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HOW NOT TO THINK ABOUT “MANAGED CARE”

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The claim of this Article is that the concept of “managed care,” like many concepts now prominent in commentary about medical care finance and delivery in the United States, is incoherent and thus a barrier to useful analysis. To demonstrate this conclusion, we first discuss the managerial context in which managed care claims have arisen and outline the diverse trends to which the category is regularly and confusingly applied. We then suggest an alternative approach to characterizing recent changes in medical care and show how this approach alters and deepens our understanding of recent economic and political developments. We conclude by arguing for more neutral categories to make sense of past and projected developments in methods of reimbursement, techniques of management, and organizational structures.

INTRODUCTION

The state of American health insurance has been a leading topic on the national policy agenda for much of the past decade. In the early 1990s, the political debate focused on two contentious goals: the expansion of health insurance and the control of medical costs.¹ Toward the beginning of the decade, the critical question for health policy analysts—and the nation—was whether President Clinton’s ambitious proposal for universal coverage through

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1. See, e.g., Erik Eckholm, *Introduction to THE WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT’S HEALTH SECURITY PLAN*, at v (1993) (asserting that President Clinton took office determined to solve two related crises in health care: the first being “the growing number of Americans who lacked the basic security of health insurance,” and the second, “the spiral in health spending that threatened to bankrupt the government and cripple American industry”).

“managed competition” would be enacted.² As the decade wore on without much progress toward universal coverage, the debate turned to the quality of health insurance for those who have it.³ The rhetorical centerpiece shifted from “managed competition” to “managed care,” a blanket expression denoting a mix of changes in private insurance that many Americans appear to view with anxiety and even hostility.⁴ The new critical question that came to preoccupy health policy analysts was how to make sense of the “managed care revolution” and its future prospects.⁵

The premise of our argument is that this question cannot be answered as currently formulated. The very term “managed care”—much like that ubiquitous reform phrase of the early 1990s, “managed competition”⁶—is a confused assemblage of sloganeering,

2. See generally JACOB S. HACKER, *THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY* (1997).

3. See, e.g., Mark R. Chassin, *Quality of Health Care* (pt. 3), 335 *NEW ENG. J. MED.* 1060, 1060 (1996) (stating that in the 1960s, improving quality was discussed in terms of increasing access to care for certain populations, while in the 1990s, quality seems to mean marketplace competition and “report cards” on health plans); see also Steven A. Schroeder, *The Medically Uninsured—Will They Always Be With Us?*, 334 *NEW ENG. J. MED.* 1130, 1130 (1996) (lamenting that the issue of expanded medical insurance coverage “erupts onto the national scene” only periodically, such as in 1993, and then disappears “back underground”).

4. See, e.g., Robert J. Blendon et al., *Understanding the Managed Care Backlash*, *HEALTH AFF.*, July–Aug. 1998, at 80, 90–91 (reporting on survey findings that Americans who were satisfied with their current health plan were still fearful that their managed care plans would not provide care or pay for care in the future when they got sick); Jerome P. Kassirer, *Managing Managed Care's Tarnished Image*, 337 *NEW ENG. J. MED.* 338, 338–39 (1997) (criticizing the superficial public relations efforts by the American Association of Health Plans to improve the public's opinion of “managed care” and suggesting that there is good reason for the American public to be critical of managed care).

5. See, e.g., Harry P. Cain II, *Privatizing Medicare: A Battle of Values*, in *MEDICARE AND MANAGED CARE: A PRIMER FROM HEALTH AFFAIRS AND THE CALIFORNIA HEALTHCARE FOUNDATION* 41, 42 (John K. Iglehart ed., 1999) (arguing that “[m]ost of us would agree that a full-scale revolution is under way”); Kenneth E. Thorpe, *The Health System in Transition: Care, Cost, and Coverage*, 22 *J. HEALTH POL. POL'Y & L.* 339, 339 (1997) (noting that the growth in market-based contracting and the “ascendancy of managed care” have generated substantial change in American medical care, and arguing that “[u]nanswered in the managed care revolution is the means for financing care for the 41 million uninsured Americans”).

6. “Managed Competition” is a phrase originally coined by economist Alain Enthoven in the early 1980s, which was then expounded as a theory and debated in the academic literature over the next decade. See generally Alain C. Enthoven, *The History and Principles of Managed Competition*, *HEALTH AFF.*, Supp. 1993, at 24. The term came to be used in such a variety of ways over the years, however, that in this 1993 article, Enthoven not only retraced the development of his ideas but also explained in some detail what managed competition was “not,” stating that “[m]anaged competition is not just the latest buzzword that anybody should feel free to appropriate. . . . Managed competition is not just a grab bag of ideas that sound good. It is an integrated framework that combines rational principles of microeconomics with careful observation and analysis of what works.” *Id.* at 45. In spite of Enthoven's efforts to reclaim the phrase “managed competition,” however, the term still suffers from

aspirational rhetoric, and business school jargon that sadly reflects the general state of discourse about American medical institutions. Because "managed care" is an incoherent subject, most claims about it will suffer from incoherence as well. Moreover, to incorporate "managed care" and other similar marketing terms into health policy research is to presuppose answers to some of the most crucial questions about the recent evolution of medical care in the United States.

Our reflections on this topic fall under four headings. Part I briefly discusses the context from which contemporary marketing slogans about medical care have emerged. Part II turns to analysis of the term "managed care" in particular and illustrates the quite diverse trends to which the category is regularly and confusingly applied. In attempting to clarify the different developments in health insurance that "managed care" seems intended to capture, we suggest in Part III what we hope is a constructive route for further discussion of the topic. Part IV completes the circle by returning to the original topic of the politics of health insurance and posing some final questions in light of our discussion of the language of medical insurance and management. Our overarching argument is that analysts should shun industry-promoted slogans and instead develop more precise and neutral conceptual tools with which to evaluate changes in modern medicine's reimbursement methods, managerial techniques, and organizational forms. Not only do we think that analytic discussions would be improved by greater clarity of this sort, but we also believe that any policy response to recent developments would also benefit from a more precise examination of the specific changes in American health insurance that have fostered public concern and professional resistance.

I. MEDICAL CARE AND THE RISE OF CORPORATE-SPEAK

The discussion of many of the major topics in modern medical care is marked by fads, sloppiness, and confusion. Marketing hyperbole and managerial jargon, rather than careful consideration

multiple warring definitions and inherent contradictions. See THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 170-72 (1994).

of alternative claims, dominate contemporary reflections on the management, cost, quality, and organization of medical care.⁷

Management commentary resembles a perpetual motion machine more than a stable source of carefully considered ideas. The popular innovations of one period give way to the enthusiasms of the next with hardly a pause. Each managerial fad is launched with high hopes and inflated rhetoric and then abandoned, while many of the promoters escape criticism for their hyperbolic marketing. Cycles of enthusiasm are regularly followed by declarations of failure, and both allow fortunes to be made out of the selling of the managerial equivalent of snake oil.

Health policy audiences will be familiar with some of the shifting fashions in general managerial commentary over the past two decades. In the 1970s, Management by Objective (MBO) and Zero Based Budgeting (ZBO) were the rage in corporate boardrooms, non-profit offices, and government bureaus.⁸ In recent years, corporate-speak has shifted to expressions like Total Quality Management (TQM), Integrated Delivery Systems (IDS), and, in the case of this symposium's focus, "managed care."⁹

In the 1970s, big was regarded as better. Politicians as well as managers embraced larger scale operations. Good managers were those who horizontally and vertically integrated firms, bureaus, and organizations into ever larger conglomerations of functions and product lines. The emphasis was on synergy, economies of scale, coordination, and the unification of functions.¹⁰ Then, within a few years, one was encouraged to think that small was beautiful. Divestiture, devolution, decentralization, and specialization—these became the watch words of managerial correctness, both public and private.¹¹

Indeed, the sheer number of internal management models has increased considerably over the past two decades, from simple hierarchies with a strict division of labor to cooperative teams.¹² The favored models among managers and employees have ranged from

7. These arguments have been made elsewhere. See Theodore R. Marmor, *Forecasting American Health Care: How We Got Here and Where We Might Be Going*, 23 J. HEALTH POL. POL'Y & L. 551, 562–64 (1998). A fuller statement of this critique can be found in Theodore R. Marmor, *Hope and Hyperbole: The Rhetoric and Reality of Managerial Reform in Health Care*, 3 J. HEALTH SERV. RES. & POL'Y 62 (1998) [hereinafter Marmor, *Hope and Hyperbole*].

8. See Marmor, *Hope and Hyperbole*, *supra* note 7, at 62–63.

9. See *id.* at 63.

10. See *id.*

11. See *id.*

12. See generally ANDRZEJ A. HUCZYNSKI, *MANAGEMENT GURUS: WHAT MAKES THEM AND HOW TO BECOME ONE* 11–58 (1996) (discussing various management models that have emerged in the twentieth century).

those emphasizing adversarial combat to those featuring bonding mechanisms.¹³ From within these broader notions of organizational design emerged a dizzying array of techniques—from “just in time” inventory management to statistical quality assurance.¹⁴ In contemporary discussions of quality in medical care, the much heralded technical panaceas are “outcomes measurement,” “integrated delivery systems,” and “evidence-based medicine.”¹⁵

Expressions like “managed care,” “integrated delivery systems,” and “evidence-based medicine” are in some respects all slogans—persuasively defined terms that imply success by their very use. We do not, for example, routinely speak of “unmanaged care,” “disintegrated delivery systems,” or “non-evidence based medicine.” The relative absence of such categories suggests that the purpose of terms like “managed care” is less to clarify than to convince, less to illuminate what an organization is or does than to bolster empirical claims and normative connotations that are neither self-evident nor, in most cases, subject to critical scrutiny.

Of course, the claims and connotations are not always positive. With the emergence of a backlash against recent developments in private health insurance, “managed care” has in many quarters mutated from a term of approval into one of opprobrium.¹⁶ The danger to coherent thought, however, is the same in either case. The categories we use to understand and explain organizational change should not prejudge its desirability, nor should they reflect uncritically the aspirations or allegations of its critics or defenders. Such categories should tell us about the structure, behavior, and evolution of an organization, not whether it is good or bad, successful or unsuccessful, benevolent or sinister. Precisely because much of the language used to describe American medical care today is meant to persuade rather than explain, even thoughtful observers often end up endorsing claims whose validity they should be assessing.¹⁷

13. See *id.*

14. See Marmor, *Hope and Hyperbole*, *supra* note 7, at 63.

15. *Id.*

16. See generally GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAK-DOWN OF MEDICAL TRUST* (1996) (detailing problems with health care that have arisen from managed care plans); MICHAEL E. MAKOVER, *MISMANAGED CARE: HOW CORPORATE MEDICINE JEOPARDIZES YOUR HEALTH* (1998) (providing extensive criticism of managed care); Robert Kuttner, *Must Good HMOs Go Bad?* (pts. 1 & 2), 338 *NEW ENG. J. MED.* 1558, 1635 (1998).

17. Consider, for example, a recent article written by René Bowser and Lawrence O. Gostin entitled *Managed Care and the Health of a Nation*, 72 *S. CAL. L. REV.* 1209 (1999). The authors state, for example, that there is a “trend toward managed care.” *Id.* at 1212. Managed care is analogized with capitation, a payment method by which medical providers are

II. MANAGED CARE: FURTHER DISCUSSION, ADDITIONAL CONFUSION

By adopting the marketing jargon of corporate medical care, analysts risk adding credence to the claims and associations that come with it. Yet there is an additional, and in many ways more serious, risk posed by unreflective reliance on persuasive definitions like “managed care”: that analysts will fail to understand the very organizational developments they seek to explain. For contemporary medical jargon not only embodies questionable claims; it also prevents us from identifying or understanding what is distinctive about recent organizational changes. Nothing illustrates this better than the ubiquitous term “managed care.”

The expression “managed care” came into widespread use only in the past decade.¹⁸ A revealing sign of its ascendance was the decision of the American Medical Care and Review Association, an insurance industry group founded in 1971, to rename itself the American Managed Care and Review Association in 1989.¹⁹ The term “managed care” does not appear once in Paul Starr’s exhaustive 1982 history of American medical care, *The Social Transformation of American Medicine*,²⁰ nor can it be found in other books on American health policy written before the early 1980s, including Lawrence Brown’s classic 1983 work on the Health Maintenance Organization Act of 1973.²¹ As recently as 1989, in fact, newspapers were publishing stories that introduced and explained the new development called “managed care.”²² In the *New York Times*, the phrase first appeared in 1985, but it surfaced in only a handful of articles during

paid a fixed amount to treat an individual patient regardless of the volume of services delivered. *See id.* at 1221. This payment method, the authors argue, creates incentives for plans to promote behavior that reduces health risks and to emphasize preventive services, two favorite industry claims. *See id.* at 1212–13. Thus the trend toward managed care should improve the “health of the nation.” *Id.* at 1294. Surely all these are common assertions made by proponents of prepaid capitated health plans. Surely, too, if every step of this familiar syllogism were true, the final claim might well be true. The point is that we do not know if the steps of the argument are true. Gostin and Bowser simply assume that they are.

18. *See infra* text accompanying notes 19–23.

19. The Association later merged with the Group Health Association of America to form the American Association of Health Plans. *See* American Association of Health Plans, *New Association Announces Name and Philosophy of Care* (visited Sept. 1, 1999) <<http://www.aahp.org/services/communications/media/1996/name.htm>> (on file with the *University of Michigan Journal of Law Reform*).

20. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

21. *See* LAWRENCE D. BROWN, *POLITICS AND HEALTH CARE ORGANIZATION: HMOs AS FEDERAL POLICY* (1983).

22. *See* Victor Cohn, *Someone Besides You and the Doctor May Be Deciding How You Get Treated: Welcome to Managed Care*, WASH. POST, Nov. 21, 1989, at Z12.

the late 1980s. In the 1990s, however, articles mentioning the phrase exploded, increasing from twenty-seven in 1990 to 287 in 1994 and 597 in 1998.²³ Because "managed care" has become such a commonly used and widely recognized expression, it is difficult to recognize just how recently it entered the mainstream of American discourse.

From the beginning, "managed care" was a category with a strong ideological edge, employed to imply competence, concern, and, above all, control over a dangerously unfettered health insurance structure. "Managed care," as the executive vice president of the American Managed Care and Review Association stated in 1989, was an alternative "to the unbridled fee-for-service non-system" that sent "blank checks to hospitals, doctors, dentists, etc." and led to "referrals of dubious necessity" and "unmanaged and uncoordinated care . . . of poor or dubious quality."²⁴ As these words indicate, managed care was portrayed less as a means to control patient behavior than as a way to bring doctors and hospitals in line with perceived economic realities. Moreover, managed care promised not only cost-control but also coordination and cooperation, not only better management but also better care.²⁵ By imposing managerial authority on an anarchic "non-system," managed care would simultaneously restrain costs and rationalize an allegedly archaic structure of medical care finance and delivery.

What exactly constitutes "managed care," however, has never been made clear, even by its strongest proponents.²⁶ To some, the crucial distinguishing feature is a shift in financing from indemnity-style fee-for-service, in which the insurer is little more than a bill-payer, to capitated payment, in which medical providers are

23. Results are based on a search using the keywords "managed care" in LEXIS, News Library, NY Times File.

24. Cohn, *supra* note 22, at Z12.

25. See, e.g., Karen Ignagni, *Covering a Breaking Revolution: The Media and Managed Care*, HEALTH AFF., Jan.-Feb. 1998, at 26, 27 (describing managed care as a "system of care whose goal is to offer superior coverage, state-of-the-art care, unprecedented accountability, and an unparalleled commitment to continuous quality improvement—all at an affordable cost").

26. See, e.g., ELLEN FREUDENHEIM, HEALTHSPEAK: A COMPLETE DICTIONARY OF AMERICA'S HEALTH CARE SYSTEM 155 (1996) (defining managed care as "a comprehensive approach to health care delivery that encompasses planning and coordination of care, patient and provider education, monitoring of care quality, and cost control"); JOSEPH C. RHEA ET AL., THE FACTS ON FILE DICTIONARY OF HEALTH CARE MANAGEMENT 376-77 (1988) (defining managed care as "health insurance plans that reduce unnecessary health care costs by way of increased beneficiary cost sharing, controls on inpatient admissions and lengths of stay, the establishment of cost-sharing incentives for outpatient surgery, selective contracting with health care providers, and the direct management of high-cost health care cases"); STEDMAN'S MEDICAL DICTIONARY 283 (26th ed. 1995) (defining managed care as "an arrangement whereby a third-party payer . . . mediates between physicians and patients, negotiating fees for service and overseeing the types of treatment given").

paid a fixed amount to treat an individual patient regardless of the volume of services delivered.²⁷ However, there is nothing intrinsic in fee-for-service payment that requires open-ended reimbursement or passive insurance behavior.²⁸ Conversely, many, if not most, health insurance plans labeled “managed care” do not rely primarily on capitation.²⁹ To other proponents, the distinctive characteristic is the creation of administrative protocols for reviewing and sometimes denying care demanded by patients or medical professionals.³⁰ Such micro-level managerial controls are likewise not universal among so-called managed care health plans.³¹ In fact, such controls may be obviated by particular payment methods, like capitation or regulated fee-for-service reimbursement, that create more diffuse constraints on medical practice. Finally, to some, what distinguishes managed care is its reliance on “integrated” networks of health professionals from which patients are required to obtain care.³² Yet some self-styled managed care plans have no such networks, and what is called a network by many plans is little more than a list of providers willing to accept discounted fee-for-service

27. See, e.g., Michael A. Morrisey, *Introduction to MANAGED CARE AND CHANGING HEALTH CARE MARKETS* 1, 3 (Michael A. Morrisey ed., 1998) (“The term [managed care] has taken on a variety of meanings. To some it means capitation; providers are paid a fixed amount per subscriber for all or some well-defined component of their care.”).

28. “Fee-for-service” is a system of reimbursement in which a medical provider charges a patient (or third-party payer) a specific price for a specific service. See MARMOR, *supra* note 6, at 260.

29. See Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, in *CONTEMPORARY MANAGED CARE: READINGS IN STRUCTURE, OPERATIONS, AND PUBLIC POLICY* 101, 108 (Marsha R. Gold ed., 1998) [hereinafter *CONTEMPORARY MANAGED CARE*]. This study, which examined 108 health maintenance organizations and preferred provider organizations, found that capitation was the predominant method of payment for primary care physicians in only 37% of plans and the predominant method of payment for specialists in just 18% of plans. See *id.*; see also Richard Haugh, *Son of Capitation*, *HOSP. & HEALTH NETWORKS*, Jan., 1999, at 38 (pointing out that “[o]nly about 5 percent of hospitals are paid capitated rates. . . . About a third [of doctors] have capitated contracts . . . and they account for less than a quarter of doctors’ revenue”). For a definition of “capitation,” see *supra* text accompanying note 27.

30. See, e.g., Mark J. Schlesinger et al., *Medical Professionalism Under Managed Care: The Pros and Cons of Utilization Review*, *HEALTH AFF.*, Jan.-Feb. 1997, at 106, 109 (“[T]hird-party authorization of medical decisions perhaps most clearly embodies what many physicians fear about managed care: its intrusiveness into clinical settings and its potential for inappropriately standardizing treatment practices.”).

31. See *id.* at 113.

32. See *INSTITUTE OF MEDICINE, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK* 339 (Marilyn J. Field & Harold T. Shapiro eds., 1993) (defining managed care as a term used “more narrowly to identify group or network based health plans that have explicit criteria for selecting providers and financial incentives for members to use network providers”); see also Morrisey, *supra* note 27, at 3; Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 *J. HEALTH POL. POL’Y & L.* 75, 89 (1993).

payments—hardly the dense coordination and integration that industry insiders routinely celebrate.³³

Perhaps the most defensible interpretation of "managed care" is that it represents a fusion of two functions that once were regarded as largely separate: the financing of medical care and the delivery of medical services.³⁴ This interpretation, at least, provides a reasonably accurate description of the most familiar organizational entity that marched under the managed care banner until the late 1980s: the health maintenance organization (HMO), a successor to the pre-paid group practice plans that began in the 1930s.³⁵ When the vast majority of American health insurers used fee-for-service payment and placed few restrictions on patient or provider discretion, it was at least possible to identify a small subset of renegade health plans that existed outside this insurance mainstream, however poorly the expression "managed care" described the organization of such plans or what they did.

Today, however, that is no longer the case. In 1997, according to estimates of the Health Insurance Association of America, only two percent of private health plans conformed to the traditional model of fee-for-service indemnity insurance.³⁶ Another sixteen percent used fee-for-service payment but employed some form of utilization review.³⁷ Thus, between eighty and ninety-eight percent of today's

33. According to the Health Insurance Association of America, preferred provider organizations (PPOs) made up roughly half of all health insurance plans in the United States in 1995, up from 28% in 1992. See HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 59 tbl.3.1 (1998). By the Association's definition, "PPOs contract with networks of providers to offer medical services according to a negotiated, discounted, fee schedule." *Id.* at 52.

34. See, e.g., Peter D. Jacobson, *Legal Challenges to Managed Care Cost Containment Programs: An Initial Assessment*, HEALTH AFF., July-Aug. 1999, at 69, 72 (pointing out that health insurance litigation under managed care differs from traditional health insurance litigation because "with the integration of financing and care delivery under managed care, refusing coverage means denying care altogether"); see also James C. Robinson, *The Future of Managed Care Organization*, HEALTH AFF., Mar.-Apr. 1999, at 7 ("For the past fifteen years the words 'managed care' have been the shorthand label for a wide variety of health plans that . . . have combined the functions of delivering and financing medical care.").

35. See STARR, *supra* note 20, at 320-27 (describing the growth of prepaid group practice after 1945). Traditional HMOs such as Kaiser-Permanente of California and the Group Health Cooperative of Puget Sound employed their own salaried doctors, operated their own medical facilities, and charged subscribers a fixed fee per month regardless of the volume of services delivered. Not only did they operate quite differently from most other insurers, they were not run by conventional insurance companies. See *id.* Most "managed care" plans today, however, are operated by insurers such as Blue Cross/Blue Shield; and very few are "staff-model" plans like Kaiser-Permanente and Group Health Cooperative. Only 15 "staff-model" plans existed in 1997. See AMERICAN ASSOCIATION OF HEALTH PLANS, MANAGED CARE FACTS 2 (1998).

36. See HEALTH INSURANCE ASSOCIATION OF AMERICA, *supra* note 33, at 58 fig.3.7.

37. See *id.*

private health insurers appear to fall into the broad category of managed care. “Managed care” therefore does not offer any guidance as to how to distinguish among the vast majority of contemporary health plans.³⁸

The standard response to this problem has been to subdivide the managed care universe into a collage of competing acronyms, most coined by industry executives and marketers: HMOs, Preferred Provider Organizations (PPOs), and Exclusive Provider Organizations (EPOs), to name a few.³⁹ This is the approach taken by Jonathan Weiner and Gregory de Lissovoy in their frequently cited 1993 article, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*.⁴⁰

According to Weiner and de Lissovoy, “[w]hat usually distinguishes . . . managed care plans from [plans] that are more traditional is that there is a party that takes responsibility for integrating and coordinating the financing and delivery of services across what previously were fragmented provider and payer entities.”⁴¹ They proceed by dividing managed care into five mutually exclusive types of plans: fee-for-service plans with utilization review (what they call “managed indemnity plans” or MIPs), PPOs, EPOs, open-ended HMOs (O/HMOs), and regular HMOs.⁴² Weiner and de Lissovoy propose a fairly complicated scheme for distinguishing among these five plan types (reproduced in Table 1).⁴³ A closer examination of their scheme indicates, however, that there are actually just two crucial distinguishing features: (1) whether plans require that patients see only certain specified medical providers (EPOs and regular HMOs do, MIPs do not, and PPOs and O/HMOs do but allow patients to receive care from providers out-

38. This is one reason why it makes little sense to claim, as does a 1997 *Health Affairs* article, that “[m]anaged care isn’t coming; it has arrived.” Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan.–Feb. 1997, at 125, 125. Perhaps it has, but one might reasonably ask what precisely “it” is or whether it makes sense to lump together recent developments in American health insurance within a single general category—especially because the article ignores any conceptual discussion of what is meant by the term “managed care” itself.

39. See, e.g., *Network-Based Health Plans Definitions* (visited Sept. 1, 1999) <http://www.aahp.org/services/consumer_information/definitions/definit.htm> (on file with the *University of Michigan Journal of Law Reform*) (containing definitions of Exclusive Provider Organizations (EPOs), Foundations for Medical Care (FMCs), Health Maintenance Organizations (HMOs) (which are further divided into Staff Model, Group Model, Network Model and Independent Practice Association (IPA)), Medicare Health Care Prepayment Plan (HCPP), Point-of-service (POS) options, preferred provider organization (PPO), Specialty HMOs, and Specialty PPOs).

40. Weiner & de Lissovoy, *supra* note 32.

41. *Id.* at 78.

42. See *id.* at 87.

43. See *id.*

side the network with a penalty), and (2) whether physicians bear financial risk.⁴⁴ Thus, as Table 1 shows, a MIP is a plan that uses utilization controls but does not have a network of providers. A PPO is a plan that has a network but allows patients to opt out of it for a price. An EPO is a PPO that does not allow opt-outs. An O/HMO is a network plan that allows opt-outs but, unlike a PPO, uses capitation. Finally, a regular HMO is a capitated network plan that does not allow opt-outs. With the exception of MIPs, Weiner and de Lissovoy dub all these plans "integrated delivery systems."⁴⁵

TABLE 1
WEINER AND DE LISSOVOY'S TAXONOMY FOR
CATEGORIZING HEALTH INSURANCE PLANS

Dimension	Type of Plan					
	FFS	MIP	PPO	EPO	O/HMO	HMO
Sponsor Assumes Financial Risk ^a	-/+	-/+	-/+	-/+	-	-
Intermediary Assumes Financial Risk ^a	+/-	+/-	+/-	+/-	+	+
Physicians Assume Financial Risk ^b	-	-	-	-	+	+
Restriction on Consumer's Selection of Provider ^c	-	-	+/-	+	+/-	+
Significant Utilization Controls Placed on Provider's Practice ^d	-	+	+	+	+	+
Plan Obligated to Arrange for Care Provision	-	-	+/-	+	+	+

44. They do only in HMOs, Weiner and de Lissovoy argue, because HMOs rely on capitation. *See id.* at 88.

45. *See id.* at 90.

Key—FFS: “traditional fee-for-service indemnity plan; MIP: managed indemnity plan; PPO: preferred provider organization; EPO: exclusive provider organization; O/HMO: open-ended health maintenance organization; HMO: health maintenance organization (including independent practice association).

– absent; + present

^a The left side of the slash reflects a plan where an employer purchases a full-premium benefit from the insurer. The right side reflects a self-insured (or minimally insured) private plan or a government plan where risk resides with the sponsor.

^b Primary care physicians at a minimum, but may also involve other providers.

^c In PPOs and O/HMOs, consumer’s choice is limited through incentives and disincentives rather than mandatory restrictions. They have the option to seek covered care from outside the plan. The right side of the slash reflects care when this “out-of-plan” option is exercised.

^d Usually defined as mandated “prior-authorization” for nonemergency hospitalization.

This taxonomy, if nothing else, conforms to popular usage. It introduces a new and more comprehensible plan moniker—open-ended HMOs—to substitute for the commonly used yet confusing label point-of-service plan (POS).⁴⁶ Otherwise, however, it merely offers extended definitions of the most common labels already used by industry actors and observers. Weiner and de Lissovoy deserve credit for trying to simplify the jumble of marketing slogans and acronyms that surround American health insurance, but the complicated scheme they come up with does not so much “raze a tower of Babel” as rehabilitate it.

To begin with, Weiner and de Lissovoy’s scheme actually tells us relatively little about each type of health plan. If a plan places financial risk on sponsors, it may be a MIP, PPO, EPO, or even a traditional fee-for-service plan.⁴⁷ If it puts intermediaries at financial risk, it may be *any* of the plan types.⁴⁸ If a plan is a “managed care” plan, we know that it places “significant utilization controls” on medical practice.⁴⁹ However, what these controls constitute (besides hospital precertification, which Weiner and de Lissovoy say is the threshold consideration) or how they might differ across

46. In a “point-of-service” health insurance plan, patients are financially rewarded for using a limited group of providers but are permitted to seek out-of-network care at higher cost. See MARMOR, *supra* note 6, at 265.

47. See Table 1, *supra* pp. 671–672.

48. See *id.*

49. See Weiner & de Lissovoy, *supra* note 32, at 89.

plan types (if they in fact do) is left unspecified.⁵⁰ We are told that if a plan has a network of providers, it is an "integrated delivery system,"⁵¹ but what integration means in this context is unclear, especially because it is a characteristic apparently shared by all but one of the managed care plan types.⁵² Why MIPs are not considered integrated medical systems is also unclear. After all, they are counted as managed care plans,⁵³ and, according to Weiner and de Lissovoy's definition, the essence of managed care is the "integration" and "coordination" of the financing and delivery of medical care.⁵⁴ Virtually the only clear criterion in this scheme is that if medical providers bear risk, then a plan is an HMO.⁵⁵

And yet, even this distinction is problematic. Many different types of health plans are experimenting with ways to shift risk onto medical providers through payment methods, withholding arrangements, and bonus schemes, as Weiner and de Lissovoy themselves note.⁵⁶ Virtually all health financing methods, even tax-financed national health insurance, place *some* risk on providers. The real distinctions are, first, how concentrated the risk is, and, second, whether it is immediate or long-term. Salaried doctors working for HMOs may face much less concentrated and immediate financial risks than those physicians who, despite arms-length relationships to health plans, face financial penalties if they provide too much or too costly care to individual patients. Over time, the salaried doctor's income will depend on the performance of the HMO, but his individual treatment decisions may be relatively unencumbered by financial concerns. Rather than classifying risk-bearing as present or absent, it is far more instructive to identify the locus of risk, which might range from all providers within a geographic area (as in a national health insurance scheme with a global budget) to a specific group of providers (such as an HMO's medical group) to an individual professional (as in many of the most recently developed incentive schemes).⁵⁷

The central problem with Weiner and de Lissovoy's taxonomy—and, indeed, with most contemporary commentary about health insurance—is the tendency to confuse reimbursement methods, managerial techniques, and organizational forms. For example,

50. *See id.* at 85, 89.

51. *Id.* at 89–90.

52. *See id.* at 90.

53. *See id.*

54. *See id.*

55. *See id.* at 88.

56. *See id.*

57. *See id.* at 88–89, 96.

fee-for-service, a payment method, is regularly contrasted with “managed care,” presumably an organizational form.⁵⁸ In Weiner and de Lissovey’s taxonomy, MIPs are distinguished from traditional fee-for-service plans by their reliance on a particular *managerial technique*, namely utilization review.⁵⁹ In contrast, PPOs and EPOs are distinguished from MIPs by their particular *organizational form*, namely their reliance on a network of participating providers.⁶⁰ And HMOs are distinguished from all these plans by their particular *payment method*, namely capitation.⁶¹

The practice of conflating organization, technique, and incentives leads to unnecessary confusion. It means that when we contrast health plans we are often comparing them across incommensurable dimensions. So, for instance, an HMO becomes by definition more “managed” than a fee-for-service plan with utilization review even when the latter uses much stricter controls on individual treatment decisions. By conflating distinct characteristics, we also are tempted to presume necessary relationships between particular features of health plans (such as their payment method) and specific outcomes that are claimed to follow from these features (such as the degree of integration of medical finance and delivery). Finally, the desire to describe an assortment of disparate plan features with a few broad labels encourages a wild goose chase of efforts to come up with black-and-white standards for identifying plan types. If a plan relies on capitation (a payment method), it is an HMO; if it has a network (an organizational form), it is an integrated medical system, and so on. As health plans employ increasingly diverse payment methods and organizational forms, the search for the “essence” of a particular plan will become all the more futile.

Another hallmark of the way we talk about health insurance today is the conspicuous failure to distinguish among the perspectives of different actors. The answers to such questions as whether a health plan is integrated or coordinated, whether it manages treatment decisions, and whether it imposes risk all depend crucially on whose perspective (patient, provider, or purchaser) we are assuming in making such assessments. A plan that appears “integrated” to outside observers, combining the delivery and financing of care in a seamless package, may rightly seem fragmented to patients who discover they have to endure

58. See *id.* at 76–80.

59. See Table 1, *supra* pp. 671–672.

60. See *id.*

61. See *id.*

complex authorization procedures and pick from a list of certified providers scattered across a region. To an employer, "management" of care may mean an administrator handling self-insured claims; to a doctor, it may signify outside control over medical decisions; and to a patient, it may denote restrictions on the providers and services covered by a plan. This is not to suggest, of course, that our judgments about health plans are entirely subjective, but rather to indicate that blanket terms like "management" or "coordination" are empty abstractions when used without specifying who is managing or coordinating what, for whom, and why.

Given the overlap among Weiner and de Lissovoy's categories and the lack of clear distinctions between them, it is hard to know what these plan types represent, except perhaps some elusive Platonic ideal never actually realized in practice. If these are simply abstract ideal types, however, then there seems no reason why they should conform to the messy categories that industry actors and their promoters employ. For these categories, as we have seen, manifestly fail to clarify the differences among plans. Instead, they identify a hodgepodge of features that are rarely exclusive to any one plan and vary nearly as much within plan types as across them. We think there is a better alternative.

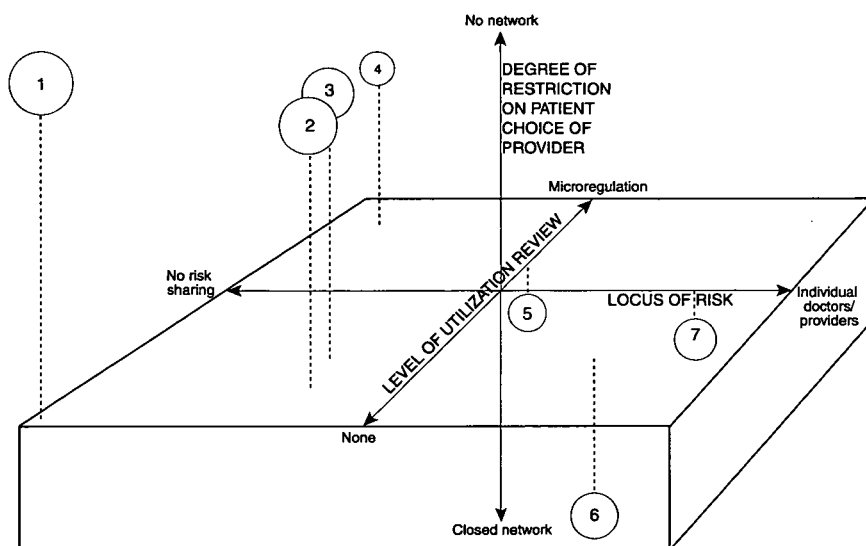
III. A REVISED CONCEPTION OF HEALTH INSURANCE ORGANIZATION

In understanding the structure of health insurance, the crucial relationship is between those who deliver medical care and those who pay for it. Even a passive indemnity insurer stands between the patient and the medical provider as a financial intermediary and an underwriter of risk. Today, with risk shifting from insurers to employers, and with financial intermediaries playing more of an administrative role than in the past, the trilateral relationship is more complex.⁶² Nonetheless, it still remains the locus of the insurance contract. To characterize this trilateral relationship, we focus on three of its essential features: first, the degree of risk-sharing between providers and the primary bearer of risk (whether an insurer or a self-insured employer); second, the degree to which administrative oversight constrains clinical decisions; and, third, the degree to which enrollees in a plan are required to receive

62. See Jacobson, *supra* note 34, at 71.

their care from a specified roster of providers. As Figure 1 shows, these three criteria create a three-dimensional space within which alternative health plans can be arrayed. We have placed a few illustrative descriptions of health plans in this space, as well as indicated where we think the federal Medicare program and most other nations' universal health programs should be located.

FIGURE ONE
THE THREE DIMENSIONS OF HEALTH PLAN ORGANIZATION



Key

1. Traditional Blue Cross/Blue Shield indemnity insurance
2. National health insurance in most other advanced industrial democracies
3. Medicare
4. Indemnity insurance with utilization review
5. Typical PPO
6. Staff-model HMO
7. Future direction of private health plans?

Note: The circles indicate the placement of the health plans. The dotted lines are included to aid in the location of the plans on the utilization review axis.

Our aim here is not to construct an exhaustive typology of health plans, if that were even possible given the rapid pace of change in American medical care. Rather, we wish to challenge the

common way of thinking about how to classify health plans. Our argument is that health plans differ across at least three principal dimensions: risk-sharing between plan and provider, managerial control of clinical decision-making, and limits on patient choice of medical professional. Each dimension crucially affects the trilateral connections among provider, patient, and plan. We also wish to emphasize that there is no simple relationship between plan label and the placement of a plan along these axes. Staff-model HMOs may seem like the quintessence of "managed care," yet because they place financial constraints at the group level they do not necessarily concentrate as much risk on physicians as do other network-based health plans, nor do they not necessarily entail as much clinical regulation at the micro-level. Microregulation may go hand in hand with restrictions on patient choice of provider, but it also may not. Indeed, management of individual clinical decisions and the creation of broad incentives for conservative practice patterns may very well be *alternative* mechanisms for lowering the cost of medical care. Finally, as recent developments in the health insurance market suggest, greater risk-sharing can co-exist with almost any set of arrangements. It does not require a closed network, much less strict utilization review. Risk sharing is a product of the payment methods and incentive structures that connect risk-bearing agents and medical providers. It does not exclusively occur in HMOs, nor does it require capitation.⁶³

Notice, too, that Figure 1 makes no mention of those popular buzzwords "integration" and "coordination." Movement toward a closed network, toward greater utilization control, or toward increased risk-sharing can create the conditions under which integration or coordination may occur.⁶⁴ They do not imply, however, that such integrative activities actually take place. Getting the right care to the right patient at the right time is a managerial accomplishment, not a product of labels.

Finally, the conventional fee-for-service versus capitation dichotomy does not remain a useful means of distinguishing among different health plans. Instead, the crucial issue is what incentives medical providers actually face. The particular mix of payment

63. For a general discussion of financial risk-sharing in health insurance, see Marsha R. Gold et al., *Behind the Curve: A Critical Assessment of How Little Is Known About Arrangements Between Managed Care Plans and Physicians*, in CONTEMPORARY MANAGED CARE, *supra* note 29, at 86–89.

64. See generally Robert H. Miller, *Health System Integration: A Means to an End*, HEALTH AFF., Summer 1996, at 92 (describing the variety of ways in which integration can occur in health care and concluding that the results of integration—positive or negative—depend upon the subsequent behavior of managers, physicians, and other actors).

methods that create those incentives is less important and will undoubtedly change as health plans experiment with new reimbursement modalities in the future.

Disaggregating health insurance into its constituent features not only helps to clarify what health plans do and how they are structured, but it also makes it easier to identify the specific trends in medical finance and delivery that are carelessly jumbled together when we speak of such grand events as the "managed care revolution."⁶⁵ Although we cannot provide a comprehensive empirical survey in this context, our reading of the evidence leads us to believe that the developments of the past decade have *not* pushed American health insurance in a consistent direction, much less toward any single organized entity that might be labeled "managed care."

Indeed, movement along these axes has been halting and inconsistent. Through roughly the late 1980s, an increasing number of health plans moved toward closed networks.⁶⁶ In the 1990s, by contrast, the trend has been toward intermediate levels of compulsion, with formerly closed plans offering opportunities for patients to opt out with a penalty and with new plans shying away from closed-network structures.⁶⁷ Utilization review was also fashionable during the 1980s,⁶⁸ yet it too has fallen somewhat into disfavor as plans have moved toward greater reliance on plan-provider risk-sharing, which in turn has become more focused at the level of the individual provider and individual service category over time.⁶⁹ If there

65. See Thorpe, *supra* note 5, at 339; see also Ignagni, *supra* note 25, at 27 ("A revolution is taking place in the organization and delivery of health care in the United States. Practically overnight, managed care has replaced fee-for-service as the nation's health care system of choice.").

66. HMO enrollment grew at an annual rate of more than 20% in the mid-1980s, but growth slowed to single digits in the late 1980s and early 1990s. See HEALTH INSURANCE ASSOCIATION OF AMERICA, *supra* note 33, at 51 fig.3.1.

67. Between 1993 and 1995, enrollment in fully closed plans grew by 22.8%, while enrollment in plans that allowed patients to exit the network for a price grew by 57%. See Jensen et al., *supra* note 38, at 127. Traditional HMOs increased their coverage at less than one-fifth the rate of HMOs that allowed patients to leave the network. See *id.*; see also Haugh, *supra* note 29, at 38 ("Open-access plans are growing much faster than traditional HMOs. . . . PPOs added 44 million members in the last five years, compared with the 30 million who joined HMOs. Even HMOs are adding point-of-service options. . ."); Ken Terry, *Hang On—The Ride's Going to Get Rougher*, MED. ECON., Apr. 12, 1999, at 176–78.

68. Conventional fee-for-service insurance without utilization review declined from 40% in 1987 to 5% in 1990. See HACKER, *supra* note 2, at 15.

69. See Stephen A. Magnus, *Physicians' Financial Incentives in Five Dimensions: A Conceptual Framework for HMO Managers*, HEALTH CARE MGMT. REV., Winter 1999, at 57–58 (arguing that "the growing popularity of financial incentives may indicate that they are becoming the method of choice for influencing physician behavior"); Andrew J. Sussman et al., *PHOs and Risk: Aligning Incentives with Internal Subcapitation*, HEALTHCARE FIN. MGMT., Aug. 1999, at 42, 42–46; *Statistical Notes—Capitation Contracts Continue to Grow Among Both*

has been any *general* movement in the past two decades—and surely there has been—it has been from the front-left-top portion of the figure toward the back-right-bottom portion. Even this development, however, has been neither consistent nor evenly paced. In fact, the clearest and most unmistakable trend has been in the direction of straightforward price-discounting, as plans have used their market clout to selectively contract with physicians willing to accept negotiated rates. This is an important development, but in both international and historical perspective, it is hardly as unprecedented as grand phrases like “the managed-care revolution” imply.

IV. THE POLITICS OF A CONTESTED CATEGORY

If recent trends in the organization of American medicine remain elusive, the political responses to these changes are in some ways fairly simple to describe. Driven in part by heart-wrenching stories about the denial of care to sick and dying patients, scores of states have enacted new health insurance regulations. Although the motives for these laws have varied, most seem to reflect generalized public fears about a perceived loss of control over medical decision-making, as well as the specific complaints of both medical professionals and patients about managerial and financial policies that are alleged to encourage providers to deliver inadequate or substandard care.⁷⁰

In response to these trends, scores of states have introduced new legislation to regulate health plans and protect “consumer rights.”⁷¹ Nearly all states have enacted at least one or two reforms, and many have implemented several different reform packages.⁷² These include protections for emergency room patients,⁷³ requirements

Physicians and Hospitals, HEALTH CARE STRATEGIC MGMT., May 1999, at 7 (stating that according to an annual survey, *Managed Care Indicator*, conducted by Evergreen Re, both U.S. hospitals and physicians are continuing to increase their numbers of capitated contracts, and the trend to use capitation is likely to continue in the coming years).

70. See Blendon et al., *supra* note 4, at 81.

71. See FAMILIES USA FOUNDATION, THE BEST FROM THE STATES II: THE TEXT OF KEY STATE HMO CONSUMER PROTECTION PROVISIONS *passim* (1998); FAMILIES USA FOUNDATION, HIT AND MISS: STATE MANAGED CARE LAWS *passim* (1998) [hereinafter FAMILIES USA FOUNDATION, HIT AND MISS]; GERALDINE DALLEK ET AL., CENTER FOR HEALTH CARE RIGHTS, CONSUMER PROTECTIONS IN STATE HMO LAWS *passim* (1995).

72. See FAMILIES USA FOUNDATION, HIT AND MISS, *supra* note 71, at 2.

73. See Diane E. Hoffmann, *Emergency Care and Managed Care—A Dangerous Combination*, 72 WASH. L. REV. 315, 368–80 (1997) (describing state legislative efforts to protect emergency room patients from problems caused by “managed care”).

of access to out-of-network providers,⁷⁴ granting of direct access to specialists for the seriously ill and to obstetricians and gynecologists for women,⁷⁵ the creation of independent appeals processes for those denied care,⁷⁶ the establishment of consumer assistance programs,⁷⁷ the banning of gag clauses and “inappropriate” financial incentives,⁷⁸ and, at the extreme, legislation permitting subscribers to sue health plans.⁷⁹ By June of 1998, the majority of states had passed more than one but fewer than five such protections.⁸⁰ Not surprisingly, the regulatory policies differ significantly from state to state (although some changes, like emergency room protections, are almost universal in states that have passed reforms).⁸¹ As of June 1998, South Dakota was the only state not to have passed any of these regulatory reforms.⁸² On the other hand, only Missouri and Texas had allowed enrollees to sue their health plans.⁸³

The ability of the states to regulate private health insurance is constrained, however, by the Employee Retirement Income Security Act of 1974,⁸⁴ which preempts most state regulations of self-insured health plans (those in which employers pay medical claims themselves) and also precludes lawsuits seeking punitive or compensatory damages against *all* employer-sponsored health plans. Only federal regulations will thus reach the roughly fifty-one million Americans covered by self-insured plans, and only federal laws can establish an expanded right to sue for the more than 124 million Americans covered by employment-based health plans. At the federal level, however, the debate over regulatory protections stalled during 1998. The Clinton impeachment struggle dominated Washington and distracted attention from health insurance reform. Moreover, Democrats and Republicans were far apart on the appropriate legislative responses to problems that many states had already addressed. In 1999, however, a faction of House Republicans that

74. See, e.g., COLO. REV. STAT. § 10-16-704(2) (1998).

75. See, e.g., ALA. CODE § 27-49-4 (Supp. 1997).

76. See, e.g., VT. STAT. ANN. tit. 8, § 4089f (Supp. 1998).

77. See, e.g., FLA. STAT. ch. 641.60(2) (1998).

78. See, e.g., KAN. STAT. ANN. § 40-4604 (Supp. 1998); R.I. GEN. LAWS § 23-17.13-3(B)(8) (Supp. 1998).

79. See, e.g., TEX. CIV. PRAC. & REM. CODE ANN. § 88.001-.003 (West Supp. 1999).

80. See FAMILIES USA FOUNDATION, HIT AND MISS, *supra* note 71, at 4.

81. See *id.* at 5-7.

82. See *id.* at 4.

83. See *id.* at 19 (“Only two states—Texas and Missouri—have passed laws exempting managed care corporations from their laws against suing corporations for malpractice. Only Texas, however, has taken the additional step of creating a cause of action so individuals can sue their health plans.”).

84. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified at 29 U.S.C. §§ 1001-1461 (1974)).

includes several Republican physicians endorsed a limited right to sue, paving the way for compromise legislation in the House.⁸⁵ Although the House proposal remains much broader than the narrowly passed counterpart bill in the Senate,⁸⁶ it is nonetheless striking that *any* legislation survived in the acrimonious partisan climate in Congress. This suggests the degree to which members of both parties interpret public dissatisfaction with contemporary health insurance developments as a potent political topic that Democrats in particular can use on the campaign trail.

Although the broad contours of that debate are clear, the underlying issues are not in our view deeply understood, even by defenders of particular legislative solutions. As political scientists, we wonder, for example, about the specific source of the pressure for federal reform. One recent article attempts to measure the depth of the managed care backlash.⁸⁷ Its conclusion is hardly startling: the backlash is real but not extremely deep, and dissatisfaction is with the medical system as a whole rather than with personal experiences with managed care health plans.⁸⁸ Many have argued that managed care regulations are being promulgated by doctors and nurses angry about challenges to their income and autonomy.⁸⁹ It is not clear, though, that there is much evidence for that claim at the national level. One wonders about how exactly "the backlash" emerged and how it has changed; about how reformers decided on specific strategies and how they got so many states to pass laws. The ground-level politics of the issue are simply not well understood.⁹⁰

Furthermore, as students of health policy, we have serious questions about the desirability and presumptions of some of the proposed regulations. Divergent tendencies appear to be at work.

85. See Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. (1999) (sponsored by Rep. Charlie Norwood, passed 275-151 (roll no. 490) on Oct. 7, 1999).

86. See Patients' Bill of Rights Plus Act of 1999, S. 1344, 106th Cong. (1999) (sponsored by Sen. Trent Lott, passed 53-47 (roll no. 210) on July 15, 1999). As of this writing (October 1999), it remains unclear what will emerge from the House-Senate conference and whether the legislation produced will pass both houses and be sent to President Clinton for his signature.

87. See generally Blendon et al., *supra* note 4.

88. See *id.* at 90.

89. See, e.g., E. Clarke Ross, *Regulating Managed Care: Interest Group Competition for Control and Behavioral Health Care*, 24 J. HEALTH POL. POL'Y & L. 599, 600-07 (1999).

90. There have, however, been some attempts to understand these issues. See, e.g., Eugene Declercq & Diana Simmes, *The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, 75 MILBANK Q. 175, 182-97 (1997) (analyzing the process by which the issue of early hospital discharge of mothers and new babies moved quickly onto the agenda of decision makers and resulted in new state laws).

One the one hand, between 1993 and 1998, many commentators celebrated the health insurance industry's apparent achievements in controlling costs.⁹¹ On the other, few seemed to like *how* the industry controlled costs.⁹² The two positions appear, if not to contradict one another, at least to call into serious question the sustainability of a lowered rate of medical inflation into the next century. Similarly, the push to regulate health plans appears at odds with the popular goal of increasing coverage. Almost every analyst acknowledges that new restrictions will increase costs, thus reducing rates of coverage.⁹³ The push for regulation does seem to be a distinctly American response—a juridical-regulatory style of policy intervention that brings in government through the back door and deals in the language of rights rather than in broader issues of social allocation.⁹⁴

Although aggressive regulation of private institutions is a recurrent strain in American politics, however, it runs sharply against the grain of recent national policy developments. After the failure of the Clinton health plan in 1994 and the subsequent election of a Republican Congress, congressional leaders sought to *ease* regulations on a wide range of industries, including the private medical sector. Along with maverick Democrats like Senator John Breaux, they also attempted to incorporate a greater role for private health insurance within Medicare, with the ultimate goal of replacing America's federal health insurance program for the aged with a system of competing private health plans.

The rise of "managed care regulation" as a leading political issue indicates that the unbridled enthusiasm for private cost-containment that motivated these efforts has waned considerably. At the same time, it highlights many of the unresolved contradictions inherent in recent public policy. Private health plans have perhaps never been more celebrated by American policymakers as the appropriate means for providing health coverage. Yet dissatisfaction with the specific practices of private health plans has probably never been greater either. Indeed, even as state and federal politicians have actively shifted beneficiaries of government health insurance programs into private health plans, they have

91. See, e.g., Morrisey, *supra* note 27, at 1.

92. See generally ANDERS, *supra* note 16.

93. See e.g., Congressional Budget Office, *Cost Estimate: S. 6, Patients' Bill of Rights Act of 1999* (last modified Apr. 23, 1999) <<http://www.cbo.gov>> (on file with the *University of Michigan Journal of Law Reform*).

94. See Robert A. Kagan, *Adversarial Legalism and American Government*, 10 J. POL'Y ANALYSIS & MGMT. 369, 369 (1991).

loudly criticized such plans for overriding patient and provider preferences or delivering substandard care.

Although policymakers have directed much of their regulatory ire at the broad (and hazily defined) target of "managed care," much of the legislative momentum thus far has been toward the passage of specific, piecemeal responses to particularly salient complaints. The regulatory reaction reflects undeniable dissatisfaction, to be sure, but this dissatisfaction seems to be with selected features of the changing health insurance market, not with a clearly understood world of "managed care." Indeed, what ultimately seems to underlie recent state and federal activity is a more fundamental tension in U.S. health policy, between a national health insurance strategy that relies heavily on nongovernmental institutions, on the one hand, and the understandable desire to alter the behavior of these putatively private institutions when they fail to meet public expectations, on the other.

CONCLUSION

We have argued that a striking feature of the discussion of American managed care is its linguistic confusion. Both political actors and medical commentators regularly trade in persuasive definitions and stylized facts, the truth or falsehood of which remain unproven. The use of the term "managed care" exemplifies this practice and illustrates how many unanswered questions it leaves. What are the essential features of managed care, if any? How does it differ from indemnity-style, fee-for-service health insurance? How does it differ from insurance plans that just rely on utilization review? Are plans we label "managed care" more different from traditional fee-for-service insurance than they are from one another? Simply put, a sensible discussion of managed care—much less a determination of the appropriate means by which to regulate it—requires that we know what is being discussed.

The starting point for improved discussion and analysis is the acknowledgment that many of the categories we are accustomed to employing are essentially slogans used for self-promotion by various actors in contemporary American medicine. In that respect, they are appropriate objects of study in their own right, but they are not analytical terms that can frame our investigations, at least not without considerable further specification.

Once we address specific features of health insurance, moreover, the category "managed care" itself becomes ambiguous. The

“managed care revolution” is really a set of related trends, few of which are accurately captured by the blanket term. When these trends are distinguished from one another, the evidence suggests that American health insurance has moved simultaneously in several different, perhaps even contradictory, directions in recent years and that many of the changes are longer standing than the rhetoric of managed care implies. This does not mean that the recent interest in regulating private health insurance is misguided or unfounded. It is only to emphasize that demands for regulation are motivated by a constellation of related but distinct changes in American health insurance that are not accurately described by the generalized expression “managed care.” To date, moreover, state and federal policymakers have largely advocated targeted and piecemeal regulatory measures designed to alter particular features of private health plans—features that are deemed undesirable quite apart from their association with the broader label of “managed care.”

The rapid changes taking place in American medical care impose a special burden on analysts to be precise about the criteria and considerations that underlie their empirical evaluations and, ultimately, their judgments and assessments. Labels and categories are indispensable, but they should be designed to elucidate the techniques, organizational forms, and incentives that characterize alternative health plans, rather than to confirm or deny the claims of industry friends or foes. The term “managed care” fails that test, and although we hardly expect our words to be heeded (especially since both of us have reluctantly used the term in our own writings), we think that it and other terms like it should be banished from the health care lexicon for good.