their practice, or medical quality and spending.

The second insurance model — PPGPs — represented a more radical development. By combining insurance with the delivery of medical services, financing became a tool to oversee medical practice, physician incentives, and the cost of medical services. PPGPs allowed laity and not-for-profit entities to oversee medical practice, creating an alternative model for medicine, and this challenged the dominance of self-employed physician-entrepreneurs.[17]

Most PPGPs were not-for-profit organizations with a public service mission. They often owned and operated medical facilities. They supplied services through a limited network of providers, rather than reimburse patients for their expenses. Most PPGPs ended entrepreneurship and fee-for-service payment conflicts by employing physicians and paying them a salary or by contracting with selected self-employed physicians and paying them by *capitation*, i.e., a fee for each patient under their care.

Organized medicine (i.e., the American Medical Association's [AMA] national and local chapters) considered PPGP a threat. It stymied their growth by charging PPGP physicians with unethical conduct and revoking their membership.[18] Professional ethical codes restricted both *contract practice* (organizations that employed physicians to treat their workers or members) and the *corporate practice of medicine* (organizations that employed physicians to market medical services to the public).[19] Without medical society membership, physicians usually could not obtain referrals from other physicians, hospital privileges, or malpractice insurance, even though they were licensed to practice. Later, following the AMA, many state courts interpreted licensing statutes as prohibiting the corporate practice of medicine.

As a result of organized medicine's opposition, it often required a combination of concerted consumer voice and exit to spur the formation of PPGPs. As part of the reforms during the presidency of Franklin Roosevelt, the Farm Security Administration assisted many agricultural cooperatives to form PPGPs. The Group Health Cooperative of Puget Sound and Group Health Association in Washington, D.C., also arose when consumers combined political action and marketplace choices and formed a cooperative. In regions where PPGPs were successful, medical societies responded by creating physician-directed insurance networks in which physicians remained self-employed and were paid either fee-for-service or by capitation. These entities, called Foundation Medical Plans, served as the model for Independent Practice Associations in the 1970s.

Some reformers supported PPGPs, but others believed they diverted attention from what was needed: NHI. PPGPs did not require the federal or state government to finance or organize medical care. PPGPs (and the Blues) followed the American tradition of volunteerism and self-help rather than the European tradition of social solidarity, which called upon the state to finance or supply social services. The growth of private medical insurance contrasted with the development of publicly funded social insurance under the 1935 social security statute, which included income support for retirement or permanent disability, some income for minor dependents in the event of the workers' untimely death, as well as some income maintenance for the poor. Private insurance represented a move away from having the government create an entitlement to medical care or manage the medical economy

1955-1966: Medical Access without Management

After the Blues grew nationally, commercial insurers concluded that they could underwrite medical insurance. They competed with the Blues by pricing premiums based on the risk of each individual or group of employees that they insured. They sold policies to those with low risks for less than the Blues (which charged everyone the same) and excluded high-risk individuals in contrast to the Blues, which insured anyone. Critics called such risk selection *cream skimming*. The Blues were left with higher risk groups and forced to raise premiums, causing a further exodus of low risk groups who sought lower premiums. By 1951, commercial insurers' market share surpassed that of the Blues.[20]

The growth of private insurance dampened consumer agitation for NHI. However, some opponents of NHI acknowledged that private insurance could not cover the elderly and poor. The elderly were likely to need medical services, so commercial insurers either did not sell them policies or charged prohibitive premiums. Often retired, seniors had less income, could not purchase insurance through an employer group, and lacked employer subsidies. The poor, by definition, lacked means to buy insurance. Some advocates of private insurance grudgingly supported the creation of two limited public insurance programs: Medicare for seniors; and Medicaid for groups historically considered the *deserving poor*: the blind, disabled, infants and mothers.[21] The AMA's lobbying stopped reform legislation in the late 1950s and early 1960s. But after Lyndon Johnson's 1964 landslide election with a strong Democratic Congressional majority, in 1965 Congress enacted Medicare and Medicaid.[22]

In designing Medicare to garner physician support, legislators preserved their conflicts of interest. The statute's preamble stated, "Nothing in this title shall be construed...to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided...." Physicians who chose to participate in the program set their fees. Medicare capped payment at levels no higher than those matching the 75th percentile of fees charged by physicians in their region. However, since all physicians could and did raise their fees, the 75th percentile cap only slowed fee increases. Furthermore, physicians could bill patients the difference between their fee and the amount Medicare reimbursed as they did with the Blues and commercial insurance. Medicaid allowed states to set provider fees, but preserved fee-for-service payment, which often fueled overused of services. These two programs turned federal and state governments into the largest medical payers, together accounting for nearly 40 percent of national medical spending. By supplying funds with few constraints and little oversight, they fueled medical spending, which increased from 5 percent of the gross domestic product in 1960 to 8.8 percent in 1970 and to 12 percent in 1980.[23]

1966-1973: Cost-Containment, Competition, and Substitute for Regulation

Most insurance did not control fees, the volume of services, or conflicts of interest which tempted physicians to make clinical choices that boost their income. Medical spending exploded. In response, states began to regulate hospital spending by setting per-diem rates. In 1972, federal legislation promoted the trend and by 1980, 30 states set hospital charges.[24] Hoping to restrict unnecessary use of resources, starting in 1964, states also required hospitals and nursing homes to obtain a state-issued certificate-of-need before new

construction, expansion of existing facilities, or purchase of capital-intensive imaging equipment. In 1965, Congress passed the Comprehensive Health Planning Act which funded state planning agencies to develop such regulation. By 1973, 20 states had certificate-of-need regulation and Medicare did not reimburse capital costs of hospitals lacking certificates of need.[25] In 1974, the National Health Planning and Resources Development Act instituted health planning overseen by federal health system agencies.[26] These forms of regulation managed spending by controlling the supply of hospital beds and capital investments and the rates hospitals charged for their services, rather than changing physician incentives or overseeing their clinical choices.

Soon after Richard Nixon became president in January 1969, he declared there was a health cost crisis.[27] He reluctantly froze Medicare fees while he searched for other ways to control spending and soon decided to promote PPGPs under the name, HMOs.[28] HMOs had incentives to reduce spending. They were paid fixed premiums for each person without additional revenue if their costs rose or they increased the medical services they supplied. HMOs also had tools to control spending. They oversaw medical practice, determined physician payment, and could influence decisions about medical choices. The Nixon administration created subsidies to start HMOs, facilitated their use in Medicare and Medicaid, and sponsored legislation to promote HMOs, enacted in 1973.[29] Federal HMO policy was an alternative to controlling spending by regulating hospital fees and expansion of hospital beds and capital intensive equipment.

Yet the HMO Act reflected competing aims. Senator Edward Kennedy (D-MA) wanted HMOs to set the ground for NHI, and so the legislation required HMOs to offer comprehensive benefits and use open enrollment and community rating. As a result, HMOs did not cost much less than traditional insurance. The Nixon administration fought to ensure that the statute permitted for-profit HMOs and the Independent Practice Association (IPA) HMOs — the renamed Foundation Medical Plans — which allowed physicians to remain self-employed entrepreneurs.

Most staff- and group-model HMOs, like most PPGPs, were not-for-profits with a public service mission that ended entrepreneurship and fee-for-service payment conflicts by employing physicians. However, they restricted exit by limiting patients to limited provider networks.[30] The poor had even fewer options as state Medicaid programs often required they enroll in an HMO.[31] In contrast, IPA-HMOs allowed physicians to remain self-employed practitioners and continue entrepreneurial practice. Nevertheless, they often mitigated conflicts of interest by compensating physicians using capitation instead of fee-for-service payment, and through utilization review and physician gatekeepers, which controlled the services supplied.

In 1970 there were 3 million HMO enrollees, and by 1976, only 6 million in federally qualified HMOs. Then, Congress dropped the requirement that HMOs have open enrollment and community rating and reduced requirements for services they must cover. Still, by 1980, there were only 9.1 million enrollees. But by 1990, HMOs covered 33.6 million individuals and by 2000 over 80 million.

Later, however, HMOs were transformed. For-profit firms became dominant. HMOs increased their use of risk-sharing, so that physicians' income decreased unless they limited the use of medical resources.[32] They replaced incentives to increase services with incentives to reduce them. Rather than eliminate physicians' conflicts of interest, this change introduced new ones.

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Medicine's Political Economy, 1973-2010

The Growth of Markets and For-Profit HMOs

Legal changes promoted medical commerce. A 1975 lawsuit challenged bar association ethics rules that prohibited lawyers' advertising. In deciding the case, the Supreme Court ended the professional exemption from antitrust law and prevented professional associations from disciplining members for engaging in competitive activities.[35] Soon thereafter, the Federal Trade Commission (FTC) sued the AMA for using its ethical code to restrict advertising and other commercial practices. By 1979, an appellate court upheld the FTC's decision that enjoined the AMA from restricting competition and required it to remove ethical code restrictions that had that effect.[36]

Then, market proponents clamored for deregulation. They explained that reimbursing hospital costs plus a percentage mark-up encouraged spending because hospitals earned more as their costs increased. They noted that HMOs could not develop lower cost provider networks if states required insurers to pay all hospitals the same rate.

Ronald Reagan ran for president in 1980, promising to limit regulation. His administration ended federal health planning and many states then repealed their own certificate-of-need laws. States ended rate regulation; today only Maryland regulates hospital charges.[37] When states stopped setting hospital rates, HMOs negotiated discounts in return for steering patients to the hospital. Under Reagan, Medicare stopped reimbursing hospitals for their costs and paid a set fee for each patient they treated, determined mainly by the patient's principal diagnosis. Hospitals that used resources frugally earned a surplus and those that did not bore most of the financial loss. These changes squeezed hospitals.[38] Many not-for-profit hospitals reduced their charity care and unprofitable services, and some not-for-profit hospitals converted into for-profit firms.

The Reagan administration ended federal subsidies for not-for-profit HMOs, promoted HMOs for private investors, and spurred their growth in Medicare.[39] Tax policy had already squeezed not-for-profit HMOs. In 1974, the Internal Revenue Service (IRS) held that, to be tax-exempt, HMOs needed to supply community benefits, not just serve their enrollees. In 1978, a court reversed the policy,[40] but the IRS then challenged the tax-exempt status of IPAs on the grounds that they were primarily in business for their physician members. Collectively, these policies helped transform managed care from being largely not-for-profits to being mainly for-profits. In 1973 most HMOs were not-for profit, but by 1985 more than half were for-profit.[41] For-profit HMO enrollment grew from 12 percent in 1981 to over 63 percent by 2000.[42] Between the late 1970s and 1985, 46 not-for-profit HMOs became for-profit firms and another 60 converted by 1997.[43]

Changes Since 1980: Diversification, Consolidation, and Convergence

In 1981, Professor Hal Luft published *Health Maintenance Organizations: Dimensions of Performance*, an authoritative study of HMOs.[44] Yet in 1986, he said we knew *less* about HMOs then than ten years previously because they diversified, which made it difficult to generalize about their organization, function, or performance.[45]

Initially, staff-model HMOs — which employed a closed network of employed physicians and group-model HMOs — which had exclusive contracts with two or more physician groups — dominated the market. IPA-HMOs contracted with intermediaries (IPAs or group practices), which in turn contracted with physicians, and had the smallest market share. But IPA-HMOs grew rapidly and soon had the largest enrollment.[46] Because IPA-HMOs contracted with intermediary groups or self-employed physicians, they offered a wide choice of providers, which consumers favored. They expanded without incurring fixed-employment costs and varied networks based on regional differences and market changes.

HMOs, particularly IPA-HMOs, spawned many different arrangements for financing, payment, and contracting.[47] Often a single HMO negotiated different payment terms with each physician group. HMOs also adopted diverse practice guidelines, criteria to determine what medical care they deemed unnecessary, utilization review protocols, and methods to evaluate quality and oversee practice.[48] By 1997, 75 major organizations had over 1,800 practice guidelines.[49] Individual firms developed thousands of others.[50] Sometimes they maintained that their guidelines were proprietary and did not disclose the details.[51]

At the same time, health plans increasingly varied their coverage. The Employee Retirement Income Security Act (ERISA) allowed employers that offer benefits through self-funded plans to ignore state insurance laws which mandate minimum coverage. ERISA plans can offer as few benefits as they wish. HMOs organized physician networks and administered benefits for ERISA plans. By the 1990s, over half of American employees received health benefits through ERISA plans.

Despite diversification, there were some notable trends. HMO ownership consolidated.[52] In 1983, organizations that owned more than one HMO controlled 25 percent of HMOs. By 1986, 62 percent of HMOs and 73 percent of all enrollees were in national organizations.[53] Today very few insurers dominate each regional market, and this restricts the opportunity of individuals to exit.[54]

When a few oligopolies dominate a market, they become complacent about losing market share and less responsive to consumer exit.[55] In fact, HMOs may prefer to lose patients with high-cost illnesses because it will increase their profit. In that case, dissatisfied patients may find equally unresponsive competitors when they exit. Switching physicians within a plan may not produce new clinical choices because HMOs influence the medical practice of all physicians through financial incentives and rules.

In addition, the differences between HMOs and indemnity insurance diminished. Indemnity insur-

ers increased their use of utilization review, making them more like HMOs. Some insurers offered a blend between HMOs and indemnity insurance: the Preferred Provider Organization (PPO). PPOs combine limited provider networks with open network indemnity insurance. Patients pay small co-payments when they receive services from preferred providers; they pay high co-payments when they consult other providers. Insurers also offered point of service plans (POS) similar to PPOs. Insurers began to offer multiple plans often including a closed network HMO, IPA-HMO, PPOs, and a POS plan.[56] These changes chipped away at restrictions on choice of providers. Still, patients paid more when consulting providers outside the preferred network. And although patients had access to more physicians, they were all subject to MCO practice guidelines and utilization review.

As distinct models gave way to a continuum of financial and organizational arrangements, analysts referred to them collectively as managed care or MCOs. Nearly all insurance became a type of managed care. Writers created new terms to distinguish between various kinds of managed care, generating what Jonathan Weiner and Gregory de Lissovoy called a *tower of Babel*.[57] Yet as Jacob Hacker and Theodore Marmor note, these taxonomies did not reveal the key differences in the degree of risk-sharing between providers and the primary insurer, the extent of administrative oversight on physicians' clinical choices, and the restrictions on patients' choice of providers.[58]

Managed Competition

Economist Alain Enthoven saw a role for *both* markets and public management. He advocated for what he first called *consumer choice health plans* and later renamed *managed competition*.[59] Enthoven favored MCOs because they had tools to control spending and quality that indemnity insurers lacked. However, he did not want MCOs to compete by selecting risk, namely excluding or charging higher premiums to high-risk individuals. Nor did he want MCOs to compete by product differentiation, i.e., creating nonstandard benefit packages, because then consumers could not easily compare plan coverage and cost.

Enthoven proposed that federal law specify standard benefit packages so that individuals could readily compare MCO coverage and premiums. He wanted the law to require consumers to pay part of the premium, rather than have it funded entirely by their employer or public financing, so that individuals would have an incentive to choose a frugal benefit package. He argued the law should mandate community rating so that MCOs competed on price and quality, not by risk selection.

These ideas influenced president Bill Clinton's 1993 proposed reforms, which envisioned most people purchasing private insurance from competing managed care plans, overseen by public authorities.[60] Clinton, however, also proposed a national cap on spending, guaranteed universal coverage, and subsidies for low-income individuals and firms. Private insurers opposed the Clinton proposal, fearing loss of income and increased regulation. The political right objected to a larger government role in funding medical care and overseeing private insurers, benefits offered, and spending. The political left objected to reliance on private insurers and markets. Many insured individuals feared the plan would disrupt their current arrangements, raise their premiums or taxes, or limit their choices. Ultimately, Congress did not enact the Clinton reforms.[61] After its demise, MCOs grew, but competed by risk selection, marketing, and differentiating their benefits, rather than in the manner that Enthoven had wanted.

1994-2010: Bounty Hunting, Backlash, Public Management, and Rebranding

Society paid MCOs to find ways to reduce spending. For-profit firms became very adept at this task. They earned profits by reducing provider payment, eliminating unnecessary services, and, perversely, by reducing beneficial services as well. Economist Uwe Reinhardt described them as *bounty hunters*.[62] MCOs employed explicit forms of rationing that limited choices of physicians and patients and undermined patient and provider trust.[63] Some evidence shows that patients even received poorer quality of care in for-profit than not-for-profit HMOs.[64] MCO restrictions irked the public and providers. The press reported on MCOs' denial of necessary services and their high profits.

The limitations of exit as a means of change are illustrated by the political backlash against managed care in the 1990s.[65] Market theory suggests that at least some MCOs would respond to public dissatisfaction by revising their policies to increase their market share. This did not occur. It required voice through the political process to address the public's concerns.[66] Consumer groups formed alliances with providers to support state and federal regulation of managed care. Between 1995 and 2001, 47 states passed legislation that regulated managed care, referred to as the *Patients' Bills of Rights* or *Patient Protection laws*. Such legislation represents public management of managed care. Legislation can set general rules, but this is not the only way to hold organizations accountable to those they serve. Some early PPGP's were consumer cooperatives and members had voice in their governance and operations. However, there are hardly

any consumer-directed MCOs today.[67] The limitations of exit suggest that policy should promote voice within MCOs.

Patient protection laws vary among states, but include common provisions. They set certain standards: rules for the adequacy of provider networks; minimum covered length of hospital stay for birthing, mastectomy, and some other services; and required disclosure of physician incentives and other information.[68] A key provision in these statutes is so-called *independent medical review* or *external review*. When an MCO claims that a service is unnecessary or experimental and denies coverage, individuals can appeal to an independent review organization (IRO) that hires a physician to evaluate the case. If the IRO decides in favor of the patient, then the MCOs must supply the service.[69]

Consumer voice spurred enactment of patient protection laws, but ironically, they restricted the ability of consumer voice to produce system-wide change. Independent medical review allows patients to complain that their HMO inappropriately denied them medical services. However, each appeal is treated as an independent patient care problem, rather than an organizational or public policy issue, and each appeal is decided by different reviewers.

Consumer voice spurred enactment of patient protection laws, but ironically, they restricted the ability of consumer voice to produce system-wide change. Independent medical review allows patients to complain that their HMO inappropriately denied them medical services. However, each appeal is treated as an independent patient care problem, rather than an organizational or public policy issue, and each appeal is decided by different reviewers. When reviewers overturn an MCO denial, they do not bind the MCO to treat the clinical issue in other patients or other patient appeals similarly. Nor do independent reviewer decisions affect other MCOs. Indeed, in all but one state, the clinical issues involved and basis for decision are not made public. Patients with similar problems, other HMOs, and regulators cannot see what choices the HMO made or reviewer's assessment of whether it was correct.[70]

By limiting the effect of appeals to individuals alone, independent review reduces the effect of consumer voice. It silences those who complain by giving them what they want, but maintains the status quo for others. It prevents patient voice from yielding collective benefits and so creates an obstacle to change. Patients and the public will therefore have to resort to other means to promote changes in managed care.

Reflecting on the backlash and ensuing changes, economist James Robinson proclaimed "the end of managed care." Peter Jacobson and other legal scholars inquired "who killed managed care?" Mark Hall performed a "regulatory autopsy."[71] However, the obituaries were premature. Rather than die, managed care morphed. MCOs changed how it used its tools, but did not jettison them.

MCOs broadened provider networks, reduced physician risk-sharing, introduced new incentives under the rubric of *pay-for-performance*, relaxed gatekeeping, and focused utilization review on high cost items.[72] They also increased their oversight of drugs. Pharmaceutical benefit managers restricted formularies, oversaw prescribing through utilization review, negotiated discounts with wholesalers, dispensed drugs through mail rather than independent pharmacies or physicians, and managed patient choices through co-payments. Similarly, they used limited networks for behavioral health, and regulated their fees, and services.

A sober assessment also reveals that in Medicaid, there was little reduction in the use of managed care or relaxing of its constraints on choice of providers, or utilization review. Over 69 percent of Medicaid recipients were in MCOs in the beginning of 2009.[73] Furthermore, president George W. Bush promoted the use of IPA-MCOs, and PPOs within Medicare with subsidies of several billion dollars. Some beneficiaries opted to receive benefits through MCOs to reduce their copayments or to receive supplemental benefits. In 2008 nearly a quarter of Medicare beneficiaries enrolled in MCOs and 40 percent added drug benefits through stand-alone private managed care drug plans.[74]

The Bush administration also sought to use managed care to devolve the federal government of responsibility to supply medical services and its financial liability for the cost of medical care. It proposed changing Medicare from a program that offered specified medi-

cal services into a program that offered a fixed financial contribution that beneficiaries could use toward the purchase of medical benefits through an MCO. In place of guaranteed benefits it would have granted only limited financial support for premiums. That would have capped the federal government's financial responsibility and shifted financial risk to individual beneficiaries and MCOs. The plan would have ended significant federal regulation of hospital and physician payment and federal oversight of hospitals and medical care quality. Congress, however, did not enact the proposal.[75]

Managed care did end in one respect. MCOs learned they had a bad public image. In a typical business marketing response they employed public relations to *rebrand* their product. As part of this process they replaced the term *managed care* and *managed care organization* with the neutral sounding *health plan*. Yet managed care tools and organizational forms continued to emerge in new guises. In 2009, reformers called for the development of *accountable health organizations*, in which physicians and hospitals form groups and take financial and management responsibility for their patients. They would earn bonuses or incur penalties depending on the medical outcomes, measures of quality, and the cost of treating the population.[76]

Globalization

Other countries also search for ways to control costs, oversee medical care, counter the power of organized medicine, and reduce physicians' conflicts of interest. They too have struggles over how to shape the medical political economy and the role of the state and the private sector. Thus, it is not surprising that managed care became an American export and that countries adopted various aspects of its elements, including alternatives to fee-for-service payment, practice guidelines, utilization review, primary care physician gatekeepers, risk-sharing, or managed competition. In essence, managed care played different roles abroad depending on how it was used.[77]

The World Bank and International Monetary Fund have promoted neoliberal health reforms in Latin America, including the privatization of public services.[78] These reforms often include having social-security funds finance the private management or ownership of health facilities as a substitute for public ownership; the supply or management of services by investor-owned firms; or a contracted physician panel that assumes some financial risk for serving a designated population. Some reforms emphasize managed care, others private insurance, and still others having public authorities to contract with for-profit MCOs.[79] Chile, Colombia, and Brazil, for example, partly privatized management or delivery of publicly financed health services.[80]

As part of changes made in order to receive World Bank structural adjustment loans, Mexico initiated health reforms in 1995 and 2004, modeled on managed competition. "The objective of reform," notes professor Asa Laurell, former Mister of Health for Mexico City, "is that all public health institutions will separate funding and provision of services, assigning to fund manager(s) the essential role of contracting services with different providers…." rather than supplying services themselves.[81] Initially, the Mexican Social Security Institute health regions and specialty hospitals supplied the services, but the model allows contracting with private sector providers. Fund managers can pay organized providers by capitation or fee-for-service. The reforms also substituted the solidarity principle, in which contributions are based on ability to pay and services delivered based on need, with a principle that emphasizes equal contributions for equal services. Now employers and the state make a uniform contribution and employers make a small contribution proportional to their income.

Other governments, however, have used managed care to oversee medical care within their existing NHI system without promoting privatization. Around 2000, France, which has NHI, began state-led managed care.[82] It offered supplemental payments for physicians to become primary care physician gate-keepers who coordinate referrals and oversee patient care, and created incentives for patients to use them. Patients who consult specialists without their gatekeeper's referral pay higher co-payments. In addition, France created an agency to adopt authoritative practice guidelines with the aim of using these to guide and oversee physician practice.

France also reformed payment and billing. It scrapped the billing codes that physicians had insisted on since 1930, which used only 28 basic categories that did not specify what services patients received, and thereby precluded the use of effective utilization review. Now, physicians must indicate the precise service using codes corresponding to over 7,000 service categories. NHI assigns fees for each billing code using a resource-based relative value scale. In the future, physicians will also have to list the patient's diagnosis. The new system makes utilization review possible. France is also replacing global budgets for public hospitals, and per-diem and fee-for-service for private hospitals with prospective payment based on each patient's diagnoses for public and private hospitals. The new system will provide incentives for hos-

pitals to treat more patients but also economize the resources they use for each patient.

Japan is also adopting managed care tools in its NHI system.[83] In the past, Japan's insurers were not permitted to review billing claims electronically, even though they had the information. In 2005, the government initiated a plan to process all health insurance claims electronically by 2012. That will make possible computer-based utilization review. By October 2009, medical facilities were submitting 65 percent of claims electronically.[84]

Japan is also reforming payment to manage medical practice and physicians' incentives. Initially it shifted from fee-for-service payment to per-diems and bundled payment, and reduced incentives to prescribe drugs. In 2004, Japan begun to institute a prospective payment system based on the patient's diagnosis in acute care hospitals. Each hospital receives a per diem that declines with the length of stay. By 2009, 48 percent of hospital beds were reimbursed using the new payment system.

Since 2004, Japan has attempted to promote practice standards through voluntary hospital accreditation and physician certification. So far, there are no government or insurance sanctions for not being accredited, and accreditation does not affect reimbursement. To make use of market incentives, the government permits hospitals to advertise their accreditation. As of 2007, 30 percent of hospitals were accredited.[85] The government has created incentives for physicians to participate in continuing medical education (CME). In 2004, it began to certify CME and allow certified CME providers to issue certificates to graduates, who can advertise their credentials.

Concluding Observations

Managing is at the core of medical practice. Traditionally, it was physicians who managed symptoms, illness, and patients' response to them. To cope with medical problems, physicians directed and coordinated the use of drugs, resources, personnel, and even institutions. More recently, laymen, organizations, insurers, and public policy have also managed medical practice. The development of public financing and insurance were a means to promote the production of medical services, change its distribution, and facilitate access to medical care. As part of these societal changes, the growth of PPGPs, HMOs, and MCOs helped direct the production and allocation of medical services as well as the choices of physicians, patients, and medical facilities. Seen in this light, managed care transcends particular tools and organizations (such as MCOs) that emerged in the United States. We will always need to manage care, even if we do not do so through MCOs. When we discuss managed care, we should remember that public policy, institutional and organizational arrangements, and the decisions of clinicians jointly manage medical practice.

Using the term managed care without elaboration often obscures understanding. In part, this is because it is malleable. Managed care's organizational forms, financing, and tools evolved over a long period of time and continue to develop. It emerged early in the 20th century and metamorphosed in response to changes in public policy and medical markets, as well as being employed to change them. In addition, because the political economy of medicine has evolved, managed care has been used in different contexts and played different roles. Furthermore, diverse parties and nations have used managed care to advance conflicting goals. Consequently, it is insufficient to focus on managed care's organizational forms and tools. We need to examine what parties are managing, what ends they seek, and the political-economic context in which they work.

Many managed care tools were developed to promote physician accountability. But patients and the public cannot rely on lay managers or MCOs alone, since they, too, may fail to act in patients' interests. Managers — whether they are physicians, administrators, firms, or public officials — are agents who are delegated authority to serve others. There is always a risk that they will not do so adequately: they may be negligent or disloyal or their judgment may be compromised. Ensuring the accountability of managers is a key problem, particularly when they have conflicts of interest.

Here is where patient/consumer voice and exit can help: by managing from the bottom up. Patients/consumers can sometimes produce change by speaking out, or by walking out. These are limited tools and do not guarantee accountability to patients and consumers, particularly when they confront other groups that promote competing interests. As this history has shown, neither the use of exit nor voice alone, nor even their combination, assure the accountability of physicians and medical organizations. Nevertheless, as nations search for ways to better manage medical care and health policy, they should try to develop mechanisms that facilitate the use of consumer/patient voice and exit in ways to promote accountability. Patients and consumers should play an important role in managing medical care and policy.

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