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AFTER MANAGED CARE: GRAY BOXES, TIERS AND CONSUMERISM

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America is at a troubling stage in the discussion of health care finance. A decade ago, discussions of the fair and efficient allocation of health care services involved the articulation and review of grand architectonic plans. Originating from various political and social perspectives, these plans proposed to organize and rationalize the financing of the health care delivery system.[1] Following the collapse of broad systemic reform in 1994, we entered a period when health finance developed in a piecemeal fashion, with care for the poor focusing on Medicaid expansions often tied to innovative state-specific reforms,[2] and care for the non-poor committed to commercial managed care plans.[3]

Managed care was the focus of health finance reform in this period for public and private programs, for the poor and non-poor alike. The social problems of access and cost containment were committed to the business plan of commercial managed care organizations. For a number of years, the strategy seemed to work. We were not quite sure why it worked; we knew that America had rejected a governmental solution to the twin problems of uninsurance and cost inflation, and had instead entrusted the problems to markets and commercial managers. The result during the mid- to late-1990s

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1. *See, e.g.*, Karen Davis & Cathy Schoen, *Universal Coverage: Building on Medicare and Employer Financing*, HEALTH AFF., Spring 1994, at 7; Mark V. Pauly, *Making a Case for Employer-Enforced Individual Mandates*, HEALTH AFF., Spring 1994, at 21; Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, HEALTH AFF., Supp. 1993, at 7; Alain C. Enthoven & Richard Kronick, *Universal Health Insurance Through Incentives Reform*, 265 JAMA 2532 (1991); John Holahan et al., *An American Approach to Health System Reform*, 265 JAMA 2537 (1991). The paradigm of the architectonic plan, of course, was the "Clinton Health Plan," the legislation introduced after much deliberation and turmoil as the Health Security Act, H.R. 3600, 103d Cong. (1993). *See* WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN: THE CLINTON BLUEPRINT (1993).

2. *See* Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7 (2001); MICHAEL S. SPARER, MEDICAID AND THE LIMITS OF STATE HEALTH REFORM (1996).

3. *See* Sallyanne Payton, *Managed Care—The First Chapter Comes to a Close*, 32 U. MICH. J.L. REFORM 573, 576 (1999).

was the seeming defeat of health care cost inflation and a slowing, perhaps even a reversal, of the trend toward higher rates of uninsurance.[4]

Managed care, as it turns out, did not solve our problems. Health care cost inflation is back.[5] Uninsurance—a problem too often ignored in the boom years of economic expansion—is on the rise. Simultaneously, research sampling has revealed that tens of thousands of patients may die each year as a result of medical errors.[6] Cost, quality and access—the subject of systemic reform proposals a decade ago—are more often analyzed today as problems of managed care.

Murder . . . or Just a Misunderstanding?

Peter Jacobson has wryly and accurately commented on the "thousand cuts" suffered by managed care in the last decade.[7] Many participants objected to central features of managed care. Patients, of course, objected to restrictions in access to providers of their choice and to plans declining coverage after second-guessing treating physicians' judgment. Physicians also objected to managed care, arguing that "medical policy must derive solely from the physician community."[8] However, these objections remained even when managed care decisions *were* being made by physicians. The real goal seemed to be to preserve the prerogatives of each individual treating physician from any impingement. State legislatures seemed responsive to patients' objections to managed care,[9] even while states in the 1990s moved their own programs—principally Medicaid—squarely into the managed care camp.

Managed care has endured a near-death experience and is emerging chastened. It will no longer be advanced as "all things to all people" or the *deus ex machina* savior of health finance. However, it may be fruitful to conceive of the troubles of managed care not just as the result of wounds

4. *See* Paul B. Ginsburg & Jon R. Gabel, *Tracking Health Care Costs: What's New in 1998?*, HEALTH AFF., Sept.-Oct. 1998, at 141, 144.

5. *See* Jon Gabel et al., *Job-Based Health Benefits in 2002: Some Important Trends*, HEALTH AFF., Sept.-Oct. 2002, at 143, 144-45; Drew E. Altman & Larry Levitt, Web Exclusive, *The Sad History of Health Care Cost Containment as Told in One Chart*, HEALTH AFF., Jan. 23, 2002, at W83, *at* http://www.healthaffairs.org/WebExclusives/2101Altman.pdf.

6. *See* Joseph P. Newhouse, *Why is There a Quality Chasm?*, HEALTH AFF., July-Aug. 2002, at 13; COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE TWENTY-FIRST CENTURY (2001), *available at* http://www.iom.edu/iom/iomhome/nsf/pages/2001+reports (last visited Jan. 6, 2003); COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000) [hereinafter INSTITUTE OF MEDICINE, TO ERR IS HUMAN].

7. Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 394 (2003).

8. *Id.* at 371.

9. *Id.* at 382.

inflicted by adversaries, or even as self-inflicted wounds of managers lacking in vision (although Professor Jacobson demonstrates that such wounds played their part in the drama). Some have argued with persuasive force that managed care, like the hero of a Greek tragedy, grew in the 1980s and 1990s with the seeds of its destruction inborn.

Americans are conflicted on the wisdom of entrusting to government the solution of social problems.[10] Although we flirt with comprehensive government control of our health care system, we settle for a mixed system with some regulation of a system dominated by the private market. The Clinton administration made reform proposals that were perceived—fairly or unfairly—as injecting government into previously private relationships, thereby diminishing consumer autonomy.[11] When the dust cleared, managed care had stepped into the breach, offering a solution to increasing costs (and perhaps by implication increasing uninsurance) through nongovernmental means. There was some overselling on the part of managed care and no small measure of both credulity and wishful thinking on our part. Managed care sought to use market mechanisms to control and channel health finances with an eye toward proper, efficient distribution of funding. Some aspects of the health finance market were acknowledged to be flawed with moral hazard, information asymmetries and entrenched misconceptions interfering with efficient transactions. Managed care-based financing, however, was touted as uniquely capable of fixing these problems, while improving quality and reducing cost. The problem, health economist Henry Aaron suggests, is that the cumulative effect of the market flaws was underappreciated.

> Some health care analysts emphasize the pernicious effects of distorted prices. Others dwell on irrationalities, poor information, and misaligned incentives. The differences among health policy analysts on why health care markets sometimes perform poorly run right through most disagreements on policy. Of course, price signals might be distorted *and* people might behave with less than perfect rationality *and* incentives of providers and patients might sometimes diverge *and* flawed information might obstruct good decisions. It is striking, however, that few disputants acknowledge that all of these problems might be present at the same time.[12]

The central mechanism of managed care in practice, for all the high-flown theoretical explication, was a classic black box. Managed care organizations objected to too much probing into their contractual affairs, positing the proprietary nature of the information and other harrumphing businesslike

10. *Id.* at 374 (citation omitted).

11. *See* THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS 133-72 (1996).

12. Henry J. Aaron, *A Funny Thing Happened on the Way to Managed Competition*, 27 J. HEALTH POL. POL'Y & LAW 31, 32 (2002).

assertions. We were satisfied to leave it at that. We asked managed care to work private sector magic on problems that had bedeviled government. As with sausage making and the passage of laws, we were too often happy not to be exposed to the precise mechanisms by which managed care controlled utilization of health care. Sponsors seemed to ask that managed care provide high quality care to more people for less money—never mind the details. As James Robinson observed, "[t]he fundamental flaw of managed care, in retrospect, was that it sought to navigate the tensions between limited resources and unlimited expectations without explaining exactly how it was so doing."[13] Yet, can it be blamed for its reticence? It was not often asked.

In hindsight, the hope that the largely for-profit managed care industry would behave as an engine of good was also wishful thinking. We did not simply buy into a black box solution to a complex problem. We also committed the complex social tasks of controlling health costs and increasing access to coverage to entities whose corporate charters charged managers with the duty of running the enterprise so as to maximize returns to shareholders. Society rejected the messiness of government and was smitten with the allure of private enterprise. However, we have no business complaining when we turn public business over to profit-oriented businesses only to find that they act like profit-oriented businesses instead of public trusts.

Whether managed care was murdered (almost), committed suicide (almost), or simply misunderstood the deal society struck, its day in the sun is over. Managed care organizations will, undoubtedly, survive as going concerns, but the curtain has dropped on their scene as saviors of health finance. What is next? I will first describe three strands of evolution that seem ready to flow from the diminished power center that is managed care. All three seem plausible, although some are more certain than others. Time will tell whether these strands will coexist, merge, further splinter or die out. Nonetheless, it is worthwhile to consider the outcome in the near and medium term if the relationship among markets, managed care and government continues along its current path. I will finish with some considerations that might animate a public policy response to this evolution.

Evolution

Three trends are emerging with various degrees of strength as managed care systems evolve. First, managed care organizations are loosening control over patients' choices of health care providers and services, blurring the distinctions among health insurers and reducing their exposure to legal, legislative and social criticism. Second, health insurance offerings are stratifying into tiers in two ways. Employers, who until recently had been paring down the number of plans offered to employees, are now sometimes

13. James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2623 (2001).

offering a menu of plans, from more expensive (but less restrictive) to less expensive (but more restrictive). In addition, plan sponsors are expanding the use of differentiation among participating providers by charging lower member co-payments for services rendered at less expensive (or otherwise preferred) providers. Third, some employers are expressing interest in emerging "patient-directed" plans, in which employees are given control over a health spending account from which they are free (or freer) to choose their services and providers. In addition, the employee is provided insurance coverage that becomes available after a sizable deductible is met.

1. Gray boxes

Managed care organizations have always been a heterogeneous bunch, and, therefore, generalizations are to be taken with a grain of salt. Central to the concept of managed care, however, is control: control of utilization to combat moral hazard, control of provider panels to reduce cost and control over medical practice to promote quality. Perhaps out of proprietary concern and perhaps to avoid criticism, managed care organizations tended not to broadcast the means by which this power was wielded—a reticence, even secrecy, leading to the black box phenomenon mentioned above. In addition, practice never quite matched theory as managed care organizations have been criticized for failing to direct their organizational energy toward managing *care*, thereby fulfilling managed competition's vision of higher quality, more efficient health care, and, instead, managing *cost* for short-term benefit.[14]

The black box is becoming less opaque as managed care plans loosen their control over health coverage decisions. The model of managed care is shifting from a tightly-controlled to a loosely-controlled system with less plan direction as to choices of provider and frequency, and source and type of treatment.[15] In addition, the lines between different types of managed care organizations have blurred, as plan sponsors "mix and match" features such as deductible, co-

14. *See* Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 10-14 (2000).

15. *See* Suzanne Felt-Lisk & Glen P. Mays, *Back to the Drawing Board: New Directions in Health Plans' Care Management Strategies*, HEALTH AFF., Sept.-Oct. 2002, at 210, 210-11; Gabel et al., *supra* note 5, at 147-48; Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, HEALTH AFF., May-June 1997, at 134, 136. Even Medicare is trying to broaden the types of managed care plans it sponsors. Medicare+Choice was Congress' 1997 effort to broaden the types of managed care organization available to Medicare participants. The effort appears to have been stillborn. Recently, the Department of Health and Human Services has announced a "demonstration program" to attempt to encourage skittish firms to offer Preferred Provider Organization membership to Medicaid beneficiaries. *See* Press Release, U.S. Dep't of Health & Human Services, HHS Expands Health Plan Options in Medicare+Choice: New Demonstration Program to Feature PPO Option in 23 States (Aug. 27, 2002), *available at* http://www.hhs.gov/news/press/2002pres/20020827.html.

insurance and co-payment.[16] This increased openness is driven by several of the suspects detailed by Professor Jacobson: consumers, employers and government.[17] As two health researchers have recently reported:

> Most recently health plans—particularly HMOs—have faced pressure to change their care management strategies and redefine themselves on several fronts. Consumers have voiced concerns about undue restrictions on choice and unnecessary administrative hassles in seeking care and have begun migrating to less restrictive health insurance products. . . . Meanwhile, providers have complained about interference with medical decision making and about burdensome administrative costs of complying with plans' care management policies; they have begun to resist these policies or withdraw from plans that use them. In many states policymakers have responded to the backlash by exploring regulatory restrictions on plans' care management policies.[18]

This evolutionary trend suggests a retreat from vigorous pursuit of some of the central features of managed care—the features that had originally differentiated managed care from other forms of health insurance. The range of management plans still varies, of course, but the movement is toward less control by plans and more freedom for members and physicians.

The proper characterization of this evolution is open to debate. To borrow from Professor Jacobson, it may be explained as the natural result of the battering of managed care plans by a variety of social actors and of the plans' own failure to live up to advance billing. It may also be seen as a convenient business move by firms that gained market share by offering something new, and that now, having consolidated and absorbed the old guard, settle into the more comfortable—although rather gray—business of merely acting as fiscal intermediaries, that is, traditional insurance companies.

2. Tiers

The second evolutionary trend in managed care is the creation of tiers of coverage—the horizontal and vertical segmentation of services through financial incentives. This trend follows from the first trend (the loosening of controls) and from the observation that cost-control remains an imperative. Supply-side managed care methods have called down society's wrath;[19] the robust movement toward differential financial incentives to contain costs suggests a move to demand-side cost containment methods. As James Robinson explained:

16. *See* James C. Robinson, Web Exclusive, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFF., Mar. 20, 2002, at W139, W140, *at* http://www.healthaffairs.org/WebExclusives/2103Robinson.pdf.

17. *See* Jacobson, *supra* note 7, at 367-68, 373, 376, 381.

18. Felt-Lisk & Mays, *supra* note 15, at 210 (footnotes omitted).

19. *See* Jacobson, *supra* note 7, at 375.

> [T]he financial turmoil among integrated delivery systems and the regulatory backlash against managed care have radically changed the industry's strategy and vision. Rather than seeking to control costs by limiting consumers' choice of providers, procedures, and products, health plans increasingly interpret their role as one of packaging health care services, pricing them at actuarially sustainable rates, gathering and disseminating information, promoting electronic connectivity among all participants, and otherwise getting out from between the consumer and the services the consumer wants to consume.[20]

The use of tiers of services can be separated into two types: horizontal segmentation, in which consumers are induced to choose the richness of coverage based on variable employee cost share, and vertical segmentation, in which consumers within plans are induced to choose providers based on variable employee cost share.

The novelty of these forms of segmentation should not be overstated. In the first form, managed care organizations (or sponsors or self-insured employers) "simply" offer incentives to encourage employees to focus on the incremental value of the aspects of benefit design, thereby permitting them to meter their costs to their preferred level of coverage, thereby maximizing their utilities. This trend might be seen as suggesting a reversal of the recent trend by which employers reduced the coverage choices available to employees, a reduction undertaken to increase the employer's leverage on plan premiums. Yet, as Robinson indicates, this trend also suggests plans turning away from direct attempts to shape provider behavior.[21]

In the second segmentation trend, managed care organizations (or sponsors or self-insured employers) "simply" expand differentiated cost sharing that has been used to provide incentives to use in-network providers. Plans are offering a menu of cost sharing to members, calibrating the member's share of the cost to the provider's charges (and sometimes other factors). Plan members may be charged different cost sharing for in-plan providers depending on the price the provider reports to the plan. This differential pricing method is now in use for hospital, physician and pharmaceutical coverage.[22] As the rate of differential and the number of tiers increases, co-payments and co-insurance seem less a gentle nudge to conform to the plan's network design than a mechanism to pass through discounts arranged between the plan and providers.

Like the trend toward loosening restrictions on medical practice, this trend represents a retreat from core principles of managed care. Plans used the threat of network exclusion as a means to strike hard bargains with providers, and used control of network providers as a means to govern protocol and data methods. In more recent years, the tables turned somewhat as powerful

20. Robinson, *supra* note 16, at W145.

21. *Id.*

22. *Id.* at W147.

providers such as hospital systems and key medical groups used the threat of withdrawal from the network as a means of increasing reimbursement. The trend toward tier pricing signals a withdrawal of managed care plans from the battlefield. A broad range of providers will be in the network, but not as equals; they will face an internal market as plan members face different out-of-pocket costs according to the tier the provider occupies.[23] The effect of this trend is to stratify providers and members as well. Wealthy members will be able to use their greater disposable incomes to see their providers of choice.[24] Those of lesser means will increasingly face substantial co-payments and coinsurance that will bar them from some providers. The size of the network will be a boon to the wealthy for whom expanded co-payments are acceptable, but an illusion to others; for the less wealthy, providers in the higher tiers may as well be out-of-network providers.

3. Consumerism

The third trend in managed care is the most controversial and least developed trend. Consumer-directed health plans can be seen alternatively as a recycling of the mid-1990s medical savings account idea, the product of aggressive entrepreneurs, or as a poorly formed attempt to segment health spending between costs properly the subject of insurance and properly expensed as annual primary and preventive health costs. The motives for the creation of consumer-directed plans track those discussed by Professor Jacobson for the attacks on managed care: providers' interest in lessening the power of intermediaries between themselves and patients, consumers' desire for greater choice and employers' twin desires to be responsive to employee wishes and to insulate themselves from coming cost increases.[25]

Consumer-driven plans combine high-deductible insurance coverage–often in the form of a preferred provider organization ("PPO")—with a personal spending account controlled by the consumer. The sponsor (usually the employer) purchases the high-deductible coverage and also contributes a sum (for example, $2,000) into an employee spending account. The employee chooses when and with whom to spend the funds from the spending account, although the sponsor may impose some limits (for example, permitting

23. *See id.* at W145; Myrle Croasdale, *Plans Setting Higher Specialist Co-Pays*, AM. MED. NEWS, Apr. 1, 2002, at 1.

24. "Luxury primary care" is another emerging service highlighting the stratification of access between haves and have-nots. Enrollees in luxury primary care pay an annual fee to a medical practice and in return receive "old fashioned" care—extended primary care consultations, comprehensive physicals with high-tech diagnostic testing and a range of amenities foreign to most modern volume-driven practices. *See* Troyen A. Brennan, *Luxury Primary Care–Market Innovation or Threat to Access?*, 346 NEW ENG. J. MED. 1165 (2002).

25. *See* John V. Jacobi & Nicole Huberfeld, *Quality Control, Enterprise Liability, and Disintermediation in Managed Care*, 29 J.L. MED. & ETHICS 305, 311 (2001).

spending on chiropractic, but not psychic consultations). If medical expenses exceed the funds in the account, the employee is then subject to a deductible (for example, $1,500) that must be met before becoming eligible for the plan's residual insurance coverage. Once the employee has spent the money in the account and has met the yearly deductible amount, the high-deductible insurance provides coverage with typical terms and conditions of payment. The funds in an employee account are usually permitted to roll over from year to year if not exhausted. Expenses incurred toward the deductible amount reset each year.[26]

Although the coverage numbers are somewhat hard to pin down, it appears that fewer than 100,000 Americans are actually members of consumer-driven plans in 2002.[27] Many people are skeptical of the long-term prospects of such plans,[28] but there have been reports of growing interest among large employers.[29] A recent analysis of these plans' business prospects reported that consumer-driven plans

> have been successful in creating concept awareness on the part of employers and, according to a Price Waterhouse survey, more than 50 percent of employers plan to shift some to some kind of [consumer-driven plan] over the next ten years. Other surveys by benefit consultants have been less sanguine . . . . [I]n the first six months of 2001 . . . [consumer-driven plans] announced contracts with several major employers . . . .[30]

The plans are new and their performance has not been tested.[31]

26. *See* Robinson, *supra* note 16, at W146-47; Jon B. Christianson et al., *Defined-Contribution Health Insurance Products: Development and Prospects*, HEALTH AFF., Jan.-Feb. 2002, at 49, 53-56; Jacobi & Huberfeld, *supra* note 25, at 310-12. *See also* Bill Brubaker, *Co-Pay, or You Pay?; Firms Hope Worker-Directed Health Plans Will Curb Rising Costs*, WASH. POST, July 28, 2002, at H1; Laura Cohn, *Giving Power to the Patient*, BUS. WK., May 6, 2002, at 102; Barbara Martinez, *Health Plan That Puts Employees in Charge of Spending Catches On*, WALL ST. J., Jan. 8, 2002, at B1.

27. *See* Brubaker, *supra* note 26, at H1.

28. *See* Gabel et al., *supra* note 5, at 150 ("[sixty-four] percent of employers say that these plans would be unattractive to workers . . . .").

29. *See* Brubaker, *supra* note 26, at H1 ("Only a handful of large U.S. employers are offering consumer-directed plans this year. But dozens more, including Toys R Us Inc., Levi Strauss & Co. and Allfirst Financial Inc. in Baltimore, will add consumer-directed plans to their employee benefit menus in 2003, more than doubling the number of U.S. workers . . . who are covered this year."). *See also* Julie Appleby, *New Insurance Plans Turn Patients into Shoppers*, USA TODAY, Jan. 8, 2002, at B1 ("While the total number of enrollees remains low, probably fewer than 350,000, more employers are signing on, including Medtronic, Novartis, Ciba Vision, Raytheon, the Budget Group and the University of Minnesota. A survey by benefits firm William M. Mercer found that 19% of all employers—and 29% of those with more than 20,000 workers—said they were likely to offer such insurance.").

30. Christianson et al., *supra* note 26, at 58 (footnotes omitted).

31. *Id.* at 59.

Recent advice from the Internal Revenue Service improved their prospects. The IRS assured favorable tax treatment of the employee spending accounts central to consumer-directed plans, ruling that the funds placed in the accounts may be permitted to roll over from year to year, and that the funds will not be counted as taxable income to the employee provided they are not associated with a reduction in the employee's salary and are used only for medical care expenses.[32] Entrepreneurs marketing this coverage have expressed hope that the IRS ruling will give comfort to firms considering consumer-driven plans that had been deterred by the fear of the tax consequences.[33]

The trend toward consumer-driven care is weaker than the first two trends at this point, although there are some indications that it is gaining strength. Like the first two trends, it also demonstrates a retreat from managed care principles–dramatically for primary and routine care, and less so for acute care. The promise of most consumer-driven plans is that consumers themselves can act as prudent purchasers if given the chance, obviating the need for managed care plans to act as expert intermediaries between consumers and providers, at least until the spending account and deductible are exhausted. These plans may be more attractive for the wealthy than the poor, because the wealthy have the means to spend through their accounts and deductibles to reach their residual insurance. Those of lesser means may spend reluctantly, attempting to husband their spending accounts against the advent of an emergency, thereby foregoing medically appropriate care.[34] In addition, there is substantial reason to suspect the ability of lay people to judge (even with the assistance of the web-based resources) the quality of caregivers. Consumer-driven plans have migrated far from the vision of managed care as an expert organizer of medical care. They are instead a reaction to the failings of managed care, and they hold little promise of advancing social goals of cost control, increased access to coverage and improvements in quality.

Public Policy Concerns

The loosening of control by managed care organizations does not suggest a return to physician-controlled expenditures. Plan sponsors, and therefore plans, will remain attentive to the need to combat moral hazard and to control

32. Rev. Rul. 2002-41, 2002-28 I.R.B. 75, 76; IRS Notice 2002-45, 2002-28 I.R.B. 93, 93, 95.

33. Press Release, Lumenos, Internal Revenue Service Rules Favorably on Consumers' Health Savings, *at* http://www.lumenos.com/press/IRSRuling (June 26, 2002).

34. *See* Jason S. Lee & Laura Tollen, Web Exclusive, *How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing*, HEALTH AFF., June 19, 2002, at W229, W237, *at* http://www.healthaffairs.org/WebExclusives/2104Lee.pdf ("[P]atients who are ill informed but empowered with choice may purchase less or lower-quality care and may pay more for it.").

cost.[35] The three trends described above are not exclusive, but they forecast a health finance system moving away from the managed competition vision of cohesive packages of coverage, with a sharp eye toward cost and quality. Instead, and in reaction to the failing of the managed care visions, health finance is drifting toward moderate decentralization with a dose of lay decision-making superimposed on a skeleton of managed care. This is not a pretty public policy picture.

The decentralization and increase in choice evident in the evolution of managed care carry with them the concomitant of segmentation of the covered population. To afford insureds more choice, plan sponsors are slicing and dicing plans by richness of coverage, depth of out-of-pocket payment and expansiveness of provider participation. This segmentation inevitably separates the fates of people in society on various bases, including wealth, age, employment status and geography. This fragmentation of insurance pools is contrary to what is most salutary about health insurance – its fundamental communal purpose. At its heart, health insurance joins us together, creating a mechanism by which we can each contribute to a fund reserved for the needs of those who come to need expensive medical care.[36] Deborah Stone captured this concept elegantly in a recent essay:

> Insurance is a social institution that particularly invites moral contemplation about questions of suffering, compassion, and responsibility. In so doing, it enlarges the public conception of social responsibility. Insurance serves as an arena for this kind of reflection and deliberation because it is kept in the public consciousness by the private marketing activities of commercial insurers, the bargaining activities of unions and workplaces, and the public debates over social insurance. The basic premise of insurance is collective responsibility for harms that befall individuals, because insurance pools people's savings to pay for individuals' future losses. Thus, whenever insurance is discussed, questions of allocating responsibility between individuals and society are barely beneath the surface.[37]

As plan design tailors itself to the perceived insurance wishes of individuals, it seeks to advance the goals of choice and autonomy. However, it also does

35. *See* Ezekiel Emanuel, *Health Care Reform:* Still Possible, HASTINGS CENTER REP., Mar.-Apr. 2002, at 32, 33 ("Leaving health care decisions to each doctor's discretion has been undermined by quality and cost data. When everyone is talking about the importance of systems for delivering safe, high quality, and cost effective care, it is hard to imagine that we will dismantle the very delivery system capable of doing this. It is much more likely that a new form of managed care will arise.").

36. S*ee* John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 315-18 (1997).

37. Deborah A. Stone, *Beyond Moral Hazard: Insurance As Moral Opportunity*, 6 CONN. INS. L.J. 11, 16 (1999) (footnotes omitted).

something more fundamental. It impairs the discussion of social responsibility and weakens the connections among members of the community.

The trends in managed care have very concrete effects as well. First, the emphasis on consumer direction imposes on consumers the responsibility (which some may think they want) of choosing when and from whom to obtain treatment. Cost-conscious consumers are notoriously poor at differentiating between unneeded and therefore dispensable treatments and those necessary to preserve life and health. Cost-conscious consumers may reject some treatment, but there is no reason to believe consumers will choose well which treatment to reject. Second, increased consumer cost-sharing regressively finances expanded choice that may be an extravagance that the poor and near poor would prefer to avoid. "Forcing the poor to purchase comprehensive insurance while forgoing goods and services to which they attach higher value is not doing them any favor."[38]

Third, increased consumer cost-sharing will lead to reduced levels of insurance for the working poor, a population already heavily over-represented in ranks of the uninsured. Employers in a slowing economy will likely increase employees' share of insurance cost as a wage-conserving strategy.[39] However, past increases in employee cost-sharing have dramatically reduced the rate of "take-up" of insurance by low-income wage earners, as they simply decline the offer of insurance because they need the income for more immediate family expenses.[40]

Finally, the fragmentation of the health insurance system and the withdrawal of plan managers from evaluative positions impairs the ability of plans to serve as engines of quality improvement. It is now widely understood that medical error results in a large number of avoidable injuries,[41] and that preventing these errors is not a matter of eliminating "bad apples," but rather of improving systems of care to avoid the occasion of injury.[42] The decentralization of managed care impairs the movement toward systemic improvement of health care because a diffusion of responsibility and governance weakens control over the provision of services.[43]

38. Robinson, *supra* note 16, at W152.

39. Lee & Tollen, *supra* note 34, at W238.

40. *See* Richard Kronick & Todd Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, HEALTH AFF., Mar.-Apr. 1999, at 30, 36-37; Philip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, HEALTH AFF., Nov.-Dec. 1997, at 142, 146.

41. *See* INSTITUTE OF MEDICINE, TO ERR IS HUMAN, *supra* note 6, at 1.

42. *See id.* at 4; 2 AMERICAN LAW INSTITUTE, REPORTERS' STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, APPROACHES TO LEGAL AND INSTITUTIONAL CHANGE 124 (1991).

43. *See* Jacobi & Huberfeld, *supra* note 25, at 314.

Managed care is a wounded vehicle for achieving society's health finance goals—whether due to its own mismanagement, the attacks of others or a fundamental misunderstanding in the social compact that lead to its emergence as a dominant public policy tool. It will remain a dominant player, but will also evolve—probably in the direction of decentralization and increased consumer responsibility—if health finance continues to drift as it does now. For the reasons James Robinson, Henry Aaron and others have offered, recent history has demonstrated that managed care plans, even as modified in reaction to backlash, are not well suited to serve the goals of increasing access, containing cost and assuring quality, absent a non-market public policy intervention.[44] Several general points of guidance emerge from an examination of this recent history.

First, there is no going back to the unmanaged care that managed care replaced. The cost pressures generated by technological advances and an aging population are real, and leaving treatment decisions entirely to individual patients and physicians will not do.[45] Second, and following from the first point, cost pressures will produce scarcity, and choices must be made—not only to reject medically unnecessary care, but also to evaluate and select among medically useful treatments.[46] Third, the maldistribution of resources among social classes and the technical sophistication required for rationing choices suggest that rationing through individual purchasing decisions by consumers will not achieve equitable results, and that some management of care decisions will be necessary. Fourth, the strong preference of consumers for choice must be accommodated.

Where, then, does managed care fit in? Whatever the source of funding for health care, managed care plans can serve as tools for organizing care. The failure of the black box method of rationing, however, suggests that the process by which rationing occurs can no longer be committed to a deeply flawed market. Perhaps a cue can be taken from consumer-driven plans in at least one regard, that the tolerance of consumers for central management and demand for autonomy may differ depending on the type of health care service. Consumers can search for information or gain direct experience with respect to some health care services (for example, the skills of a physical therapist, the personality of a primary care physician or the quality of orthodontic

44. In addition, and although it is beyond the scope of this brief comment, Russell Korobkin has persuasively described the "bounded rationality" of health care consumers, and therefore the limitations on the extent to which providing additional information or other correctives to health care market failures could correct for the inefficiencies identified by Aaron. *See* Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 48-62 (1999).

45. *See* Emanuel, *supra* note 35, at 33.

46. *See id.*

services).[47] Other services, including most acute care services, are simply beyond the layperson's ability to evaluate.[48] Consumer-driven plans loosely match their financing methods to this market reality—primary and preventive care can be thought of as within the ambit of consumer-directed spending accounts, and the acute care is within the ambit of managed insurance coverage.

Chronic care is more problematic. Care for chronic illness includes aspects of primary and acute care, and accounts for a large and growing percentage of health expenditures. Managed care plans seem ideally suited to the coordination of care for the chronically ill. Plans could guide a chronically ill member to the most appropriate level of care, create and facilitate a comprehensive care plan, and ensure communication among the broad range of providers responsible for the member's direct care. Unfortunately, managed care plans have promised more than they have delivered here, although some plan sponsors finally seem interested in developing their potential.

The managed care backlash does not negate the need to restrain spending; indeed, it seems inevitable that restrictions in care will be more necessary in the future. However, the backlash suggests that black box management has failed and that some combination of public and consumer management of the distribution of health care resources must come to the fore. Most significantly, rationing decisions will not be committed as easily to commercial firms operating in a deeply flawed market, but must be made in a public process of some sort.[49] Managed care's role within a new system could be borrowed from consumer-directed plans, and the financing or management or both of care could be literally or virtually segmented to treat the separate rationing concerns associated with acute, primary and chronic care. This segmentation may paradoxically assist in melding the public governance and individual choice imperatives, employing a model of organizational structure emerging from managed care plans.

47. Korobkin, *supra* note 44, at 27-28 (describing "search," "experience," and "credence" goods).

48. *Id.* at 28.

49. On a different aspect of managed care regulation, Korobkin makes the case that an expert governmental commission might possess the correct blend of independence and accountability to handle such a delicate task. *Id.* at 83-85.