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WHO KILLED MANAGED CARE? A POLICY WHODUNIT

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INTRODUCTION

The Accusation

When I first heard the news that managed care was dead, I could hardly believe it. After all, I was enrolled in a managed care plan and had not received any notice that the form of my health care coverage had changed. Of somewhat greater concern, I was worried about what my future health care would be and how much it would cost.

After the initial shock faded, I decided I needed to explore a few questions. Most importantly, is managed care really dead? While I was aware that physicians, patients, and the media often reviled managed care, I had no idea it was in such dire trouble. If so, who or what killed managed care and what would replace it? As we will see, this question turned out to be the focus of my inquiry.

The Crime Scene

As crime scenes go, this one was eerily silent and devoid of direct clues. I looked around, but I was unable to find the body (the *corpus delecti*). In most crime scenes, there are grieving relatives and friends to console the survivors, but no one came to mourn managed care. Or, if there were mourners, they were certainly doing so in private.

Nonetheless, some circumstantial evidence of managed care's putative demise was not hard to see. The most obvious was the return of double-digit inflation in health care costs. One of managed care's greatest successes, restraining the growth of health care costs, was in jeopardy, along with managed care's long-term viability. Perhaps more ominously, managed care

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organizations ("MCOs") seemed to be retrenching on their most coveted cost containment programs, such as requiring preauthorization for expensive medical procedures, limiting direct access to plan specialists, and contracting only with physicians and physician groups meeting the plan's quality standards (known as selective contracting). Under considerable assault from managed care subscribers, the industry was forced to adopt point-of-service plans that relaxed some of the more stringent cost controls.

The assault, however, was not limited to patients. In fact, there has been a backlash from the public and much of the medical community against the perceived deficiencies in the managed care approach.[1] The signs of backlash were evident at the crime scene. But the problem was that there were too many participants to isolate anyone who might have led the backlash and committed the murder. Not just patients, but physicians, hospital administrators, judges, politicians, and the media were all complicit in the backlash. How to sort out each of their respective contributions promised to be a major problem of this investigation. Indeed, how did the managed care industry ever manage to engender such widespread hostility? Curiously, despite the forces arrayed against it, the perpetrators of the backlash have not been able to enact the one piece of legislation designed to address the perceived deficiencies: the patients' bill of rights. This bill would guarantee patient access to independent grievance processes and direct access to specialists. This failure should give one pause before declaring managed care's demise.

One final piece of evidence should be noted. Under cover of the managed care backlash, physicians and hospitals began to reassert their prerogatives. With the erosion of stringent cost controls, physicians gained greater leverage in clinical decisions. Likewise, hospital administrators pushed through payment increases that had been all but impossible during the few years that managed care was ascendant.

The absence of clues and witnesses made it difficult to identify the perpetrator and the motives. As I would soon learn, there were plenty of suspects with myriad motives for wishing managed care's demise. But at this point, both the perpetrator and the motive were neither identifiable nor obvious. Beyond that, it was not even clear how managed care died. What act killed it? Three possibilities occurred to me. First, that it was simply a death by natural causes. This made sense because the crime scene lacked any indicia of foul play. From that observation, a second possibility followed—that managed care died of self-inflicted wounds. Given my sense that managed care offered a good product that had not been implemented as well as it might have been, this seemed a strong possibility.

1. For a comprehensive discussion of the backlash, see the articles collected in 24 J. HEALTH POL. POL'Y & L. 653-1420 (1999).

Yet, I could not rule out a third, and perhaps more intriguing scenario—that managed care was murdered. At first, this seemed a bit far-fetched. As the behemoth of health care delivery since the mid-1990s, it would be difficult for any suspect to have the means to slay such a large enterprise. And even if the actor had the means, how could this be done so silently as to leave no overt clues? With all of the public and scholarly attention to managed care, patients' rights, and so forth, it seems preposterous to think that managed care could be killed so effectively without leaving a trace as to the killer's identity. And yet. . . .

The Suspects

It did not take long to conjure up a list of suspects who had no love for managed care and might even revel in its demise. But would they actually be so brazen as to commit or be complicit in murdering managed care?

Physicians and patients were the most obvious suspects. Each group had reason to kill managed care—physicians for loss of autonomy and patients for the perceived loss of access to needed services. But we cannot forget about politicians. Both state and federal legislators had their own reasons for controlling managed care. The judicial system would be at the top of some observers' lists of suspects. Since the judiciary was initially hostile to incursions on physician autonomy, several scholars argued that the courts would undermine managed care's cost containment initiatives.

A prime suspect could well be the media. From the managed care industry's perspective, the media irresponsibly portrayed a few horror stories as indicative of all managed care operations. In the industry's view, the media has ignored managed care's positive attributes of being a needed corrective to the excesses of the fee-for-service system.

Less obvious suspects included health insurers, employers, and hospitals. As we will see, each of these actors has mixed motives for killing managed care. Although health insurers might benefit from less competition, they need to worry that the carnage would spill over to them. Employers certainly want to see lower health care costs, but they also want to satisfy their employees. If employers receive too many complaints about managed care, their support for cost containment programs may quickly attenuate. Hospitals also have mixed motives. As contractors for managed care patients, hospitals have an interest in cooperating with the managed care industry. But as hospital revenues declined under pressure from MCOs, hospitals needed to fight back to maintain their economic viability.

Each of these suspects has reason to celebrate the end of managed care. Could any of them individually kill managed care? Probably not. More likely, perhaps they secretly colluded to destroy managed care. Even if there was no collusion, there may well have been support as each suspect attacked one piece

of managed care's operations. At a minimum, no one defended managed care against these attacks.

The Background

Anyone with even a passing interest in health care delivery learns immediately that the U.S. health care system is in trouble. Take, for example, the three main public policy concerns of costs, quality, and access. After a short period during the 1990s in which cost increases were limited, health care costs are once again escalating at double-digit rates. Despite ongoing efforts to improve overall quality of care, many observers complain that quality remains a problem. And the rising number of people without health insurance remains an intractable social problem.

From the rise of modern medicine to prominence after World War II until the early 1990s, health care delivery and health policy were largely dominated by physicians.[2] In the fee-for-service model, there was very little interference on physician autonomy from payers, hospital administrators, or patients. The costs of care mattered little to either patients or physicians. Except for the premium charge, the entire health care bill was paid by a third party insurer. No one in the system had an incentive to control costs.[3]

Managed care revolutionized health care delivery by combining the financing and medical (clinical) aspects into one package.[4] Instead of paying a fee for each service, the patient subscribes to a managed care plan for a monthly fee that covers and provides a defined set of benefits. For each visit or service, patients make an additional co-payment of $10 or $20. At the heart of managed care is the promise that a new approach could lower costs by imposing restraints on the amount of care provided without sacrificing quality of care. To do so, managed care initiated the widespread use of cost-containment practices designed to reduce the costs of health care by encouraging providers to limit medical treatment. These practices range from aggressive utilization management to capitated funding arrangements, limitations on choice of providers, limitations on benefits (for example, ten physical therapy visits), exclusive contracting arrangements, and other

2. For an excellent and thorough history, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

3. Economists term this "moral hazard." *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 290-91 (1982). Moral hazard is defined as changes in behavior as a result of insurance or other mechanism protecting individuals from the consequences of their actions. An example of a moral hazard is that some will drive recklessly if they think that safety devices, such as anti-lock brakes, will protect them.

4. This is a far more transformative departure than the shift from in-office physician care to hospitals as the locus of health care delivery because it changes all aspects of the health care enterprise. *See, e.g.*, Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

financial incentives such as bonuses and withholds. While these techniques are now also used by commercial insurers, managed care providers have been more aggressive in using them to reduce costs.

Many commentators believed that managed care would be the savior—the free market alternative to the governmental takeover by the Clinton Administration's proposed Health Security Act. With hindsight, it seems clear that the managed care concept, however sound, suffered from excessively high expectations that were impossible to meet. Those expectations were most manifest during the 1994 debate over the Clinton Administration's proposed Health Security Act. At the heart of the debate was the lack of consensus over whether health care should be left to the private sector to be run by marketplace rules, or should involve significant regulatory oversight. After the media creatively pilloried the Health Security Act as a governmental takeover of the health care system, the Act was resoundingly defeated.

In retrospect, it seems clear that in the 1994 policy debate, the country decided to religion market mechanisms to shape our health care delivery system as opposed to relying on government to redress the perceived deficiencies of the health care system. For a time, the market indeed achieved what competitive markets are best at doing, relentlessly reducing the cost excesses of the old health care order. But reliance on the market had other consequences the public found troublesome, and managed care was declared dead.[5] Whether dead or merely dying (reports of its death may well be premature), a crime (murder or at least attempted murder) was committed that I am determined to solve. Keep in mind that, even if managed care disappears tomorrow, the health policy dilemma will remain what it was at the start of the managed care era: how to contain the high cost of health care without unduly limiting individual access to needed health care services.

THE SUSPECTS: MOTIVE AND OPPORTUNITY

This story has numerous suspects, but no heroes. Even the sleuths, the academic community (and other health policy observers), have not always clarified the complex developments that seem overwhelming to most patients. Nonetheless, the job of explaining who killed managed care is well-suited to the academic community. Before determining who killed managed care, I analyzed each suspect's motives and opportunities for wanting to see managed care eliminated. As we will see, finding many suspects with both motive and opportunity was relatively easy. Eliminating suspects and finding the true culprit proved much more difficult.

5. James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2623 (2001); Katherine Swartz, *The Death of Managed Care as We Know It*, 24 J. HEALTH POL. POL'Y & L. 1201, 1202 (1999). This claim is ahead of itself. There are still several large MCOs, including Kaiser-Permanence, United Healthcare, Aetna, etc. Smaller plans may be more vulnerable.

Physicians

The logical starting place among the numerous suspects for the investigation is with physicians. Historically, physicians have dominated, defined, and shaped health care delivery. But what exactly is their relationship to the victim? What would they gain from the demise of managed care? What, in short, is their motive?

Motive. Managed care changes the physician's role in health care delivery in ways that provide a clear motive for wanting managed care to disappear. Although many physicians have adapted to the managed care environment, the profession, as a whole, remains resistant to managed care because it upsets the profession's traditional control over medical practice.

Historically, the attributes of medical practice included professional dominance, where physicians controlled the allocation of health care resources. At the heart of the clinical encounter was professional autonomy—physicians alone made medical decisions, with insurers paying for the recommended treatment. Physicians alone controlled access to private health information upon which medical decisions were made. In addition, physicians achieved considerable social status and economic attainment. All of this was diminished by managed care.

In a relatively short period of time, managed care challenged and undermined each of these core doctrines. Most importantly, the physician-patient relationship is no longer sacrosanct. Physicians no longer dominate health care delivery, but are subordinate to the managed care industry. Concepts such as preauthorization, utilization review, and economic incentives to reduce the cost of health care compromised physician autonomy. Clinical decisions must be "authorized" based on coverage limits, formularies, or worse, the opinion of an authorizing managed care agent (usually a non-physician, nurse or clerk, for the initial approval). One scholar refers to this process as the "1-800-MOTHER-MAY-I model of telephone approval."[6] The process shakes the foundation of physician autonomy, imposes resource-consuming and vexing bureaucracy on medical practice, and necessitates a frustrating exercise for the practitioner. But physicians are still responsible both legally and ethically to act in a patient's best interests. This squeeze between patient demands for more care and MCOs' demands to reduce costs created a fundamental ethical dilemma not present in fee-for-service medicine.

Another factor is the capitation method of reimbursement initiated by managed care. Under capitation, a physician (or physicians' group) receives a flat, per member, per month fee to manage the care. If there is a surplus, the physician retains the money; but if there is a shortfall, the physician absorbs the risk. Aside from the inevitable squeeze capitation places on physicians'

6. Harold S. Luft, *Why are Physicians So Upset About Managed Care?*, 24 J. HEALTH POL. POL'Y & L. 957, 963 (1999).

revenue, the physician faces increasing liability exposure to the patient without being able to control how resources are allocated.

In view of these changes, it is hardly surprising that physician satisfaction substantially declined. Research indicates that primary care physicians' perception of clinical autonomy is negatively correlated to the proportion of Health Maintenance Organization ("HMO") patients in their practices.[7] "[O]nly 18 percent of practicing physicians indicated that they held a positive view of the changes occurring in the health care system."[8] Only sixty-five percent (65%) of physicians surveyed expressed satisfaction with practicing in a managed care HMO environment.[9] Employed physicians in group or staff model HMOs are not statistically more dissatisfied than independently practicing physicians. Primary care physicians whose income is derived from capitated managed care contracts are significantly more dissatisfied than primary care physicians who do not receive capitated income.[10]

Opportunity. There is no shortage of evidence of grumbling, complaining, and effective character assassination by physicians about managed care. Nor is there any shortage of opportunities to sabotage the managed care. But does it add up to a deathblow? Although it seems unlikely that physicians retained the political or social power to single-handedly kill managed care, it seems very plausible that physician opposition to managed care's cost containment initiatives contributed significantly to the industry's demise.

At a minimum, physicians provided some of the most vociferous opposition to managed care that contributed to the public backlash beginning in the mid-1990s. No one has attempted to quantify physicians' influence on the backlash, but a look at the activities, policies, politics, and positions of the American Medical Association ("AMA") is quite revealing. The medical profession historically has taken the position that it alone is trained and sufficiently competent to police physicians and, consequently, medical policy must derive solely from the physician community. The AMA has a long and distinguished track record of politically championing these interests of the profession. As a result, the AMA has opposed non-physician control over medical decisions, dating from the emergence of pre-paid health care in the 1930s and continuing through the advent of managed care. Its current strategy includes a web-based managed care complaint box for physicians to file their managed care woes to serve as evidence in the on-going feud.[11]

7. Sharon B. Buchbinder et al., *Managed Care and Primary Care Physicians' Overall Career Satisfaction*, 28 J. HEALTH FIN. 35, 36-37 (2001).

8. Mike Magee & Mohammadreza Hojat, *Impact of Health Care System on Physicians' Discontent*, 26 J. COMMUNITY HEALTH 357, 358 (2001).

9. *Id.*

10. Buchbinder et al., *supra* note 7, at 42.

11. Amy Snow Landa, *AMA to Catalog Doctors' Woes on Health Plans*, AM. MED. NEWS, Dec. 10, 2001, at 6.

Yet the AMA's ability to block the erosion of physician autonomy and the rise of managed care has diminished steadily since the 1970s. The diminished political clout limits the profession's ability to enact legislation blocking managed care's cost containment programs or protecting physician autonomy. As one scholar notes, "Once deferential to professional guidance in policymaking, politicians now have begun to question and even alter organized medicine's political stances."[12] The outcome was a diminution of membership, solidarity, and political allies. State chapters, medical societies, and competing organizations stepped in to fill niche vacuums. By the 1980s, when managed care was wreaking havoc on physicians' practices and incomes, the AMA no longer wielded the political clout to forge alliances and bring about the death of managed care.

The result of this loss of political power can be seen at both state and federal legislatures, which limits the profession's opportunity to sabotage managed care. For example, despite the AMA's persistent support for a federal patients' bill of rights (which would help restore physician autonomy), Congress failed to enact a federal patients' bill of rights. At the state level, however, physicians have been somewhat more successful in enacting legislation that protects their interests.[13]

That is not to say that the physician community, and even the AMA, has not attempted to undermine managed care. Physicians responded to the business of managed care with business tactics of their own. The earliest managed care visionaries described a system with a rich, broad group of primary and specialty care providers who assume the responsibility for comprehensive, high quality care of a defined population.[14] Unfortunately, the realization of that model left the majority of providers, especially Primary Care Physicians ("PCPs"), who were in solo or small practices, disenfranchised and impotent in negotiations with behemoth insurers-turned-MCOs. These physicians abandoned their entrepreneurial practices, often under pressure and with deep regret, and merged with hospitals in Integrated Delivery Systems ("IDS"), Physician Hospital Organizations ("PHO"), Independent Physician Associations ("IPA"), and a plethora of other larger organizational forms. This gave physicians the scale and scope necessary to get in the game with the giants like Aetna, United Healthcare, and Cigna. Eventually, physicians

12. Mark Schlesinger, *A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession*, 80 MILBANK Q. 185, 186 (2002). *See also* Mark A. Peterson, *From Trust to Political Power: Interest Groups, Public Choice, and Health Care*, 26 J. HEALTH POL. POL'Y & L. 1145 (2001) (describing the political power and efficaciousness of the AMA through the 1960s and the factors thereafter that disrupted the old power relationships).

13. *See* discussion *infra* pp. 382-83 regarding willing provider laws.

14. *See* Alain C. Enthoven & Carol B. Vorhaus, *A Vision of Quality in Health Care Delivery*, HEALTH AFF., May-June 1997, at 45; Andy Pasternak, *Jackson Hole Revisited, at* http://www.healthleaders.com/magazine/feature1.php?contentid=20048 (June 1, 2001).

learned to effectively negotiate managed care contracts, but not without many casualties in the learning process. More recently, the number of physicians accepting capitation is in a downward trend and those that do accept capitation are savvier than before.[15] The trend away from capitation increased physicians' leverage against MCOs. As one managed care executive said, "We asked our doctors to act like insurance companies; that didn't work well."[16]

Patients

The next most obvious suspects are managed care's patients. They are at the locus of all the disparate competing interests and are most affected by managed care's cost controls when they are vulnerable and needy. Could their frustration have culminated in murder?

Motive. The horror stories about managed care's deficiencies are easy to find. A Kentucky woman with a precancerous cervical lesion successfully sued her managed care company for more than $13 million, virtually all in punitive damages, when the managed care company refused the ob-gyn's recommended treatment.[17] A court granted class action status to a lawsuit stemming "from improper denial of medical coverage" when a Prudential Concurrent Review Nurse countermanded the patient's physician's orders for ninety-six hours post-surgical hospitalization following removal of two tumors weighing more than 3½ pounds.[18] United Healthcare discontinued in-patient coverage for a woman with a high-risk pregnancy in her last weeks contrary to her wishes and her physician's orders.[19] Consequently, her baby died in utero, but she was denied a C-section and must wait days to deliver her dead infant.[20]

Are these cases representative of most patients' experiences? If they are, it easily provides a motive for murder. Or are there other forces and factors that cumulatively constitute a motive for murder? According to many observers,

15. J.A. Jacob, *Fewer Physician Groups Accept Capitation*, AM. MED. NEWS, Mar. 5, 2001, at 20. Interestingly, recent data shows that although physicians are generally participating in managed care capitation arrangements, those who do accept capitation are making more money and their capitation income represents a larger portion of their total income. Ken Terry, *Managed Care: Could You Live Without It?*, MED. ECON., Dec. 3, 2001, at 26.

16. Leigh Page, *Capitation at the Crossroads*, AM. MED. NEWS, Mar. 5, 2001, at 17, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_01/bisa0305.htm (Mar. 5, 2001) (quoting Stanley Borg of Anthem Blue Cross and Blue Shield of Colorado). Of course, physicians could refuse to participate in managed care arrangements, but few can afford to do so.

17. Robert Lowes, *Straightforward UR—or a "Machine of Denial"?*, MED. ECON., May 8, 2000, at 180.

18. AIS Managed Care, *HMO Lawsuit Watch: Batas v. The Prudentail [sic] Ins. Co.*, at http://www.aishealth.com/ManagedCare/HMOLawsuitWatch/Bates.html; Batas v. Prudential Ins. Co. of Am., 724 N.Y.S.2d 3, 9-10 (N.Y. App. Div. 2001).

19. Melanie Eversley, *Grieving Mom an Icon for Patients' Rights; Out of Baby's Death Came HMO Crusade*, ATLANTA J. & CONST., June 23, 2002, at 1A.

20. *Id.*

actual health outcomes—an attempt at measuring quality of care—are not appreciably different between MCOs and fee-for-services providers. As one scholar notes, "[n]or is it true that we're any sicker now from all this managed care and denial of services and so on."[21] If this is correct, what is the source of patients' state of mind regarding their experiences with managed care?

Several factors contribute to patients' perceived antipathy. For one, as discussed below, media reports tend to emphasize managed care's failures without describing managed care's successes. For another, many people may derive their aversion to managed care based on reports from others rather than on personal experiences.[22] Beyond these considerations, the shift from fee-for-service medicine to managed care has been jarring for many patients. In contrast to the relatively simple world before managed care, where physicians recommended treatment and insurers paid, managed care offers patients a bewildering array of acronyms and concepts that even specialists sometimes have trouble characterizing. In fee-for-service, patients expected almost unlimited care where cost was rarely an issue (for those with insurance coverage). As will be described below, the managed care industry did little to explain the concept to the public and provided the public with little or no input into the design or implementation of cost control programs. And the industry has been remiss in not offering formal grievance mechanisms for patients to contest delayed or denied care.

Polls vary widely in measuring patient satisfaction with managed care. A review of health care policy public opinion polls over a fifty-year period concludes:

> [T]he American public has conflicting views about the nation's health policy. They report much dissatisfaction with the health care system and with private health insurance and managed care companies, and they indicate general support of a national health plan. However, most Americans remain satisfied with their current medical arrangements, do not trust the federal government to do what is right, and do not favor a single-payer type of national health plan. The review also finds that confidence in the leaders of medicine has declined but that most Americans maintain trust in the honesty and ethical standards of individual physicians.[23]

21. Gina Kolata, *A Conversation with: Victor Fuchs; An Economist's View of Health Care Reform*, N.Y. TIMES, May 22, 2000, at F6. Other prominent analysts agree. *See, e.g.*, Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?: A Survey of Recent Studies Shows Mixed Results on Managed Care Plan Performance*, HEALTH AFF., May-June 1997, at 7.

22. Gail R. Wilensky, *What's Behind the Public's Backlash?*, 24 J. HEALTH POL. POL'Y & L. 1015, 1016 (1999).

23. Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, HEALTH AFF., Mar.-Apr. 2001, at 33.

Given these somewhat conflicting viewpoints, there are, nonetheless, some noteworthy consistencies. One study found that among 827 Californians there was a correlation of lower satisfaction with their health plans and little or no choice among provider-sponsored health plans.[24] The study reported that nationwide in 1999 approximately half of individuals covered by employer-sponsored plans had no choice or limited choice of health plans.[25] These findings are generally consistent with other recent nationwide research.[26] We can reasonably infer from the polling noted above that patients trust their doctors, but do not equally trust either big government or institutional health care providers (that is, MCOs). In fact, hospitals, representing direct health care services, rank very high in consumer satisfaction, while managed care companies rank lowest. Limiting access to the physicians in whom patients place their trust clearly creates a fertile environment for discontent.

Opportunity. The lack of choice, resentment over restrictions on health care, and anecdotal horror stories give patients sufficient motive for homicide. But patients have fewer opportunities than physicians to strike the deathblow. Like physicians, patient dissatisfaction was an integral part of the managed care backlash, especially taking their complaints to the media. Unlike physicians, patients have only limited ability to influence legislation.

Groups such as the American Association of Retired Persons ("AARP"), Families USA, California Health Decisions, numerous local and regional health care consumer advocacy organizations, as well as state ombudsmen services, all attempt to represent the patient perspective and interests in health care delivery. Notwithstanding the work of each of these groups, patients remain a highly fragmented group without an effective, collective voice or role in influencing managed care policy. One observer writes:

> When decisions are made about healthcare policy, procedures or processes, the consumer's point of view is somehow lost. Patient satisfaction surveys rarely probe for answers that reveal the patient's real beliefs. Employer coalitions don't often invite member/employee/consumers to participate. And they rarely represent public sector populations such as Medicaid recipients. As valuable as such efforts are, they are not enough to give us consumer-driven solutions to the problems in managed care.[27]

24. Alain C. Enthoven et al., *Consumer Choice and the Managed Care Backlash*, 27 AM. J.L. & MED. 1, 4, 6 (2001).

25. *Id.*

26. Wilensky, *supra* note 22, at 1018; Kenneth E. Thorpe, *Managed Care as Victim or Villain?*, 24 J. HEALTH POL. POL'Y & L. 949, 951 (1999).

27. Ellen B. Severoni, *How to Keep Patients, Plans and Purchasers in the Loop*, MANAGED HEALTHCARE, Feb. 1, 1999, at 50, 50. Professor Marc Rodwin has written extensively about the need for a more effective consumer voice in managed care policies. *See, e.g.*, Marc A. Rodwin, *Exit and Voice in American Health Care*, 32 U. MICH. J.L. REFORM 1041 (1999) [hereinafter Rodwin, *Exit and Voice in American Health Care*]; Marc A. Rodwin, *Consumer Protection and*

Perhaps the most effective patients' response to their complaints about managed care is to switch their health care coverage away from traditional managed care plans to other alternatives, such as Preferred Provider Organizations ("PPOs") and Point-of-Service Plans ("POSs").[28] POS plans in particular allow patients more flexibility in seeing specialists, hence eroding MCO's stringent cost controls. Employees have encouraged employers to offer alternatives to managed care plans.

Employers

The impact of the employers' role is not as readily apparent as patients or physicians. In many ways employers determine the types of insurance coverage available and the price employees will pay because most people receive health insurance through their employer. The reality of modern health care purchasing is that employees have only a limited voice in the benefits available and employers might not purchase benefits individual employees would select on their own.[29]

After World War II, health benefits became "a job entitlement . . . because health coverage became a corporate practice to entice scarce workers under wage controls during World War II and in the boom years that followed—and is now given tax-free to employees."[30] This places employers in a somewhat conflicted position. On the one hand, employers act as the employee's agent in selecting available insurance coverage options. On the other hand, employers have their own economic interests at stake. Thus, employers may favor options that are less desirable to employees.

Motive. If anything, employers have a strong interest in facilitating managed care's success. Since the premise of managed care is that it can reduce costs while maintaining or even improving quality of care, employers would not be well-served by its untimely demise. On the contrary, managed care allows large employers to keep their health benefits' costs manageable. The promise was that if business practices and processes were applied to the

Managed Care: The Need for Organized Consumers, HEALTH AFF., Fall 1996, at 110.

28. Rodwin, *Exit and Voice in American Health Care*, *supra* note 27, at 1055.

29. Empirical evidence on the employee-employer agency relationship is mixed. Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 MILBANK Q. 5, 16-17 (2000) (reported survey and focus group results showing that employers may act as good agents for employees, in particular that employees would not be better served by purchasing their health insurance directly). *But see* Mark W. Legnini et al., HEALTH AFF., May-June 2000, at 173, 175 (finding that this might not hold for small employers). *See also* Dennis P. Scanlon et al., *Consumer Health Plan Choice: Current Knowledge and Future Directions*, 18 ANN. REV. PUB. HEALTH 507, 508, 524 (1997) (reporting limited employer involvement in helping employees to interpret quality of care report cards).

30. Richard J. Mahoney, *Missing in Action: The Health Care Consumer*, DIRECTORSHIP, Oct. 1999, at 1.

delivery of health care, costs could be brought under control. Consequently, managed care products rapidly proliferated as employers anticipated cost-control relief. Unfortunately, the medical "march of science" and other factors continued to drive costs up, eroding managed care's ability to restrain cost increases. Managed care premium rates increased 15.3% for 2002 and are expected to increase another twenty-two percent (22%) for 2003, with little or no room for employers of any size negotiating more favorable rate increases.[31]

The motive for undermining managed care occurs when employees express their dissatisfaction with their MCO choices. In a delicate balancing act, employers must weigh their cost concerns against employee complaints. This was especially true during the booming economy of the mid-to-late 1990s. During this period, employers competing for human resources knew that health care benefits were crucial to attracting and retaining a quality workforce. A "study of 528 U.S. employees found health care ranks as the most important benefit, outscoring compensation by a margin of two to one."[32] So if you are an employer in a globally competitive marketplace, how do you resolve the runaway costs and employee expectations of quality, choice, and self-determination? Given these staggering financial assaults on profitability, could it be that employers are the guilty parties and are responsible for the murder?

Opportunity. Despite their mixed motives, employers have had numerous opportunities to sabotage managed care. The employers' primary contribution to managed care's travails was their inability to demand that MCOs adhere to stringent cost containment programs. Instead, employers succumbed to employee dissatisfaction in two ways. First, employers failed to restrict the number and types of benefit choices. Employers began offering PPOs and POSs that, as noted above, operated to reduce the managed care industry's ability to restrain cost increases. In addition, employers did little to educate their workers for the need for cost containment and why managed care was the best vehicle for achieving a more stable health care environment. Second, business health purchasing coalitions were unable to use their combined leverage to ensure the promised cost constraints coupled with improved quality of care.[33]

To reduce their costs, employers are now seeking alternatives to the current system of providing health insurance benefits, primarily by opting for plans that would shift costs back to the employee or patient. Some employers are considering providing a fixed amount of money for health benefits (called

31. Press Release, Hewitt Associates, HMO Rates Continue to Rise at Double Digit Pace, *at* http://was.hewitt.com/hewitt/resource/newsroom/pressrel/2002/06-04-02.htm (June 4, 2002).

32. Press Release, Hewitt Associates, Employees Rank Health Care as Number One Benefit and Want More Control and Choice, *at* http://was.hewitt.com/hewitt/resource/newsroom/pressrel/2002/02-25-02.htm (Feb. 25, 2002).

33. *See, e.g.*, JACK A. MEYER ET AL., EMPLOYER COALITION INITIATIVES IN HEALTH CARE PURCHASING (1996).

defined contribution programs) and allowing employees to shop for their own health care coverage.[34] Defined contribution programs shift more of the health care cost to employees than under the current defined benefits system, where most of the cost is absorbed by employers. Defined contribution plans are a method where "employers give employees more choice and control of their health care, but set employer contributions at a fixed dollar amount and expect employees to pay premium costs above that amount."[35] The changes to health care delivery that lurk within the defined contribution strategy have the potential to destroy managed care once and for all. Patients would choose their own physicians, contracting for favorable negotiated rates. Capitation would be nearly impossible at the individual level.

If successful, this would certainly influence the structure and operation of MCOs because it would make managed care, already suspect to many employees, even less attractive. As part of the strategy, employees' copays for doctor visits, emergency room services, prescription drugs, and specialist visits have all increased. The goal is to shift costs away from the employer and to sensitize employees to the cost of their health care consumption. It could have that potential. But, according to insurance insiders, "[n]ewfangled consumer-driven health plans, which allow individuals to customize their own benefits packages, have yet to catch fire."[36]

A shift from seemingly unlimited paternalistic health care financing management to consumers determining and designing their own health care plan is loaded with challenges and obstacles. One obstacle is educating employees in effectively analyzing plan benefits and options and making decisions that fit their needs. This creates a huge support burden for employers' human resource staffs. Another more potentially damaging obstacle is simply creating a new flavor of backlash. Employees may quickly discern that they are assuming significantly more risk and cost along with added choice. Employers could quickly find themselves more desperate for solutions than they currently are.

To their credit, employers have renewed their collective interest in using their leverage to impose quality of care improvements. Several new strategies have emerged through organizations such as the Leapfrog Group. For example, these groups are insisting that providers adhere to evidence-based

34. For a discussion of the defined contribution strategy, see Stephen Blakely, *Defined Contribution Health Benefits: The Next Evolution?*, EBRI NOTES, Aug. 2001, at 1; John V. Jacobi & Nicole Huberfeld, *Quality Control, Enterprise Liability, and Disintermediation in Managed Care*, 29 J.L. MED. & ETHICS 305 (2001)

35. Julie A. Jacob, *Consumer-Driven Health Plans Could Mean End of Capitation*, AM. MED. NEWS, Aug. 13, 2001, at 15, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_01/bisa0813.htm.

36. Karen Pallarito, *Health Care Inflation May Mean Workers Share Costs*, REUTERS, *at* http://www.clarian.org/content/reuters/037_06062002.jhtml (last updated June 6, 2002).

medicine standards and increasingly expect that MCOs include disease management plans in their products. Disease management entails a focus on the common diseases responsible for the majority of health care costs.[37] Managed care companies concentrate management of these conditions on a case-by-case basis and implement a variety of monitoring mechanisms ranging from telephone calls with nurses to electronic monitoring of critical indicators, such as weight and blood pressure. One can hardly consider disease management as a deathblow to managed care. Instead, it may arguably reinforce the concepts inherent in managed care.

In the final analysis, employers have and continue to use their clout to pose a threat to managed care, but we still have no more than circumstantial evidence that they perpetrated the crime.

Courts

At the dawn of the modern managed care industry, many doubted whether the courts would support managed care's cost containment programs. After all, neither the courts nor the legislative branch welcomed previous attempts to impose institutional controls over physicians. The legal system relied on the corporate practice of medicine doctrine to block institutional controls. One study of previous efforts in the fee-for-service system to limit costs and physician autonomy led to the ominous prediction that the cost containment innovations in managed care would not survive judicial scrutiny.[38] To many observers, the courts were poised to disrupt the core premises of the new managed care industry's financial incentives.[39] Without doubt, these predictions were based on sound interpretation of judicial attitudes at that time. What the scholars were unable to account for were changes in judicial attitudes, fundamental ways in which managed care cases would depart from fee-for-service litigation, and how the Employment Retirement Income Security Act ("ERISA") would undercut all previous perceptions.

Motive. Thus, the judicial motive to attack managed care is not diabolical.Rather, the court's motive is to play its traditional oversight role in

37. The benefits executive at Calpers (California Public Employees' Retirement System), Allen Feezor, claims that sixty percent (60%) of health care costs are attributable to eighteen (18) chronic diseases. Milt Freudenheim, *A Changing World Is Forcing Changes on Managed Care*, N.Y. TIMES, July 2, 2001, at A1.

38. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988). For a more detailed analysis of the role of the courts in shaping health care delivery and policy, see PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA (2000) [hereinafter JACOBSON, STRANGERS IN THE NIGHT].

39. *See, e.g.*, Mark A. Hall & Gerard F. Anderson, *Models of Rationing*: *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992); John H. Ferguson et al., *Court-Ordered Reimbursement for Unproven Medical Technology*, 269 JAMA 2116 (1993).

economic and social relations and in interpreting congressional statutes. Although state courts tend to favor individual litigants, the historical development of common law suggests that courts move slowly to impose liability on a new industry such as managed care.[40] In this case, liability principles already applicable to hospitals might be applied to managed care litigation.

One would also expect jurors to be sympathetic to patient challenges given the managed care backlash, especially at the beginning of the litigation cycle. If given the chance, I suspect that jurors would indeed punish MCOs for denying care. But ERISA preemption has limited the ability to take cases to state court juries, leaving open the question of how jurors would respond if ERISA preemption were eliminated.

Opportunity.[41] Regardless of potential motives, courts, especially federal, have had considerable opportunity to derail managed care. All it would take is for courts to rule that managed care's cost containment programs and financial incentives can be challenged in state courts. The cases decided so far suggest that courts are not systematically impeding the implementation of cost containment initiatives. Instead, courts have relied on ERISA preemption to limit patients' state tort litigation against MCOs. This limits the ability of state courts, which might otherwise be receptive to patients' lawsuits, to impose significant damages or restrictions on managed care operations. The conventional wisdom that the courts would undermine cost containment initiatives has not happened. Whatever problems the managed care industry faces, the industry's fears about judicial intervention have largely been avoided. Legal challenges to the managed care industry have proven more difficult to win than expected.

Even though judges have struggled with some aspects of managed care, the judicial decisions present a clear, overriding theme: courts are facilitating the market-based arrangements that drive managed care. In most aspects of health care litigation, courts treat the health care field as they would any other industry. This amounts to deference to prevailing market principles in health care delivery, as courts have shown no inclination to reflexively overturn market decisions. The clearest evidence is in courts' increasing deference to contractual arrangements, in physicians' litigation against MCOs, and in antitrust cases where courts are not protecting MCOs from competitive forces in the health care market.

40. Peter D. Jacobson & Scott D. Pomfret, *Establishing New Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change*, 32 U. MICH. J.L. REFORM 813, 813 (1999).

41. This section is borrowed liberally from JACOBSON, STRANGERS IN THE NIGHT, *supra* note 38. *See also* Peter D. Jacobson, *Legal Challenges to Managed Care Cost Containment Programs: An Initial Assessment*, HEALTH AFF., July-Aug. 1999, at 69.

A second theme evident from the litigation is the slow development of MCO liability. Neither physicians nor patients have been successful in directly contesting managed care practices. Patients and physicians have brought a wide range of challenges to managed care's cost containment programs, most of which have been unsuccessful. For instance, patients have sued MCOs alleging negligence for injuries resulting from delayed or denied care or from the improper operation of financial incentives to limit care. Primarily because of ERISA, these challenges have often been futile. Even outside of ERISA, plaintiffs have not won a majority of cases.[42]

Physicians have not fared much better in challenging MCO practices. Except for some inroads on fair procedures, courts have been unsympathetic to physician arguments. Physicians have been primarily put at a disadvantage in liability challenges to MCO practices. Largely because of ERISA, patient challenges in state courts to delayed or denied care have often been preempted, leaving the treating physician exposed to liability without being able to "share" responsibility with the MCO. Also, courts have upheld the use of utilization review for controlling costs, especially under ERISA, regardless of the treating physician's recommendation.

Finally, courts are sending the message that restrictions on managed care innovations should be made by the legislatures, not by the courts. In the ERISA cases, for example, judges have complained, at times vociferously, that ERISA preemption results in unjust outcomes preventing courts from holding MCOs accountable for their actions.[43] Even so, judges have largely deferred to Congress to change ERISA preemption rather than judicially reinterpreting ERISA to achieve more equitable results. As a general proposition, judges have determined that complaints about the organization and delivery of managed care should be resolved by elected officials.[44]

Legislatures

Since the courts punted to the elected officials, how have they responded? Not surprisingly, much of the backlash to managed care led to calls for tighter legislative and regulatory oversight. At the federal level, the primary legislative debate has been over the proposed patients' bill of rights. In brief, such legislation would amend ERISA and permit patients to sue their MCO and states to regulate managed care. Currently, ERISA doctrine acts to

42. For a more detailed empirical analysis of these trends, see Peter D. Jacobson et al., *The Role of the Courts in Shaping Health Policy: An Empirical Analysis*, 29 J.L. MED. & ETHICS 278 (2001).

43. *See, e.g.*, Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997).

44. For a clear statement of that principle (and for the institutional reasons why courts should be reluctant to intervene), see *Pegram v. Herdrich*, 530 U.S. 211, 221-22 (2000). In other words, courts have protected the market winner—MCOs. In the fee-for-service era, courts also protected the market winner—but then it was the physicians.

preempt the application of state laws and state tort litigation to ERISA-covered employee benefit plans ("EBPs"). Courts have uniformly held that MCOs are part of an EBP, and can, therefore, assert ERISA preemption.[45] Despite repeated news reports of congressional compromise, the patients' bill of rights has not been enacted as of this writing.

At the state level, there has been much more legislation enacted. However, because of ERISA preemption, it is difficult for states to predict which legislation will survive judicial scrutiny.[46] In view of the continuing congressional stalemate, the likely venue for debates about regulating managed care will be in state legislatures.

Motive. Both patients and physicians are demanding greater accountability through legislative and regulatory oversight. Since health care has traditionally been regulated at the state level, it makes sense that state legislatures will be active participants in determining managed care's fate. For re-election purposes, state legislators have an incentive to protect patients. At the same time, legislators are highly influenced by the managed care industry's lobbying clout.

As a result, legislators' motives for attacking managed care are quite mixed. Thus, while neither Congress nor state legislators can ignore the backlash, the industry's ability to block legislation (currently stronger in Congress than in state legislatures) suggests a continuing stalemate. One way of responding would be for legislators to act by imposing benefit coverage mandates. For example, thirteen state legislatures mandated that health insurers cover autologous bone marrow transplants with high dose chemotherapy (ABMT/HDC), despite disputed evidence of the procedure's efficacy. While not a direct attack on managed care, mandated benefits certainly limit the managed care industry's ability to control costs by limiting benefit coverage.

Opportunity. There is little question that legislators, especially in Congress, have the opportunity to alter how managed care operates. By amending ERISA, Congress could open MCOs to patient litigation for delayed or denied care and expand the reach of state legislative efforts. For many reasons, the congressional patients' rights debate has become more symbolic than of real consequence. Although Congress has chosen not to amend ERISA, it has taken action on certain issues (often called legislation by body part). For instance, Congress prohibited so-called drive-through deliveries by

45. For a more detailed explanation of ERISA preemption, see Peter D. Jacobson & Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 JAMA 921 (2000).

46. *Compare*, *e.g.*, Rush Prudential HMO, Inc. v. Moran, 122 S.Ct. 2151 (2002) (upholding a state law imposing an independent patient grievance process), *with* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (barring punitive damages recovery).

mandating that women could not be discharged before forty-eight hours following delivery.[47]

The picture is certainly different at the state level where MCOs face increasing scrutiny. In many ways, the managed care backlash has been most evident in state-level attempts to control MCOs. States have attempted to impose external grievance processes, which would allow patients to sue for delayed or denied care, or to require the disclosure of financial incentives. Early laws governing MCOs focused on the right of physicians to participate in MCO networks (so-called "any willing provider" laws), and on the right of physicians to discuss any aspect of care with their patients that related directly to managed care's financial incentives (so-called "anti-gag" rules). More recently, some states have imposed requirements mandating direct access to specialists. Many states limited managed care's financial incentives by prohibiting incentives that would lead to the denial of medically necessary care.[48] Some of these laws have gone into effect, but others have been preempted by ERISA.

Take, for example, any willing provider ("AWP") laws as a proxy for a range of state legislative attempts to regulate MCOs. AWP laws would require MCOs to contract with any physician willing to meet the MCO's established criteria. These laws are intended to preserve patient choice of physician. MCOs oppose these laws because they eliminate at least one cost reduction mechanism—a managed care plan's ability to choose physicians who will be willing to offer lower prices in return for guaranteed patient volume. AWP laws affect another cost reduction mechanism, the power to control quality of care by restricting membership in the plan's network to those physicians meeting rigorous quality standards. Without the ability to select participating physicians based on cost and quality standards, MCOs argue that they cannot as easily monitor the quality of care. Almost two dozen states have enacted such laws, but the courts are split as to whether ERISA preempts them.[49] The Supreme Court agreed to resolve the split in the lower courts.[50]

In sum, mixed motives resulted in limited exercise of the legislative opportunities to hold managed care accountable.

47. This type of legislative intervention has been heavily criticized. *See, e.g.*, David A. Hyman, *Drive-through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5 (1999).

48. Tracy E. Miller, *Managed Care Regulation*, 278 JAMA 1102 (1997).

49. *See*, Tanya Albert, *High Court Weighs Any-Willing-Provider Laws*, AM. MED. NEWS, July 29, 2002, at 1, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_02/gvl20729.htm (last visited Dec. 30, 2002).

50. *Id.* at 2.

The Media

Any scrupulous murder investigation will turn its attention to a suspect that is known to have scrutinized, exposed, berated, vilified, and generally tormented the victim. Newspapers, magazines, network and cable news reports, television programs, and even movies have led the charge to discredit managed care. Could this outspoken critic be the guilty party?

Motive. It may be an overstatement to suggest that entertainment and broadcast media, particularly television and the movies, thrive on salaciousness, controversy, and creating a villain—but not by much.[51] Not too long ago, one local television news broadcast attempted to downplay local crime and to focus on in-depth reports of local interest. Ratings tanked, and the experiment ended quickly. One reason is that crime and similar stories grab our attention, while softer features or serious investigative pieces tend to drift by largely unnoticed.[52] Instead, media circuses such as the O.J. Simpson trial capture the public's interest much more readily than most events. Since the media do not publish or broadcast information for their own use or gratification, without the ability to hold readers and viewers, the media would cease to exist. The motive? Simple—ratings.

In this kind of dog-eat-dog scenario, managed care provided everything the media needed to galvanize the public's outrage. Corporate profiteers, a plethora of tear-jerking human interest pieces, double-minded and double-crossing politicians, a labyrinth of indecipherable regulations and legislation and physicians reduced to assembly-line medical bureaucrats all contributed mightily to wave upon wave of assaults on an embattled industry.[53] Horror story after horror story decried managed care's heartlessness, callousness, indifference and venality. What the media forgot, or chose not to report, were managed care's successes, along with why it replaced the fee-for-service system. There has been little balance in media coverage of the industry.

True, the managed care industry has served up plenty of material for a media group spurred on by the scent of blood. So much so that the American Association of Health Plans ("AAHP") recently retained a public relations firm to use its clout and influence for AAHP to obtain audiences with the power brokers of pop-culture.[54] The public relations objective is to "offer itself as a resource on medical topics that may be interesting" and presumably influence the storyline in movies such as *John Q* and *As Good as it Gets*.[55] The fact that

51. *See Local TV News and Violence*, MEDIASCOPE, *at* http://www.mediascope.org/pubs.htm (last visited Sept. 28, 2002).

52. *See id.*

53. Barbara Martinez, *Tired of Being Cast as the Villain, HMOs Hire Talent Agency*, WALL ST. J., July 9, 2002, at B1.

54. *Id.*

55. *Id.*

the managed care industry as a whole spends its resources on a Hollywood talent agency for public relations spin instead of substantive quality and process improvement certainly confirms that it, at least, believes the media has a motive for murder. Indeed, the industry may have waited too long to unleash a media counter-attack.

Opportunity. The media helped set the policy agenda. As a vast enterprise with the ability to keep a story alive for as long as it wants, the media can create a groundswell of interest that can be disproportionate to the seriousness of the event. Witness the frenzy over the O.J. Simpson trial. On the other hand, media attention to a particular problem can be beneficial in forcing politicians to respond to social problems or in holding public officials and corporate executives accountable. A good example is the recent focus on corporate greed and the resulting legislation. In short, the media has an extraordinary opportunity through its vast reach, repetition via multiple media, and attention-getting headlines to slay managed care or to adulate it.

However, that same focus can be destructive, as with the emphasis on managed care's failures while ignoring its successes. Even assuming that the horror stories are true, the question is one of balance and perspective. Out of the millions of patient encounters, it is not surprising that a few result in bad outcomes or that the industry acts in bad faith. Yet how representative are the horror stories and how much media play do they deserve? To what extent are the horror stories evidence of systematic failures or merely aberrations that deserve, at best, only brief media attention? How should those instances be weighed against the many encounters that result in appropriate outcomes with overall reduced costs?

Of equal concern to industry and patients alike, the media message may be fragmented, with sectors portraying the same facts differently, and not always correctly. An example is the media response to a report on research on the length of physicians' visits under managed care versus traditional financing methods. The original published report surprisingly revealed empirical evidence that "[t]he average time physicians spend with patients increased during a period in which managed care penetration grew."[56] This finding contradicted commonly held beliefs by physicians and the public about managed care physicians spending far too little time with their patients. Distressingly, the media coverage was woefully inadequate and sometimes inaccurate, even though the authors conclude that the overall media coverage was credible.

56. David Mechanic & Donna D. McAlpine, *"Fifteen Minutes of Fame": Reflections on the Uses of Health Research, the Media, Pundits, and the Spin*, HEALTH AFF., Nov.-Dec. 2001, at 211. The original findings were reported in David Mechanic et al., *Are Patients' Office Visits with Physicians Getting Shorter?*, 344 NEW ENG. J. MED. 198 (2001).

> Some reporters who wrote stories for local newspapers got the facts wrong. Stories adapted from these reports further disseminated these errors. . . . In the case of one medical publication, we twice reviewed its coverage for accuracy and provided factual corrections. The final copy included this medical editor's note:
>
> > "It should be emphasized that managed care has resulted in an increase in the administrative aspects of patient care, and the time required to do these administrative tasks may contribute to less time actually spent with the patient but more time spent on the patient's records."
>
> We informed the publication that this statement was inconsistent with the AMA data reported in the paper; the writer responded that "I know what you are saying is that the data does not uphold his comment, but I am going to leave it in there as an editor's note, because it is in his experience."[57]

Although the industry has been on the defensive because of the selective reporting of managed care, the industry is fully capable of using the media to manipulate public opinion. One way is to place advertisements that shape the policy environment. For example, the famous "Harry and Louise" campaign played a large role in defeating the Clinton Administration's proposed Health Security Act ("HSA") in 1994. In this public relations effort, the Health Insurance Association of America ("HIAA") produced an advertising campaign to derail the HSA. The ad showed a couple pouring over the details of the HSA and becoming increasingly concerned that the government would dictate their health care choices. The ad simultaneously elevated the ability of the market to provide the most effective health care system and demonized governmental efforts to regulate the market. As a media event, it succeeded brilliantly.[58] Many news reports covered the ad, repeatedly and widely showing it and discussing its content. At a minimum, it contributed significantly to the HSA's demise.[59] At the same time, it had the unintended

57. Mechanic & McAlpine, *supra* note 55, at 213. *See also* Theodore R. Marmor, *A Summer of Discontent: Press Coverage of Murder and Medical Care Reform*, 20 J. HEALTH POL. POL'Y & L. 495, 501 (1995) (noting that "[t]he nation's political reporters know relatively little about health care issues" and permitted the creation of media stars opposed to health care reform to offer their views without adequate scrutiny).

58. For an empirical argument that the ad campaign reversed public opinion away from trends unfavorable to the insurance industry, see Raymond L. Goldsteen et al., *Harry and Louise and Health Care Reform: Romancing Public Opinion*, 26 J. HEALTH POL. POL'Y & L. 1325 (2001). For a skeptical view of the empirical evidence, see Mollyann Brodie, *Impact of Issue Advertisements and the Legacy of Harry and Louise*, 26 J. HEALTH POL. POL'Y & L. 1353 (2001). Brodie, nevertheless, agrees about the general impact of the ad campaign, at least in changing how the debate was framed.

59. This successful strategy is likely to be emulated in future health policy battles, such as debates over patients' rights and pharmaceutical benefits. *See, e.g.*, Jennifer Schecter, *The Return*

consequence of overselling the market's ability to provide high quality health care at low cost. In turn, the overselling contributed to managed care's travails when it was unable to perform as anticipated.

Another way is to hire public relations firms to burnish the industry's image. According to published reports, the industry's public relations effort will focus on two complementary strategies.[60] The first will be to build bridges with movie and television scriptwriters to influence how the scripts portray managed care industry. The second will be to blame others, especially attorneys, for managed care's perceived deficiencies.[61]

One further caveat remains regarding the media. By the time the various interest groups, from industry representatives to pop culture panderers, get through with their treatment of the subject, the public may only be left with more confusion and a general sense of distrust and discontent. As a result, the opportunity to kill managed care may not be as clear-cut as initially suspected.

Health Insurers

What a perfect suspect health insurance companies make. They were the suppliers of what had become a commonplace employment benefit—health insurance—and had seemingly limitless resources to topple a competing industry. Also, managed care indisputably surpassed health insurance as a health care financing plan. Yet, in this murder mystery, can we take anything simplistic at face value? More importantly, there are many overlapping interests that the competitors share, so that protecting one would inevitably help the other. For instance, both have an interest in avoiding state benefit mandates.

Health insurance benefits had become a method for employers to attract employees during wage controls after World War II. By the 1980s, they were a familiar employee benefit, and insurance companies profitably marketed indemnity products far and wide. Many factors, not the least of which was technological advances in medicine, brought about year after year of increased premium costs and, with them, pressure from all sides to stop the rapid rate of increases. The ideas of nationalizing and reforming the U.S. health care delivery and financing system, including the ill-fated Clinton plan, were soundly trounced on several occasions, in no small part due to insurance industry efforts. This left the private sector free to organize and deliver health care.

of Harry and Louise, MULTINAT'L MONITOR, Jan.-Feb. 1998, at 35, *available at* http://www.multinationalmonitor.org/mm1998/mm9801.11.html (last visited Sept. 4, 2002).

60. CNN.com/Health, *Health Care Group Hires Hollywood Agent to Improve Its Image*, *at* http://www.cnn.com/2002/HEALTH/07/13/hmo.pr.ap (last visited July 13, 2002).

61. *Id.* "Instead of attacking the film, the AAHP bought ads deflecting the focus of anger from insurance plans to 'a runaway litigation system and expensive government regulations.'" *Id.*

However, by this time, commercial (indemnity) health insurers were in decline, largely supplanted by MCOs. For a variety of reasons, large employers have shifted their coverage toward managed care. That leaves commercial insurers with a much riskier and less lucrative market for small employers and individual policyholders.

Insurance companies often transformed their product lines into managed care products and themselves into managed care companies. Frequently, managed care companies were born out of the decline of traditional insurance companies. In many instances, they became for-profit MCOs, particularly in California.[62] Thus, the managed care landscape became populated with insurance companies in a new role. Just as we asked doctors to act like insurance companies in accepting risk through capitation, we have asked insurance companies to act like doctors in combining the insurance and clinical aspects in one corporate entity. Neither plan has worked very well. However, it does deflate the evidence that insurers perpetrated the murder, since, as it turns out, many have come to reap the monetary benefits of managed care.

Hospitals

During managed care's ascendancy, it seems fair to suggest that hospitals got run over. As managed care entities grew in size and scope, hospitals had little negotiating leverage in rates they could charge. Hospitals were dependent on managed care for patient referrals, thereby limiting hospital administrators' abilities to negotiate over fees.

Although MCOs still hold the balance of power, times have changed. Since the late 1990s, hospitals have gained negotiating leverage and are able to demand higher reimbursement rates. Under pressure to close unneeded beds and to streamline operations, the number of hospitals has declined by nine percent (9%) since 1990, even as the population has increased.[63] Some facilities have closed, but others have consolidated into larger chains, equivalent in size and power to MCOs. Not surprisingly, the hospital chains, which control large numbers of beds in many markets, are demanding and receiving a higher price for their services.[64]

It seems unlikely that hospitals set out to kill managed care. After all, hospitals are still dependent on MCOs for patients. Yet it seems highly likely

62. Alain C. Enthoven & Sara J. Singer, *Managed Competition and California's Health Care Economy*, HEALTH AFF., Spring 1996, at 39. *See also* Robinson, *supra* note 5, at 2623.

63. Joseph Weber & John Cady, *The New Power Play in Health Care*, BUS. WK., Jan. 28, 2002, at 90; Barbara Martinez, *With New Muscle, Hospitals Squeeze Insurers on Rates*, WALL ST. J., Apr. 12, 2002, at A1. Both articles document instances where hospitals forced MCOs to pay higher rates in showdowns.

64. Martinez, *supra* note 63, at A1. According to Martinez, two hospitals in Cleveland, Ohio control sixty-eight percent (68%) of the beds, while one hospital system in Grand Rapids, Michigan controls seventy percent (70%). *Id.*

that hospitals "piled on" once the decline set in. After years of rates that squeezed hospital revenues and services, hospital administrators responded in ways that were designed to provide greater negotiating power. That their subsequent success further damaged MCOs' ability to control costs offers little evidence of murder.[65] It may reflect opportunism, but that is the American way.

The Managed Care Industry

One by one, the investigation has carefully scrutinized each of the possible murderers, eventually raising questions about motive or opportunity for each and every one. Where, then, to turn? At first glance, it seems rather silly to implicate the managed care industry itself. What motive for self-destruction could it possibly harbor, given what one managed care executive calls the "[unfulfilled] promise of managed care"?[66] To be sure, the industry overpromised what it could achieve, but there is nothing unusual or untoward about creating high, and even unrealistic, expectations.

Managed Care as a Concept. In fact, managed care as a concept is a good idea. Conceptually, combining the financing and clinical functions into one entity as a mechanism for saving costs and improving quality makes sense. Managed care's cost containment programs were offered as a needed corrective to the excesses of the fee-for-service system. In the ideal construct, balancing access to care with cost controls is imperative in view of the reality of scarce resources. Indeed, any system that replaces managed care will still need to confront the reality of scarce resources. In addition, managed care's desired focus on evidence-based medicine to guide clinical decisions offered a sound basis for determining whether care should be provided to an individual patient. Furthermore, the industry's stated emphasis on prevention and improving quality of care were welcome innovations in health care delivery.

Initially, managed care delivered many of its promises. For many years, its cost containment programs reduced the rate of increase in health care costs. As noted earlier, many scholars have concluded that managed care quality is roughly equivalent to fee-for-service medicine. And the industry has steadily improved on providing preventive care to its members and, in many instances, to the community at-large. Over time, however, managed care was unable to restrain cost increases, as double-digit health insurance premium increases

65. At the Symposium, Professor Nicolas Terry observed that pharmaceutical manufacturers also pursued strategies that helped undermine managed care's ability to control costs. For example, the direct-to-consumer marketing effort has clearly raised the cost of providing prescription drugs by helping to eviscerate tolerance of pharmaceutical formularies designed to restrict which drugs can be prescribed. *See, e.g.*, Vanessa O'Connell, *FDA Survey Says Doctors Often Prescribe the Brands Consumers Name from Ads*, WALL ST. J., Apr. 15, 2002, at B4.

66. Glenn Howatt, *Brainerd Takes the Helm at HealthPartners*, MINNEAPOLIS STAR TRIB., May 5, 2002, at 1D.

have returned. The horror stories undermined the industry's claims of combining quality improvements and access to care.

Implementation. What went wrong? Although there is no scholarly agreement as to why managed care failed to meet its promise, several reasons seem plausible. To begin with, the concept was not implemented very well. Patients and physicians were needlessly antagonized. Published reports of high salaries for executives amid demands for cost controls did nothing to enhance the concept's credibility. Repeatedly, the industry allowed the perception to fester that it was more interested in managing costs than in providing care—a perception of profits over care that fueled patient suspicions of rampant conflicts of interest. The industry failed to educate patients about the concept of managed care and the need to control costs, and it failed to include patients in determining how cost containment would operate. For instance, patients were rarely told about why a treatment recommendation was denied and were rarely granted a grievance process to review the denial. A supporter of the concept captured the scope of this failure, as follows:

> HMOs are not helpless victims of the managed care backlash. Rather, at times they seem to be their own worst enemies. . . . Some health plans have needlessly antagonized physicians in their cost control efforts rather than try to find ways to win their cooperation in an effort to improve quality while reducing costs. Many have done a poor job of recognizing and responding to reasonable and legitimate consumer and patient concerns. Although this behavior is not true of all health plans and not always true of any of them, such resistance, lack of responsiveness, and antagonistic behavior reflect negatively on the industry.[67]

Equally important, the industry failed to accept accountability for its role in clinical decisions.[68] At this point, the managed care industry has not demonstrated a willingness to hold itself accountable for its products and, there is no legal or political constraint on its activities. The case of *Maio v. Aetna*[69] is indicative and instructive of the lack of accountability. Aetna elected to defend a legal challenge to its managed care operations by asserting that public statements touting its primary commitment to quality of health care were "mere puffery."[70] Translated from the technical language of the law, the essence of Aetna's defense was that reasonable consumers would understand that its avowed commitment to quality was a statement of opinion not intended

67. Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions,* 24 J. HEALTH POL. POL'Y & L. 931, 935-36 (1999).

68. This analysis is borrowed from a more extensive examination in JACOBSON STRANGERS IN THE NIGHT, *supra* note 38.

69. 221 F.3d 472 (3d Cir. 2000).

70. *Id*. at 479.

to be relied upon or to convey anything factual about its managed care plans.[71] Regardless of the merits of Aetna's legal argument, a voluntary characterization of public and repeated commitments to quality medical care as "mere puffery" seems an unusual way to represent one of managed care's core functions. It is ironic that when quality of care is perhaps the central issue concerning public attitudes toward managed care, one of the industry's major players simply discounts its own stated commitment to high quality care. *Maio* exposes the absence of voluntary accountability.

Reacting to *Maio*, a prominent health law scholar argued that

> such advertising provides a weak basis for a consumer class action. If such advertising works at all, it is most likely to attract healthy rather than unhealthy subscribers . . . . It is simply too much to expect competing health plans to pay special attention to quality when it is clearly against their commercial interests to do so.[72]

As far as it goes, that may be accurate. Yet the dismissiveness of the false advertising claims betrays the effects of the false advertising on an individual patient. The managed care industry is also likely to argue that *Maio* is a trivial example and not indicative of the industry's overall commitment to quality health care. Perhaps so. Yet Aetna's stance in that case was certainly consistent with a philosophy that puts patients a distant second to other considerations.[73] Moreover, this is not the only time when the industry's public posture was at odds with its private actions. The incongruity between public statements and private decisions further exposes the accountability gap.

Equally important, *Maio* is symptomatic of a larger failure to provide adequate information to the public. Maintaining a market-based health care system requires that patients have adequate access to information that allows them to make an informed decision about the type and amount of health care to purchase. A fundamental flaw in the market approach in health care is the patient's inability to judge the quality of health care. Deliberately depicting a commitment to quality of care in terms that an MCO has no intention of upholding may be nothing more than puffery in the law and may not amount to false and deceptive advertising. Nevertheless, it certainly undermines the rationale for a self-regulated market-driven system that proponents have offered. The managed care industry conveys to the public and to political

71. Ivan L. Preston, *Puffery and Other "Loophole" Claims: How the Law's "Don't Ask, Don't Tell" Policy Condones Fraudulent Falsity in Advertising*, 18 J.L. & COM. 49 (1998).

72. Clark C. Havighurst, *Consumers Versus Managed Care: The New Class Actions*, HEALTH AFF., July-Aug. 2001, at 8, 15-16.

73. In response to patients' claims for access to payer databases to substantiate promises of quality of care and to determine whether physician reimbursements were adequate, Aetna's attorney was quoted as saying that granting access would be "abusive, oppressive, and overreaching." Catherine Wilson, *Lawsuits Pending on Managed Care*, TALLAHASSEE DEMOCRAT, July 17, 2002, at E10.

officials that it shares professional values in ways that differ from those of other sellers in several key dimensions. In contrast, the defense of mere puffery about commitment to quality strikes at the heart of the managed care enterprise and the social contract between the managed care industry and the public.

Managed Care as an Industry. These implementation failures have been compounded by an industry-wide strategy, reflected in the major trade association's policies, that is largely about image management. The American Association of Health Plans ("AAHP") was created in 1995 from a merger of two managed care/insurance organizations and quickly became the voice of this burgeoning industry. Its stated mission is "to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans,"[74] but it focuses much of its activities on lobbying and public relations management as opposed to "advancing quality."

As managed care took off, it was concurrently praised for putting a lid on runaway expenditures and vilified for restricting care and physician payments. The AAHP's response to much of the criticism and proposed patients' rights legislation has been like that of a recalcitrant child—just say no.[75] Take, for example, AAHP's response to a survey finding that one in seven could not get needed healthcare services, regardless of their insurance status.[76] AAHP ascribed the decline in access that occurred during this period of managed care market penetration to "some providers . . . contracting with fewer insurers, and others [being] too overwhelmed to take new patients. Changes in employer-sponsored plans also mean that a favorite doctor or hospital could be dropped from the patient's network."[77] AAHP seems to suggest that the inability to get medical care when needed has nothing to do with managed care restrictions. Instead, it is caused by physicians who refuse large numbers of patients and patients who are not sick enough to justify being overly selective about the doctor they see.

After successfully contributing to the defeat of the Clinton plan for healthcare reform, the industry, the HIAA,[78] and AAHP have doggedly fought

74. American Association of Health Plans, *Who We Are*, *at* http://www.aahp.org/Content/NavigationMenu/About_AAHP/Who_We_Are/WhoWeAre.htm (last visited Sept. 6, 2002).

75. This is also a reference to Nancy Reagan's "Just Say No" campaign against teen drug use.

76. Bradley C. Strunk & Peter J. Cunningham, *Treading Water: Americans' Access to Needed Medical Care, 1997-2001*, *at* http://www.hschange.com/CONTENT/421 (Mar. 2002).

77. Alicia Ault, *One in Seven in U.S. Can't Get Healthcare as Needed*, Reuters Health, *at* http://www.handi-stop.com/bbs/messages/1246.html (Mar. 21, 2002).

78. Jeanne Schulte Scott, *ClintonCare II: The Revenge*, HEALTHCARE FIN. MGM'T, Jan. 1998, at 24.

any attempt to take an incremental approach to reforming the system, without offering any alternative to the status quo. As early as 1996, AAHP attempted to obfuscate the public cry to give patients an appeals process and to provide an escape route from pre-authorizations and non-covered emergency services. The organization sought to preempt legislation by launching a "Putting Patients First Initiative" that included voluntary member guidelines and no enforcement provisions whatsoever for their one thousand member MCOs.[79] Critics characterized the initiative as a way to avoid more stringent legislative and political oversight.[80] As one critic noted, "It is based on the faulty premise that there are not really any problems with managed care—only confusion resulting from anti-managed care misinformation—and asserts that the answer lies merely in health plans holding themselves accountable."[81]

At the same time, AAHP vigorously opposed "prudent layperson" legislation that would codify a patient's right to obtain treatment outside the plan in emergency situations. Despite the commitment to voluntary grievance procedures, AAHP has opposed state legislation mandating them and has supported legal challenges to such laws even when the voluntary approach showed few results.[82] The managed care industry has consistently opposed similar federal legislation even though AAHP's studies have concluded that independent reviews are relatively infrequent and about half of the cases reviewed by independent reviewers confirm the insurers' medical decisions.[83]

Faced with the possibility of Congress granting physicians the right to bargain collectively with MCOs, AAHP decried the initiative. Somewhat disingenuously, AAHP does not claim that this right would be problematic for MCOs negotiating with large powerful physician groups. The stated concern is only for the "working families" and the increased cost and reduced quality that would result from collective bargaining by physicians.[84]

79. *AAHP Sees the Handwriting on the Wall*, BUS. & HEALTH, Mar. 1997, at 13.

80. *The Managed-Care Industry Fights Back*, MED. ECON., June 23, 1997, at 119.

81. Peter V. Lee, *The True Test of Whether Health Plans Put Patients First*, HEALTH AFF., Nov.-Dec. 1997, at 129.

82. *See, e.g.*, Rush Prudential HMO, Inc. v. Moran, 122 S. Ct. 2151 (2002).

83. See Michael Milt Pretzer, *The Case for Less Regulation of Managed Care*, MED. ECON., June 15, 1998, at 48, 56; M. Freudenheim, *Big HMO to Give Decisions on Care Back to Doctors*, N.Y. TIMES, Nov. 9, 1999, at A16; American Association of Health Plans, *Independent Medical Review of Health Plan Coverage Decisions: A Framework for Excellence*, *available at* http://www.aahp.org/Content/NavigationMenu/About_AAHP/News_Room/Press_Releases/Press_Release_Archive?IndepenMedReviewBook.pdf (last visited Jan. 15, 2003).

84. Press Release, AAHP, Barr-Conyers' Legislation Advances Provider Interests at Expense of Consumers (Mar. 7, 2002), *available at* http://www.aahp.org/Content/NavigationMenu/About_AAHP/News_Room/Press_Releases/AAHP__Barr-ConyersandNum8217;_Legislation_Advances_Provider_Interests_At_Expense_of_Consumers_(3_07_.htm. Denying that United Healthcare's move to discontinue preauthorization requirements was in response to the threat of patients' rights legislation, AAHP's Susan Pisano attributed it to "the

I am hard pressed to find a meaningful, constructive dialogue taking place that includes managed care industry organizations. While the managed care industry fights legislation, regulations, and public opinion that call for managed care reform and accountability, the industry is very open to legislation that benefits their members. Amidst AAHP roadblocks to patients' rights, the organization's calls for limits on litigation and added Medicare prescription drug benefits can be heard. All of these examples demonstrate the industry's oppositional, protectionist approach.

THE VERDICT

Each of the actors had either motive or opportunity to kill managed care. Yet each also had what amounts to an alibi. Either the motive was mixed or the opportunity to act was limited. At first glance, the most obvious conclusion would be that each actor contributed to what might be considered death by a thousand cuts. There is much to support this outcome, since it seems undeniable that actions taken by each of the suspects contributed in some way to managed care's travails. This conclusion is also convenient for each of the players because they can avoid blame. Each can legitimately say "I didn't do it—you can't attribute managed care's death to me. 'X's' contribution was much more significant than mine. Sure, I played a role, but I was just protecting my own interests. I had no desire to sabotage managed care." In this sense, each actor played a necessary, but not alone sufficient, role in killing managed care.

Yet that verdict seems wrong to me because one of the participants above all is complicit. I conclude that the primary perpetrator was the managed care industry itself, a result of failures from within. Through self-inflicted wounds, the industry self-destructed. To be sure, implacable opposition and political interference from outside beset the industry and made survival a difficult challenge. In this context, the fate of managed care has many similarities to *The Perfect Storm*.[85] This popular book and subsequent film depicted the story of three different and distinct weather patterns that converged to create a storm of power and destruction that was far greater than the aggregate of the individual storms. By analogy to that story, the howling wind from the north was simultaneous pressure from employers/purchasers who wanted relief from soaring costs and from employees/patients who wanted options and choices. The gale from the south was patient dissatisfaction that manifested itself in the form of thunderous opposition. Finally, the hurricane from the east was

next stage in the evolution of health care, the edge of a wave of change." Freudenheim, *supra* note 82 at A1.

85. SEBASTIAN JUNGER, THE PERFECT STORM: A TRUE STORY OF MEN AGAINST THE SEA (1997). I am indebted to my research assistant, Deanna Hanks, for suggesting and developing the analogy.

physician dissatisfaction that set off hardball negotiating strategies with deep antagonism toward MCOs. With high hopes the ship *Andrea Gail* sailed into the vortex of the 1991 convergence of three storms, just as the advent of managed care converged with high public policy hopes and expectations of providing high-quality health care while controlling costs.

The captain and crew of the *Andrea Gail* did not intend or anticipate being killed any more than managed care intended to be a victim. The visionaries and innovators of managed care saw an organizational form that would rely on the power of the marketplace to integrate the financing and delivery functions of health services. Unfortunately, the implementation failed to achieve these goals without alienating too many stakeholders. Perhaps the expectations were too great, and the window for success too narrow, but the poor implementation of managed care unwittingly created the opportunity to fall victim to itself.

Certainly, the other suspects contributed to the mauling, making it difficult for the industry to overcome its mistakes. At a minimum, these suspects hastened managed care's demise. Physicians and patients clearly aided and abetted the demise. There is little question that neither group will be mourning at the funeral. Politicians contributed by constantly threatening to intervene and focusing unwanted attention on the industry's shortcomings, though the courts were, surprisingly, largely bystanders. Hospitals continued the pressure by ratcheting up their fees, and employers succumbed to employee demands for greater choice in health care coverage. Indeed, employers squandered the opportunity to hold MCOs and employees to the cost-access tradeoff. Moreover, the media played a central role as handmaidens to the slaughter by overplaying the horror stories and not reporting on managed care's successes.

Managed care could, nevertheless, have overcome the combined contributions of its detractors. It offered a good concept at the right time. The country was looking for ways to reduce health care costs without sacrificing quality of care, and managed care offered the conceptual model to accomplish those objectives. Yet, the design was poorly implemented, with little regard for legitimate patient and physician complaints. The industry's "just say no" response to criticism is eerily reminiscent of how the tobacco industry responded to mounting scientific evidence of the harms its products caused. In both cases, the industry failed to adapt to public discontent, resulting in vilification and a public backlash. To that extent, managed care's death did not occur as a result of natural causes.

The Implications

Future health care historians may well look back and see managed care as a transition between the fee-for-service system and an entirely new way of delivering and financing health care. Whatever managed care's current

problems, it seems premature to declare that it is dead. It is certainly in retreat and may well be on life-supports, but it is not dead yet.[86] In either case, policymakers will need to address several questions: Is it worth resuscitating? If so, what will it take to revive it? If not, what will replace it?

Answering these questions is beyond the scope of this article. My short answers are as follows. First, it is worth saving managed care because the concept is sound and the implementation failures can be addressed. Second, the industry needs to reverse its "just say no" strategy and embrace public accountability. This would include a strong, expedient, and independent grievance process to resolve challenges to delayed or denied care. Individual MCOs should also welcome a patient advisory board with meaningful oversight of cost containment strategies, along with providing a patients' rights advocate. Above all, the managed care industry needs to educate patients and physicians about why cost control is imperative and how cost containment decisions are made.[87]

As for the future, let me note that the cost-quality-access tradeoffs at the heart of managed care will remain regardless of what replaces it. Whatever replaces managed care will confront the same policy conflicts present at the dawn of the managed care era—patient demands for access to increasingly expensive care and insurer demands to control those very costs. At present, there is no obvious successor waiting to take managed care's place. Shifting to a fully private system is as unlikely as replacing managed care with universal health coverage. All indications are that, in the short-term, more and more of the health insurance burden will be shifted to individuals. Employers are shifting from defined benefit to defined contribution programs, which will increase employees' out-of-pocket health care expenditures.

CONCLUSION

In this article, I have taken a somewhat irreverent look at the current state of the health care delivery system in the United States, but this parlous situation is a very serious matter. For health care affects all of us, and the current *sturm und drang* is unsettling for all but the wealthiest citizens who can still afford private health insurance. Whether it is the high cost of health care or the absence of health insurance, something is terribly amiss in the system. My fear is that it will get much worse before the political system will be forced to develop solutions.

86. In this sense, the managed care industry most resembles the Ottoman Empire during its decline at the beginning of the 20th century when it was widely referred to as "the sick man of Europe." *See* LORD KINROSS, OTTOMAN CENTURIES: THE RISE AND FALL OF THE TURKISH EMPIRE (1977).

87. As one participant in the Symposium noted: managed care was designed to ration health care, but never told the public how it would be done. Now that we know, we don't like it!