Breaking Down Health Care Insurance from HMO to PPO and Beyond

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Learning Objectives

After completing this chapter, the reader should be able to answer the following questions:

- Understand the history of the health care insurance industry in the United States.
- Understand how the development of health maintenance organizations (HMOs) and the managed care industry affected the US health care system.
- Understand what caused the decline of HMOs and the affect this had on the health care landscape.
- Understand the effect on the future of the health care industry of the introduction of Accountable Care Organizations (ACOs) and payment reform initiatives.

Historical Underpinning of Insurance

The health care insurance industry in the United States is arguably the most maddeningly complex and confusing system in the world. Other chapters will examine some of the quality, equity, access, and consistency challenges of America's hydra-headed approach to health insurance; this chapter attempts to reduce the complexity by tracing the historical origins and examining the structure and processes of our health insurance system.

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We begin by providing a basic glossary of terms (Table 4.1) that will help you understand this system. Like many complex systems, the health insurance industry has its own language and jargon, and this table will serve as a basic English to "health insurance language" dictionary. Next, we provide background on the history of health insurance in this country from its origins in the late 1920s to its expansion and sophistication today. While the focus of this chapter is on private commercial insurance, we also refer to Chapters 2 and 3 and the interconnection of the private insurance system with publically funded insurance programs. We will then segue into the rise of health maintenance organizations and managed care in the 1980s, which morphed into a variety of coverage options in the 1990s, including Preferred Provider Organizations (PPOs), Administrative Services Only (ASOs), and some degree of return

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Table 4.1 Glossary of health insurance terms

Term	Definition	Citation
Accountable care organization (ACO)	A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare fee-for-service patients they serve	Center for Medicare & Medicaid Services. (2012). Accountable care organizations. Accessed April 24, 2012 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html
Administrative Services Only (ASO)	An arrangement in which an employer hires a third party to deliver administrative services such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Adverse selection	People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool	Kaiser Family Foundation. (2009). Glossary of health reform terms. Menlo Park, CA: The Henry J. Kaiser Family Foundation
Capitation	Method of paying for health care where the provider of services receives a set amount of money per person for all care the person receives during a set time period (usually a year). Payment is "capped" and therefore creates an incentive for providers to provide the best care at the lowest cost	Barr, D. (2007). Introduction to US Health Policy: The Organization, Financing, and Delivery of Health Care in America. Baltimore, MD: Johns Hopkins University Press
Coinsurance	A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Rates may differ: • If services received from an approved provider or if received by providers not on the approved list • For different types of services	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Copayment	A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. Two things to remembers: • There can be separate copayments for different services • Some plans require that a deductible first be met for some specific services before a copayment applies	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Deductible	A fixed dollar amount that an insured person pays before the insurer starts to make payments for covered medical services	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics

Employee Retirement Income Security Act (ERISA)	The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans Important amendments made to ERISA: • Consolidated Omnibus Budget Reconciliation Act (COBRA) provides some workers and their families the right to continue their health coverage for a limited time after certain events, such as the loss of a job • Health Insurance Portability and Accountability Act (HIPAA) provides important new protections for working Americans and their families who have preexisting medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health • Newborns' and Mothers' Health Protection Act • Mental Health Parity Act • Women's Health and Cancer Rights Act	U.S. Department of Labor (2011). Health Plan & Benefits – Employee Retirement Income Security Act (ERISA). Accessed from http://www.dol.gov/dol/topic/health-plans/erisa.htm
Fee-for-service (FFS) plan	Health coverage in which doctors and other providers receive a fee for each service (office visit, test, procedure, or other health care service). There are no restrictions on physician, hospital, or ancillary services. The amount the plan plays dependent upon established fee schedule. Usually considered the most expensive type of health insurance	U.S. Office of Personnel Management. (2012). Health and insurance glossary. Washington, DC: U.S. Office of Personnel Management
First dollar coverage	Coverage for an insured individual who is not required to make an initial payment for care before insurance benefits is available. Limited to eligible charges or duration of coverage for specific procedure or expense	Scofea LA. (1994). The development and growth of employer-provided health insurance. Monthly Labor Review 117(3), 3–10
Flexible spending account (FSA)	Savings account offered and administered by employers for employees to set aside funds, on a pretax basis, for employee's share of insurance premiums or medical expenses not covered by employer's health plan. Funds must be used within a benefit year or employee loses funds	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Health maintenance organization (HMO) plan	A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
	Restrictions on physician, hospital, and ancillary services. A primary care physician must provide referrals for specialty care. Preapprovals are necessary for procedures and tests in order to be covered by HMO	Torpy JM, Burke AE, Glass RM. (2007). Health care insurance: The basics. The Journal of the American Medical Association 297(10), 1154

(continued)

Table 4.1 (continued)

Term	Definition	Citation
Health savings account (HSA)	Tax-exempt accounts that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees, and if the employer contributes to the HSA, the contributions are excluded from employee gross income. In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP), which can be provided by the employer or purchased from any company that sells health insurance in a state	Claxton G. (2008). How Private Health Coverage Works: A Primer, 2008 Update. Menlo Park, CA: The Henry J. Kaiser Family Foundation
Indemnity insurance	Coverage of some health expenses and allows individual to select a physician or a hospital without restrictions. Patients are responsible for paying the portion of a medical bill not covered by insurance	Torpy JM, Burke AE, Glass RM. (2007). Health care insurance: The basics. The Journal of the American Medical Association 297(10), 1154
Independent practice organization (IPO)	Organized entity that contracts with individual physicians from an array of specialties. IPOs do not conduct marketing, financing, or pricing. IPOs are not licensed as an HMO; therefore, they cannot sell directly to employers and usually cover a specified (and limited) geographic area. Therefore, IPOs usually contract with an HMO	Taylor RJ, Taylor SB. (1994). The AUPHA manual of health services management. Gaithersburg, MD: Apsen Publishers, Inc
Integrated care organization (ICO)	A group of providers and suppliers of service that has as its hub either a primary care center or a small group practice and also includes APRNs, specialists, hospitals, pharmacists, behavioral health practitioners, and providers of long-term care that will work together to coordinate care for individuals who are dually eligible for Medicare and Medicaid	
Managed care plans	Managed care plans generally provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include: • Health maintenance organizations (HMOs) • Preferred provider organizations (PPOs) • Exclusive provider organizations (EPOs) • Point-of-service plans (POSs)	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics

Maximum dollar limit	The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Medical savings account (MSA)	Savings account designated for out-of-pocket medical expenses. Employers and individuals are allowed to contribute on pretax basis and carry over unused funds at end of year	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Moral hazard	Additional health care that is purchased when a person becomes insured	Nyman JA. (2004). Is 'Moral Hazard' Inefficient? The Policy Implications Of A New Theory. Health Affairs 23(5), 194–199
Point-of-service (POS) plan	HMO/PPO hybrid. POS plans resemble HMOs for in-network services. Out-of-network services are usually reimbursed like an indemnity plan	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Primary care physician (PCP)	A physician who serves as the primary contact within the health plan for a group member. The PCP provides general medical care and coordinates and authorizes referrals for specialized services	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics
Preferred provider organization (PPO) plan	A network of selected health care providers (such as hospitals and physicians) working for specific health insurance company. The enrollees may go outside the network but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers	Torpy JM, Burke AE, Glass RM. (2007). Health care insurance: The basics. The Journal of the American Medical Association 297(10), 1154
Risk pooling	Large groups of individual entities (individuals or employers) whose medical costs are combined in order to calculate premiums	American Academy of Actuaries. (2009). Critical issues in health reform: Risk pooling. Washington, DC: American Academy of Actuaries
Usual, customary, and reasonable (UCR) charges	The charge is the provider's usual fee for a service that does not exceed the customary fee in a specific geographic area and is reasonable based on the circumstances. Indemnity plans operate on UCR charges	U.S. Department of Labor. (2011). Glossary of Employee Benefit Terms. Washington, DC: U.S. Bureau of Labor Statistics

to Fee-For-Service (FFS)/indemnity plans. Finally, we will examine the degree to which we may have moved "back to the future" with the current discussions and movement toward accountable/integrated care organizations.

Health insurance in the United States, and elsewhere, is a relatively recent concept. Several factors contributed to the lack of health insurance offerings before the twentieth century including a lack of expensive (and effective) health interventions and the lack of interest by insurance companies. For example, it was only in 1895 that X-rays were invented and they were not in routine use until 1917 during World War I in aid stations and hospitals [1]. X-ray services were not covered by Blue Cross Blue Shield or other insurance providers until the 1930s [1]. The first vaccine for polio came in 1955. Most women had children at home; for example, only half of the US births were in hospitals in 1938; by 1955, 99 % of women were giving birth in hospitals as a result of the expansion of private health insurance [2]. Well into the twentieth century, surgery was a relatively rare intervention. It would be many years before the explosive advances in medical and pharmaceutical technology would lead to interventions that people would want and need. For much of the period through World War I, families needing medical assistance paid for it out of pocket and, if anything, purchased "disability" insurance that would provide income supplementation or replacement in the event of crippling illness or accident [3].

Even for families interested in paying for this concept of "health insurance," most commercial insurance companies were uninterested in offering such a product. The prevalent line of thought was that health was not an insurable commodity as a result of two concerns that continue to complicate health insurance discussions even today: moral hazard and adverse selection. Moral hazard is the notion that individuals would engage in more dangerous (or hazardous) activities because they believed they were covered by a safety net (in this case, the safety net being that insurance would cover any medical costs arising as a result of risky behavior). Insurance companies wanted to avoid covering people who would then be free to treat their health as risk that someone else covers the cost of treating. Today, one will often hear it said that "the consumer/patient must have skin in the game." Adverse selection is the concept that the most unhealthy, and thus costly, individuals would disproportionately purchase insurance, making it difficult to correctly calculate risks and determine appropriate pricing considering the variation in baseline health and needs of the intended population.

While moral hazard and adverse selection could have been addressed, at least in part, by making health insurance compulsory or publically funded (as many European nations did by the 1920s), physicians and pharmacists strongly resisted this option as they believed it would significantly reduce their power and profits. The disinterest of the commercial insurance industry, the lack of demand from consumers, and the resistance of the medical professionals combined to delay the formation of an active US health insurance market. But slowly, things began to change.

Workers' Compensation and Health Insurance:
Workers in the late 1800s and early 1900s often faced difficult, unsafe, and life-threatening conditions [4]. This was challenging both for the workers themselves and for their employers. In order to address this situation, the first workmen's compensation law was passed, entitled the Federal Employer's Liability Act in 1908 to protect railroad workers. Slowly, individual states began to adopt workers' compensation laws, and today all American workers have some type of compensation benefits including provision of some medical costs and partial wages for work-related injuries. In this way, workers' compensation was one of the earliest forms of health care insurance in the United States.

Several demographic, scientific, and economic advances accrued to make medical care more expensive, and the possibility of commercial

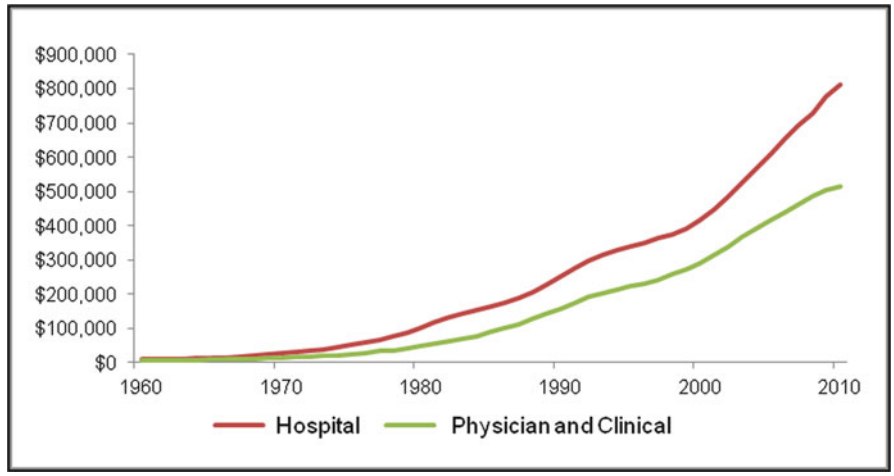

Fig. 4.1 US National Health Expenditures, 1960–2010 (Data from Centers for Medicare and Medicaid. National Health Expenditure Data. Washington, DC: Centers for Medicare and Medicaid; 2010)

insurance began to seem more profitable and necessary. This section briefly outlines some of those factors:

1. More faith in medicine: By the 1920s and1930s, breakthroughs in medicine and science [5] made medical care more innovative, more trusted, and more expensive. With the rise of standardization in medical education, medical schools became more costly, and these higher costs were passed through in the pricing of medical services. At the same time, hospital costs were also rising dramatically. In addition, many women began to choose hospitals to deliver their babies, at a significant and uncovered cost for many families.

   See Fig. 4.1 for an overview of US National Health Insurance Expenditures (1960–2010).
2. Rising incomes: Increasing incomes and a sense of general prosperity in the years before the Great Depression stimulated more demand for health care services [6].

The Baylor Plan and Blue Cross

While these factors were brewing, a group of teachers in Dallas, Texas came together to make health insurance history. In 1929, Dr. Justin Kimball became an administrator at Baylor Hospital and, as a result of his prior experience as school superintendent, noted that many Dallas school teachers were unable to pay their bills. He created the "Baylor Plan" which allowed participants to pay $.50 a month into a fund for care at Baylor Hospital. The plan was guaranteed to provide 21 days of hospital care for $6 a year.

The plan was limited and small and was considered an experiment. Today, it is considered to be the origin of modern health insurance and quickly spread to other cities and towns under the name Blue Cross. This bold experiment was considered a great success and was quickly spread and modified in important ways including an expansion to multiple hospitals (the first multi-hospital plan began in New Jersey in 1931). Within a decade, it further expanded to provide payment for medical services under the name Blue Shield. Before we turn to the development of Blue Shield and the later merging of hospital (Blue Cross) and medical care (Blue Shield) insurance programs, it should be noted that Dr. Kimball's decision to link payment to a specific hospital put hospital care at the center of health insurance, a placement that significantly continues to shape health insurance, health care delivery, and health care costs today.

"A godsend to thousands."
–Brian Twitty, Assistant to Dr. Justin Kimball regarding the Baylor Plan.

More than 1,300 teachers initially signed up for the Baylor plan, and within 5 years, more than 408 employee groups with more than 23,000 members were covered by this new type of plan [7].

Blue Shield

Almost exactly a decade after Dr. Kimball began his grand experiment, the Blue Shield concept was developed by employers in the lumber and mining camps of the Pacific Northwest. While paying for services instead of hospital stays was different, the basic concept was the same. A monthly payment was made to "medical service bureaus" that included groups of physicians who would provide all needed care. A key feature, and one that continues to shape the most basic structure of American health insurance to this day, was that fees were paid by the employers, not the employees. This key new worker benefit made certain employers more appealing and also had the potential to reduce missed days of work for illness or disability. This first official Blue Shield Plan began in 1939, and in 1948, the symbol was informally adopted by nine plans and called the Associated Medical Care Plan, which was later renamed the National Association of Blue Shield Plans. It was not until several decades later, in 1982, that Blue Shield merged with the Blue Cross Association and formed the Blue Cross and Blue Shield Association.

World War II and the Rise of Nationally Subsidized Employer-Based Insurance

While Blue Shield and similar plans were beginning to spring up across the country, before World War II, few people were covered. However, during the war, the federal government placed a freeze on wages [8], making the ability to offer fringe benefits appealing. Employers began offering health insurance as a key benefit. The fact that this benefit was not subjected to taxation for either the employee or the employer made it highly appealing. Today, the majority of Americans receive their health insurance as a nontaxable fringe benefit of employment.

The seeds of the managed care revolution were planted about 10 years after Baylor was beginning its grand experiment, by another inventive doctor named Sidney Garfield. This experiment took place in the late 1930s in middle of the Mojave Desert.

Dr. Garfield built the Contractors General Hospital in an effort to treat sick and injured workers associated with the construction of the Los Angeles Aqueduct. Though some workers had health insurance, most did not. Dr. Garfield did not turn away any worker needing care. The result was a rise in hospital expenses. Harold Hatch, an insurance agent, advised insurance companies to pay Dr. Garfield a fixed amount per day, per covered worker in advance, introducing the concept of prepayment. Thousands of workers enrolled for five cents per day and received the treatment needed, making the Contractors General Hospital a success. Another massive construction project, the Grand Coulee Dam, signaled a need for a new hospital and the recruitment of physicians in a "prepaid group practice" to provide care to 6,500 workers and their families. This first "replication" was again well received, and, hearing of Dr. Garfield's success, Henry J. Kaiser created the ultimate test, providing health care for 30,000 shipyard workers. The association formed between Dr. Garfield's innovative health system and Kaiser's extensive industries created Kaiser Permanente, the organization which still exists today [9]. See Fig. 4.2 for a diagram depicting the development of employer-based health care plans.

HMO Era

The development and history of health maintenance organizations (HMOs) and other related managed care organizations in the United States

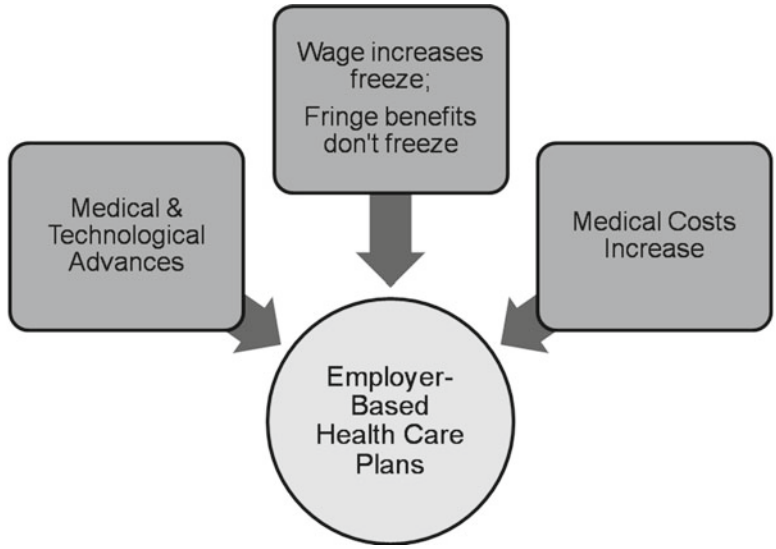

Fig. 4.2 Development of employer-based health care plans

span decades. The concept began to develop as early as 1929 with Blue Cross and 1937 with the Kaiser Foundation Health Plans and Group Health Association (GHA). It continued to evolve and expand in the 1960s and 1970s, and its influence in the delivery of health care peaked in the 1980s and 1990s. But by the late 1990s, that influence on health policy began to decline as a direct reflection of its failure to restrain growing health care costs. The cartoon in Fig. 4.3 depicts this.

The 1970s

Since 1965 when President Lyndon B. Johnson signed amendments to the Social Security Act creating Medicare and Medicaid, the US economy continued to grow. Congress became frustrated with the combination of inflation, uncontrolled health care costs, and utilization of the Medicare program. In 1971, President Nixon enforced control on wages and price freezes to curb further inflation [10]. In an effort to limit further growth in the Medicare budget, the Nixon Administration requested the assistance of Dr. Paul Ellwood to present his ideas for reducing health care spending [11]. Dr. Ellwood was a close colleague of Dr. Philip Lee, Assistant Secretary of Health during the Johnson Administration, and knew too well the health care situation that was unfolding. Dr. Ellwood proposed the concept of the health maintenance organization as a strategy to improve the existing health care system, using government funding to support the growth of prepaid health plans [12]. The underlying concept was essentially the same as that introduced decades earlier by Drs. Kimball and Garfield. A group of providers are "prepaid" a fixed sum for all of the care required by an individual. This creates an incentive for the doctors and other providers to keep that person healthy, limiting the amount needing to be spent on "sick care." In insurance parlance, it also shifts the utilization risk to the providers.

By 1973, health care costs increased from 4 % of the federal budget in 1965 to 11 % [10]. The discussions with Dr. Ellwood laid the groundwork for the Health Maintenance Organization (HMO) Act of 1973. Signed by President Nixon in December 1973, the HMO Act provided start-up funding in the form of grants and loans for new HMOs and access to employer-based insurance markets [11]. The Act provided $325 million

Fig. 4.3 HMO cartoon (Used with permission. Copyright © John McPherson J. Distributed by Universal Uclick via CartoonStock.com. That's how much time your HMO allots for bypass surgery [image on the Internet]. 2005 Dec 25 [cited 2012 Apr 17]. Available from: http://www.cartoonstock.com/cartoonview.asp?catref=jmp060725)

in appropriations, spread over 5 years, a fraction of the $3.9 billion proposed during initial discussions. It also assisted new HMOs with marketing, initial operating costs, and facility design [13].

However, the establishment of the HMO Act of 1973 and further amendments in 1976 did not accomplish the initial vision of Dr. Ellwood and President Nixon's HMO strategy. Health care spending did not decline. The Act caused HMOs, particularly federally funded HMOs, to be heavily regulated by federal and state regulations and legislation [13]. The HMOs that were established through federal funding were limited. Rather than continue to support additional spending, Congress passed a bill in 1981 to phase out and end both the grant and loan programs created by the HMO Act of 1973. Though federally funded HMOs were limited in number and enrollment, both government and nongovernment interests continued to search for a more effective and less expensive health care system. This led to continued and widespread development of HMOs without federal assistance in the later part of the 1970s and early 1980s and generated new models of insurance, collectively referred to as "managed care" [13].

The Development of HMOs

The economic recession in the early 1980s reinforced the need to control costs and expenditures. HMOs were developed to reduce health care utilization and expenses and were widely adopted during the 1980s and 1990s. Beyond their original focus on prevention (health maintenance), HMOs supported the imperative to reduce health care spending by controlling hospital utilization, the specialist referral process, and

selecting providers. Provider competition grew as HMOs implemented "selective contracting" with providers as an effective cost-containment strategy, limiting their subscribers to specific providers and hospitals and negotiating lower fees with those limited groups [14]. Many of the HMOs (formerly called prepaid group practices) that were developed during this era reflected the models of the Kaiser Permanente and Group Health plans. Initially, this model led to reduced utilization, created some efficiencies, and limited payments to physicians [15].

As the pressures for cost containment continued, the managed care movement shifted from the management of care by a primary care physician (PCP) to the management of physicians by HMO administrators "intent on reducing costs, limiting services and increasing margin" [16]. This signaled a shift of authority and control from physicians to the HMOs as the managers of care and services. Many consumers perceived a transformation in health care into a "corporate industry" with HMOs working with employers to provide cost-effective health care to their employees through managed care plans. The employee benefit created in the 1930s to attract and retain employees, in lieu of increased pay, had become an enormous and uncontrollable financial liability for employers. Employer selection of the HMO model grew from 5 % in 1984 to 50 % in 1993 as companies sought to control these costs [17].

The Rise of PPOs and POS Plans

With the rise in HMO adoption came a significant backlash against the core features and management techniques of this type of plan, as well as what many saw as excesses in their application. By 1985, managed care organizations began to restructure and evolve. The Preferred Provider Organizations (PPOs) and point-of-service (POS) plans that were created became competitors to HMOs in the provision of health care coverage. PPOs consist of a network of selected health care providers (such as hospitals and physicians) working for a specific health insurance company. Patients are given strong financial incentives to stay within this set network of providers. Care outside the network costs more, often significantly more, in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers. From the provider perspective, PPOs may be appealing because patients not in the PPO network can still be seen, and providers may charge more than PPO network providers for services. Providers agree to discounted rates for in-network services in exchange for increased volume of referrals. Though PPOs do not require referrals from the primary care physician for specialty care, this could promote uncoordinated care as patients may receive care from specialists without the knowledge of the primary care physician.

Another variant that developed at about the same time as the PPO was the point-of-service (POS) plan. A POS plan is a type of managed care that is a hybrid of the HMO and the PPO. Members of a POS plan do not have to decide which system (in network or out of network) to use until the point in time when the service is being used. However, as a managed care plan, the individual is required to choose a primary care physician (PCP) to be the main "point of service" and care coordinator. There are cost and convenience incentives for the member to choose providers within the network, but either choice is permitted. See Table 4.2 for a listing of types of health insurance plans and their descriptions.

As HMOs began to offer PPO and POS products, PPOs obtained HMO licenses, and HMOs contracted with employers on a self-funded rather than capitated or fully insured basis, shifting more risk back to employers [11]. The differences between the various types of managed care plans began to blur.

With this restructuring and rapid HMO growth, enrollment grew from 3 million in the 1970s to 13 million in the early 1980s and to over 80 million in 1995 [12]. While enrollment continued to increase, the number of licensed HMOs peaked in 1986 and has since declined [15]. The rapid growth in HMOs had outpaced their ability to manage costs. By the 1990s, the influence of HMOs began to diminish rapidly.

Table 4.2 Types of health insurance plans

Type of plan	Key characteristics	What it means for providers
HMO	• Members must choose primary care physician (PCP) from provider network	• Shared financial risk
	• Referrals are required to utilize specialty services	• Medical group paid on negotiated rate
	• Members pay fixed monthly fee	• Primary care physician provides referral for specialty services
	• Low out of pocket expenses	• May provide services to HMO and non-HMO members
	• Various models: group, staff, network, individual practice association (IPA)	
PPO	• Member not required to select primary care physician	• Payment incentives for providers (through a variety of mechanisms)
	• Receive care from any physician in PPO network or out of network	• Prompt payment features for favorable payment rates
	• No referrals from PCP necessary	• Utilization management services to control utilization and cost of health services provided
	• Member may use non-PPO providers, at additional (usually higher) cost	
	• Members pay for services as they are rendered	
POS	• Hybrid of PPO and HMO plans	• Reimbursement through capitated payments/fee schedule
	• Member must choose a PCP	• Primary care physician "gatekeeper" of referral and medical services
	• PCP provides referrals	• Physician payments paid upon achieving utilization and cost targets
	• Resembles HMOs for in-network services	
	• Out-of-network services are reimbursed on fee schedule	
ACO	• Group of providers responsible for group of patients	• Shared responsibility for treatment of a group of patients
	• Provider payments based on the care the ACO as a whole provides to patients	• Providers must coordinate care with other physicians
		• Providers share any cost savings received

The Fall of HMOs

There were a number of factors that contributed to the decline of HMOs in the late 1980s and 1990s. Many providers objected to risk contracting terms, which pressured them to take on more risk. Patient and provider backlash against managed care business practices became widespread. New regulations to limit unfavorable HMO practices provided patients with more legal rights to sue HMOs. A number of class litigation actions were brought by consumers, physicians, and other providers against managed care business practices that included injury or death resulting from alleged decisions to withhold or limit medical care. As a result, physician relationships with HMOs and managed care organizations, a descriptor that had become prevalent by the mid-1990s, soured sharply.

Responding to pressures from purchasers (the employers who purchase most commercial health insurance on behalf of their employees) to control rising premiums, managed care organizations adopted a variety of techniques to limit utilization of health care services or shift their costs to consumers. Under the heading of utilization management, health plans implemented prior authorization, specific benefit restrictions, quantity limits, referral requirements, and retrospective review and denials. Among the cost-shifting

techniques that were developed or expanded during this era were annual and specific-service deductibles, copayments and coinsurance. While all were part of a rational effort to control the national rise in health care costs, the cumulative effect was perceived by consumers as intrusive and burdensome and by providers as an abrogation of the prerogatives reserved by law and tradition for the medical profession. Ultimately, this prompted a substantial backlash by a consumer movement and organized medicine.

This backlash prompted changes in the business approaches of HMOs, which in turn significantly transformed the business model of the health insurance industry. Anything that was perceived as a limitation on access to or choice of providers was softened or eliminated. On the other hand, use of all forms of cost shifting intensified and accelerated. These moves could be portrayed as "consumers have access to any provider or service they wish, as long as they are willing to pay for it." Insurance product design also evolved further. More and more HMOs began to offer products that were similar to PPOs and POS plans [18]. The choice of providers was not limited to a finite network. Cost shifting to the consumer took the place of utilization controls.

Despite these changes in the business model, health plans did not succeed in restraining rising health care costs for very long. The annual percent change in per capita health care spending increased from 2 % in 1996 to 10 % in 2001 [17]. The retreat from traditional cost controls by HMOs resulted in a resumption of the previous growth curve in medical spending and a search for new ways to restrain it.

What's Next for HMOs and Managed Care

In recent years, the persistent and inexorable rise in health care costs has become one of the United States' most persistent and vexing economic issues. While previously much of the pressure to restrain rising costs had come from purchasers, cost shifting to consumers has activated them and increased the national level of frustration around health care. The nexus of these pressures from consumers, employers, providers, and government regulators falls on health plans. A careful examination of the history outlined here revealed that among the cost control methods that have been successful in the US in previous decades were government price controls, capitation, and what was previously termed "managed care." The former is unacceptable in contemporary politics. The second failed because providers were in many instances unprepared to accept and manage risk. And the latter, while successful in controlling costs, ultimately sank under the weight of a mixture of corporate excesses in failed implementation. The next generation of cost control initiatives is drawing from the best of these, while learning from recent experiences.

> *"If all we're doing is adding more people to a broken system then costs will continue to skyrocket, and eventually somebody is going to be bankrupt, whether it's the federal government, state governments, businesses or individual families."*
>
> –President Barack Obama, White House Health Care Summit, 2/2010 [19]

Back to the Future: Accountable Care Organizations (ACOs) and Integrated Care Organizations (ICOs)

Among a wide number of sweeping changes, the Patient Protection and Affordable Care Act signed into law on March 23, 2010, contains a provision to develop accountable care organizations (ACOs) as one of the first new payment reform initiatives. Though initially established as a new way of paying for health care provided to Medicare beneficiaries, there is significant opportunity for pilot programs to test this payment model by private payers and Medicaid agencies [20]. ACOs are organizations comprised of physicians, hospitals, and other health care

providers who accept prepayment and risk to manage a group of patients. They are responsible (accountable) for all, or a contractually defined range, of health care services. As part of this management, they assume many of the functions previously performed by managed care organizations or health plans, including utilization management, care and case management, and cost control. The reimbursement system often includes rewards for attainment of quality of care and outcome benchmarks, as well as cost control [21].

The implementation of the ACO model will need to overcome several challenges to be successful. The ACO will need to build trusting relationships among physicians, payers, and other partners. This trust may prove difficult to reconcile as the turbulent relations between physicians, patients, and insurers during the late 1990s created an unfavorable climate. Individual physicians may be reluctant to accept responsibility for the care of an unselected panel of patients within an organization. Hospitals and health care organizations may experience difficulty in aligning their medical staff to promote accountability [22]. And hospitals, the financially dominant partners within an ACO, will be driven by conflicting incentives: reducing utilization to achieve savings and keeping their beds filled. But a full collaboration among the provider, healthcare organization, patient, and payer is critical to the success of the ACO. Data management and data sharing present further challenges. Organizations will be required to develop data-sharing agreements and exchange performance and financial data between providers and payers [21]. These data will also be critical for providers to understand their patient populations and health care patterns and to establish performance measures.

The implementation of health information technology (HIT) is vital for ACOs. HIT, including electronic health records and care management systems, will be the basis for data sharing across providers, organizations, and payers [23]. Without such technology, the coordination of care, establishment of performance measures and metrics, and management of care spending will remain difficult. Health information exchanges, currently under development in many states, will support these efforts. But they are currently in their infancy. It will be critical to ensure that solutions to these challenges are available if ACOs will be successful.

At this time, the ACO as a payment model is relatively new; the benefits to improving the health care system and reducing health care costs are still undetermined. Pilot programs are being implemented between providers, health care organizations, and payers, both government and commercial, to determine the viability and cost effectiveness of ACOs as a payment and care model.

Conclusion

Since its earliest roots in the 1920s, health insurance in the United States has evolved into the costliest and one of the most complex in the world. This chapter traces the history and evolution of the employer-based system of health insurance and documents shifts both into and away from a managed care and health maintenance systems (Fig. 4.4). The massive growth in number of plans and complexity of payment systems has contributed to higher costs and to some modest improvements in quality and access. The most recent shift, brought about by the passage and imminent implementation of the federal health care reform law (Patient Protection and Affordable Care Act) will significantly shift the health insurance landscape toward a model based on some form of "accountable care organizations." If past is prologue, the ultimate impact of the dramatic changes envisioned in the new law will surprise us and will not be fully understood for many years.

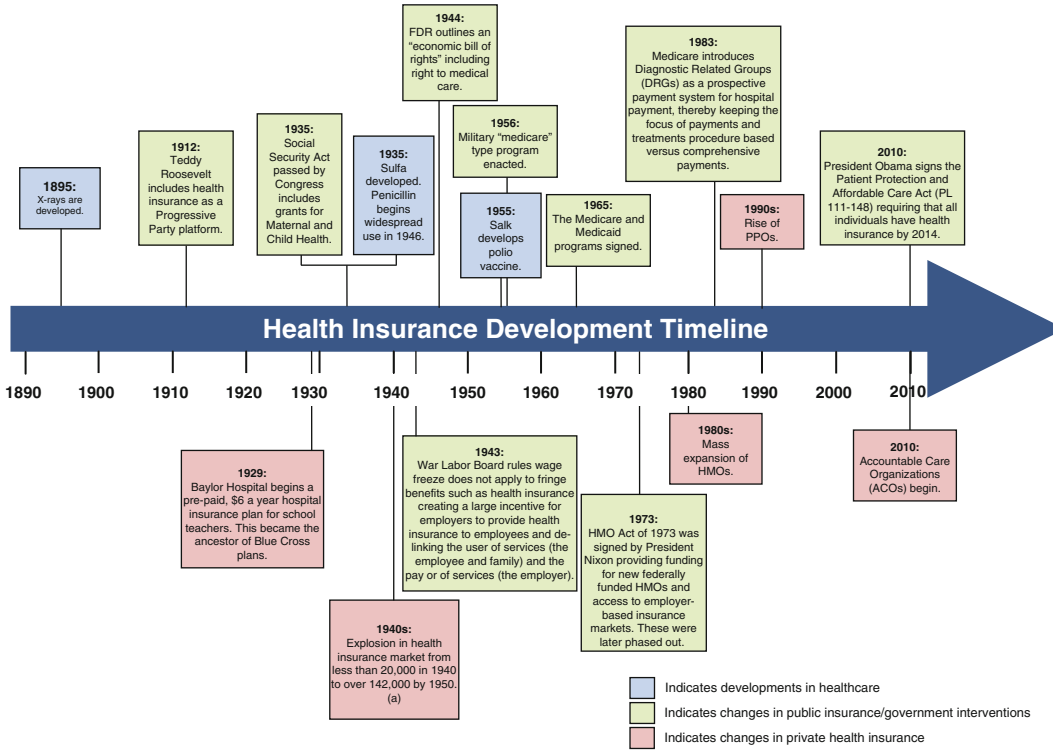

Fig. 4.4 Health insurance development timeline (a: Data from Health Insurance Institute. Book of Health Insurance Data, 1965. New York: Health Insurance Institute; 1966)

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