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The demise of the debate over comprehensive health care reform in 1994 spawned several innovations in the organization and delivery of health care. Topping the list is the growth in managed care. In the midst of the debate over reform, 37 percent of the insured workforce was enrolled in managed care. Today, over 85 percent of the insured workforce receives health care through some form of "managed delivery" (Mercer 1998). Managed care in general, and health maintenance organizations (HMOs) in particular, arrived with much fanfare. A Robert Wood Johnson Foundation survey found that nearly 60 percent of respondents expressed the view that the trend toward managed care was a "good thing" and a similar percentage touted its ability to control health care costs (Knickman et al. 1996). Indeed, the prospects of aligning incentives for cost containment with incentives to invest in health were and remain compelling.

The early fanfare over the promise of managed care appears to have been replaced with catcalls. The positive reports of satisfaction with managed care expressed in 1994 and 1995 have been replaced with mounting criticism, cynicism, and broad calls for "reforming" managed care. What gives? Was managed care oversold? Are the purported problems with managed care contrived or real? What are the problems, how and why did they arise? Are the problems intractable or soluble? My remaining discussion focuses on these issues.

My sense of the series of issues grouped under the managed care "backlash" label has its genesis in several key changes in the structure of the delivery system, including:

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1. The rejection of managed competition as the preferred regime for controlling costs, with employers relying instead on bilateral negotiations with plans and restricted choice of plans for consumers
2. Largely excluding an increasingly sophisticated consumer, armed with reams of new data and studies delivered through the Internet from the process of medical decision making
3. The dominant role assumed by the for-profit sector in the growth of managed care
4. The changing role of the physician

The Ascendancy of a New Regime: Supply-Side Cost Controls

Whether managed competition would have assuaged the concerns I will outline below is debatable. Ironically, despite the promise that consumers would face greater choice of plans, the public largely feared that President Clinton's reform proposal would force them to join health plans against their will (Blendon, Brodie, and Benson 1995). This has not only apparently occurred in the absence of the Health Security Act, but it has done so without the luxury of consumers selecting from a menu of plans!

The demise of comprehensive health care reform squarely placed employers and other purchasers in charge of controlling health care spending. During the reform debate, managed competition was the cost control vehicle of choice, appearing in nearly every major proposal advanced during the 103rd Congress. Managed competition would have created several new institutions to be negotiator and broker with health plans and would allow consumers to select among several plans. Cost control in this world focused on the bidding and negotiation process, as well as on providing financial incentives for consumers to be cost conscious when selecting plans. Presumably, several variants of plan design would be offered to enrollees, fee-for-service, "diet" managed care (i.e., discounted fee-for-service) as well as more heavily managed plans. With managed competition, enhanced bargaining power ceded to the purchasing pools, combined with choice and structured financial incentives, represented the key tools for controlling costs. Even as the debate ended, many observers believed, or perhaps hoped, that employers would rely on this approach for controlling costs.

Of course, this is not how the private insurance system has evolved over the past five years. Rather than relying on competition among health plans and consumer choice to drive savings, large purchasers have

relied largely on bilateral negotiations with a single (or a few) plans to deliver the best price. Structuring financial incentives to allow employees to select their desired style of medical practice (at the appropriate cost) has remained largely on the conceptual drawing board. Of course, there are a few notable and important exceptions, including the Federal Employees Health Benefit (FEHB) program and the California Public Employees' Retirement Systems (CalPERS), among others.

Employer expectations concerning cost growth have been aggressive —no or low growth. By selecting a preferred vendor to achieve these objectives, employers have effectively shifted financial risk downstream to health plans. For-profit managed care, eager to attract market share and increase revenues, promised to meet these lofty expectations. In short, through restricting the choice of plans and guaranteeing volume, managed care has become the employer's vehicle of choice to deliver the expected savings. The transformation in how employers have structured health benefits has been dramatic. During 1994, well over half of all employers offered their workers more than one health plan. By 1996, approximately 50 percent offered only one plan, generally some form of managed care, often with a plan design allowing workers to receive care out of network (KPMG Peat Marwick 1996).

The Changing Role of the Consumer in How Costs Are Contained: Demand-Side versus Supply-Side Rationing

The results of this change has been impressive. The new plan design used by employers to structure benefits, relying on managed care to deliver the savings, is widely credited with a substantial reduction in the growth in spending. Private health spending has increased by only 1.6 percent per year since 1994, a remarkable slowdown (Mercer 1998). While employers, their benefits managers, and managed care plans congratulated themselves, many consumers were less impressed. Of particular concern were the new tools used by managed care plans to control costs. To many, the tools used by fee-for-service plans may appear more benign. Fee-for-service plans affect total expenditures on the demand side through the use of deductibles, coinsurance, and out-of-pocket caps. For better or worse, consumers largely make their own internal cost-benefit calculations regarding the decision to seek medical care. Within this system, however, consumers largely control the timing of when they seek care, when to see the specialist of their choice, and may choose their own

hospital. Of course, each of these decisions comes with a cost—the consumer sharing in the financial aspects of care seeking. In contrast, managed care largely controls costs through supply-side controls, by selectively contracting with providers and shifting financial risks to them. Unlike fee-for-service, those enrolled in managed care must seek care from a list of network physicians and hospitals, and often may not directly access specialists for care. Though many managed care plans allow consumers to seek care outside the network, such choices come at a high cost—with cost-sharing levels higher than those found in "typical" fee-for-service plans.

The pact which developed between employers and health plans to control costs largely excluded consumers from the equation. This exclusion has coincided with the explosion of information in treatment options and new technologies now available to consumers via the Internet. The multibillion dollar investment in direct to the consumer advertising by the pharmaceutical industry has also opened the eyes of many consumers to the emerging new medical developments spawned by the Human Genome Project. Thus, the demand for services among consumers has been fueled both by the growing volume of available medical information as well as by the substantial reduction in cost sharing resulting from the movement into managed care. Running contrary to these developments is the rise in capitation and managed care which restricts unlimited access to providers. Thus, the battle has been engaged.

As the tools used by fee-for-service and managed care to control costs differ substantially, it is not surprising that the style of medicine (i.e., use of health care) differs. Yet what is it about this new style of medicine that consumers object to? Simple comparisons of overall satisfaction often yield conflicting results (some surveys show similar levels of satisfaction, others show less satisfaction with managed care). More information is available, however, when one examines consumers' satisfaction with the tools and approaches used by managed care plans to generate savings. Indeed, consumers appear to react negatively to the approaches commonly used by managed care plans to control costs, such as the length of time required to see a physician, the restricted access to hospital care and specialists, and the interpersonal aspects of care (Newhouse and IEG 1993).

This is only part of the story, however. Satisfaction with managed care is substantially greater when consumers can choose among multiple plans. Multiple choice of plans may, in part, explain the fascination with and popularity of the FEHB—even though managed care is the domi-

nant form of care it offers. At least two studies have revealed that consumers facing only a single choice of plan are twice as likely to rate their managed care plan negatively compared to those offered more than one choice (Commonwealth Fund 1995; Gawande et al. 1998). Presumably, these results stem partially from selection. Those choosing managed care in multiple-plan choice settings may have a preference (both financial and practice style) for such plans. Not surprisingly they are more likely to be happy with their selection. Conversely, absent a choice, given the large underlying variation in preferences among consumers, many will be unhappy when offered a single plan to select.

The Changing Structure of the Managed Care Industry

Between 1992 and 1997, approximately a third of those with private health insurance shifted from fee-for-service to managed care (Mercer 1998). Publicly traded health plans played the dominant role in this transformation. The concomitant growth of managed care and for-profit health plans may have also generated suspicions about the "true" motives of managed care plans. Indeed, the media have assumed an important role in fueling these fears and suspicions. References to the managed care industry and insurance companies in general have figured prominently in recent films (*As Good As It Gets*) and books (notably, John Grisham's *The Rainmaker*). The media have increased their criticism of the managed care industry over time (Brodie, Brady, and Altman 1998). Two key issues seem to underlie the concern about managed care. First, do profits, or concern for the best quality of care for the patient, motivate the new style of medicine practiced by managed care? In short, when I get sick, will my plan assure that I receive the highest quality of care available, or will I suffer Donny's fate in *The Rainmaker*? Of course, critics of this dichotomy are quick to counter, perhaps quite appropriately, that the relationship between organizational ownership, form, and outcomes is immensely more complicated. However, not-for-profit forms of organization seem to engender more comfortable feelings concerning motives and trust, compared to for-profit firms.

A second, and related, issue concerns the beneficiaries of the savings created through managed care. In short, who receives all the savings we keep hearing about? While economists try to tell us that workers receive it through higher cash wages, the public does not believe this for a minute. Instead, nearly three-quarters of Americans believe that the sav-

ings generated by managed care, using tools that the public often objects to, are retained by the health plans (Blendon et al. 1998).

Consumer angst concerning managed care has also been echoed by the physician community. Surveys of physicians clearly report their concern over the loss of clinical autonomy, a reduction in time spent with patients, and slower growth in their income. Fewer than one in four physicians report that they are very satisfied with medical practice (Commonwealth Fund 1997). Again, choice assumes an important role here. Physicians choosing to work in a group or staff HMO environment report higher levels of satisfaction than those where managed care is "imposed" on them involuntarily. This is particularly true when physicians participate in several managed care plans.

The growth in managed care has generated several responses within the "physician community" (which I label loosely here). The first is the rising interest within elements of organized medicine, particularly the American Medical Association (AMA), in encouraging the development of medical savings accounts (MSAs). As in fee-for-service medicine, MSAs reduce spending through cost sharing, primarily high deductibles. Encouraging the development of the MSA concept under the guise of "returning control and responsibility" to the consumer could achieve several goals. From the consumers' standpoint, it would replace the oft-objected-to supply-side tools used by managed care plans with demand-side controls. Again, consumers would be in charge of making their own cost-benefit decisions when seeking coverage. Second, MSAs would largely eliminate interventions and rules developed by managed care to monitor health care use and costs, and reestablish the physician's primacy in clinical decisions.

Finally, managed care has created a new alliance between physicians and labor unions, particularly physicians paid on a capitated or salaried basis. Both the AFL-CIO and the Service Employees International Union (SEIU) have stepped up their efforts to recruit physicians intent on enhancing their bargaining positions with manage care plans.

The Future of Managed Care: Where Do We Go from Here?

The managed care industry is not entirely at fault for the reported consumer and physician "backlash." In fact, attention should also focus on employers and other large purchasers which created the environment in which we now operate. Indeed, the managed care industry has simply

delivered precisely what employers demanded; low cost growth with similar or better quality of health care.

Yet, much to the chagrin of employers, and despite their favorable record in controlling costs, several states have started to "reform" managed care plans, while the Congress continues to debate its future through various "patients' bill of rights" proposals. Targeted in these reform efforts are some of the tools used by managed care to control spending (i.e., restricted access to specialists, formal appeals processes) that have drawn fire from consumers and physicians. The managed care industry and major employers have resisted aspects of these reforms. Opponents contend that broad-based reforms will undermine employers' efforts to control costs and result in higher health insurance premiums. Consumers and physicians see the reforms as an effort to force managed care plans to cede decisions concerning medical necessity and appropriateness to physicians.

I have argued that the institutional structures created by employers in which consumers are restricted in selection of their plans have assumed a key role in shaping negative reactions to managed care. Managed care, however, is clearly here to stay. At issue is how to reconcile elements of consumer and provider dissatisfaction with managed care's potential for controlling health care costs. Part of the solution may entail broader choice of health plans. As noted above, consumers are substantially more satisfied with their managed care plans when they may choose among multiple health plans. The popularity of the FEHB is a case in point. The rising legislative interest in purchasing pools is also illustrative.

Perhaps the message is that purchasers and employers need to rethink their approach to controlling costs through restricted plan choice. Failure to do so will either result in continued state and federal legislation targeting managed care or spark interest in broader health care reforms, such as replacing employment-based coverage with large purchasing pools offering a choice of plans.

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