Witten Herdecke University

Managed Care

How it affected the US health care system

Fionn Kientzler
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Managed Care and how it affected the US Health Care System

Introduction

If you want to know how European health care systems are likely going to change in the near future, you need to take a close look at managed care as utilized in the United States of America. Gatekeeping, case management, guidelines and many other features that have become so popular among European health policy analysts, can ultimately be traced back to the managed care movement in the United States. It is clear that managed care provides the health care sector with more competitiveness and transparency. On the other hand, when we look at the recent developments of the US health care system, it seems as though, in the long term, managed care might not be able to contain costs due to exogenous as well as endogenous factors. The purpose of this paper, then, is to provide a concise but not all-encompassing summary of the features of managed care and to explain why managed care has neither been popular among US patients nor been able to control health care costs in the long term. Thus, we will first take a close look at the elements, organizational features and instruments of managed care. Then, we will examine how managed care came about and what caused the managed care backlash. Finally, we will analyze the US health care system and explore the exogenous and endogenous factors that led to the rise in costs despite the cost control purpose of managed care.

Elements of Managed Care

Definition

Managed Care is a generic term for health plans that take active steps to affect the type or amount of care their enrollees receive. Managed care plans differ from traditional indemnity plans primarily in that they have detailed contractual or employment relationships with health care providers. There is a large spectrum of organizational elements that might be referred to as "managed care".[1]

On the more managed end of the spectrum, plans require enrollees to choose a primary care physician who in exchange for a fixed monthly payment, furnishes the primary care and directs the referral of patients to specialists. In that case consumers sacrifice their freedom to choose care providers. This might be achieved through financial stimuli.

On the less managed end of the spectrum, some plans allow beneficiaries to use services from any provider within the network and pay providers on a discounted fee-for-service basis. Providers might be offered and patients can select any of them from the given network. Co-payments to outsiders will be considerably higher.[2]

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[1] Suppanz E., H. Docteur, and Woo J. "The US Health System: An Assessment and Prospective Directions, for Reform", *OECD Economics Department Working Papers*, No. 350, OECD Publishing. (2003) S. 15

[2] Ibid

There are three tasks managed care organizations typically undertake to achieve cost efficiency. They may intervene in the relationship between the provider and the insured individual to provide direct cost saving incentives. They may constrain the service in particular circumstances to limit unnecessary treatments. They may selectively contract with a defined set of providers to achieve a higher level of cost control by means of integration.

Organizational Features

HMO (Health Maintenance Organization)

An HMO is an insurance plan under which an insurance company attempts to control all aspects of the health care of the insured. The plan requires that each member is assigned a "gatekeeper", a primary care physician (PCP) who is responsible for the overall care of members assigned to him. Specialty services require a specific referral from the PCP to the specialist. Non-emergency hospital admissions also required specific pre-authorization by the PCP. Typically, services are not covered if performed by a provider not an employee of or specifically approved by the HMO, unless it is an emergency situation as defined by the guidelines of the HMO. [3]

The HMO has the contractual obligation to deliver a specified service package for the recipient. On the same token, the HMO is not only responsible for the financial administration but also the service provision. Regarding the service provision, the amount of insurants is predefined which enables the HMO to plan ahead and efficiently distribute patients to physicians and hospitals. This allows for steady capacity utilization.

The financing is organized in the following manner. Insurants pay a fixed annual or monthly premium. The premium covers all expenses with minor exceptions. The premiums are risk and not income dependent and family members must be insured individually. A fee for service plan, where insurants directly pay providers for their services and subsequently submit the claims to their insurance company for reimbursement is also common way of financing HMO's. The HMO typically takes on the partial financial risk as external insurances often cover for unexpectedly high health expenses. [4]

HMOs operate in a variety of forms. They can have manifold divisions, each operating under a different model, or blend two or more models together. In the staff model, physicians are salaried and have offices in HMO buildings. In this case, physicians are direct employees of the HMOs. This model is an example of a closed-panel HMO, meaning that contracted physicians may only see HMO patients. In the group model, the HMO does not pay the physicians directly, but pays a physician group. The group then decides how to distribute the money to the individual physicians. This model is also closed-panel. Physicians may contract with an

[3] Werthman M. J. Behavioral Managed Care, Mcgraw-Hill Healthcare; 1 edition (1997) 5-20 pp

[4] Moore, Perry (Perry D.) Evaluating health maintenance organizations : a guide for employee benefits managers , New York : Quorum Books, 1991. 20-31 pp

independent practice association (IPA), which in turn contracts with the HMO. This model is an example of an open-panel HMO, where a physician may maintain his own office and may see non-HMO members. In the network model, an HMO will contract with any combination of groups, IPAs, and individual physicians. [5]

PPO (Preferred Provider Organizations)

Rather than contract with various third party administrators, providers may contract with preferred provider organizations. They generally agree to a discount off of a relative value-based fee schedule or simply a discount off of whatever they bill. The PPO, in turn, promises convenience, less administrative expenses, and prompt payment. In terms of using such a plan, unlike an HMO plan, which has a copayment cost share feature (a nominal payment generally paid at the time of service), a PPO generally does not have a copayment and instead offers a deductible and a coinsurance feature. The deductible represents the first dollar of coverage and is paid by the patient. After the deductible is met, the coinsurance portion applies. Since the deductible is usually quite a considerable share of the coverage, the PPO represents the least expensive form of insurance.[6]

POS (Point Of Service)

A POS plan utilizes some of the features of each of the above plans. Members of a POS plan do not make a choice about which system to use until the point at which the service is being used. In terms of using such a plan, a POS plan has levels of progressively higher patient financial participation as the patient moves away from the more managed features of the plan. For example, if the patient stays in a network of providers and seeks a referral to use a specialist, they may have a copayment only. However, if they use a network provider, but do not seek a referral, they will pay more.[7]

Instruments

Payment Systems

Fee for service

Fee-for-service payment plans exist where specific payment is made for specific services rendered as opposed to retainer, salary, or other contract arrangements. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. Consequently, these plans have weak incentives to save costs. That is why, fee for service plans lead to lower resource efficiency. On the other hand, they lead to higher care intensity, which, as opposed to low care intensity, can be quite beneficial for the patient.[8]

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[5] Luft, Harold S. Health maintenance organizations, dimensions of performance, New York : Wiley, 1981.

[6] Norma L. Nielson, Chairholder in Insurance and Risk Management, Faculty of Management, University of Calgary. Coauthor of Ethical Uses of Information in Insurance and Financial Planning as an Employee Benefit. "Managed Health Care," Microsoft® Encarta® Online Encyclopedia 2007 http://encarta.msn.com

[7] Ibid

[8] Amelung, V./Schuhmacher H. , Managed Care – Neue Wege im Gesundheitsmanagement, 2nd edition, Gabler: Wiesbaden 2000

Fixed income with a bonus option

Another typical payment system is a fixed annual income with an optional bonus. Under a payment system that is entirely fixed, the physician would not have an incentive to save costs, and since his payment does not depend on the amount of patients he is treating, he might not be willing to maximize his productivity. That is why HMOs add a cost savings and productivity incentive in form of a bonus. The size of the bonus depends on the profitability of the HMO. [9]

Capitation

Capitation means that a specified amount is paid periodically to a health provider for a group of specified health services, regardless of the quantity or intensity of health care rendered. Providers are not reimbursed for services that exceed the allotted amount.[10] Amounts are determined by assessing a payment per member. The rate may be fixed for all members or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization. This type of system leads to high resource efficiency as medical staff has a strong incentive to save costs. On the other hand, they need to maximize the amount of patients using their services to maximize their revenue. To attract patients, in turn, they need to deliver good quality, which leads to quality competition among different providers. [11] On the other hand, if the risks are not adequately compensated there can also be a strong negative incentive of risk selection or under provision.

Case based lump sum

The most prominent case based lump sum system is the diagnosis related groups system. Diagnosis-Related Group (DRG) is a system to classify hospital cases into groups, expected to have similar hospital resource use. DRGs are assigned by a "grouper" program based on diagnoses, procedures, age, sex, and the presence of complications or co-morbidities. Now that hospitals are being paid per case, they have an incentive to increase the number of cases dealt with in the hospital, therefore increasing the bed utilization rate. Since hospitals are getting the same amount of money per case (adjusted by a case mix index accounting for the differences in treatments severity), they have to try to lower their costs if they want to be competitive or if they want to generate profits. [12]

However, there is also an incentive for health care providers to expand the cases which is very difficult to control. Likewise, there is a danger of saving costs on the qualitative aspects of the treatment for example by sending home patients too early. Thus extra measures for quality management and cost monitoring have to be undertaken. If these should work effectively, they require monitoring and supervision by external control organizations as documentation alone can be used in a biased manner by the hospital staff. These monitoring costs, in turn, could lead to an increase in the overall costs of the system. [13]

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[9] Luft, Harold S. Ibid

[10] Augurzky, B. et al. Strukturreformen im deutschen Gesundheitswesen, RWI:Materialien, Issue 8, Essen. 2004, P. 33-35

[11] Cutler, D. M. (1994), A Guide to Health Care Reform, in: The Journal of Economic Perspectives, Vol. 8, No. 3, pp. 13-29.

[12] Office of Technology Assessment, Diagnosis Related Gorups (DRGs) and the Medicarte Program: Implications for Medical Technology—A Technical Memorandeum Wachsington, D.C.: U.S. Congress, July 1983. This technical memorandum was performed as a part of OTA's assessment of Medical Technology and Costs of the Medicare Program.

[13] Pointer, Dennis Dale. Essentials of health care organization finance : a primer for board members, San Francisco : Jossey-Bass, 2004.

Quality and Cost Control Systems

Utilization Review

Utilization Review is the review of how certain medical services are requested and performed. The review examines medical records to see if the patient was given an economical level of care consistent with their needs and the past needs of similarly-afflicted patients. The review typically involves pre-authorization, a concurrent review, or inpatient evaluation of care and needs; and retrospective review, or the larger historical picture of how physicians, labs, or hospitals handle their patient populations. Most HMOs have written standards for what items are reviewed, and what might be considered appropriate for amount, time, and sources of evaluation and treatment. An independent review organization will also perform utilization review functions. Utilization Review may be performed by the HMO or insurer itself, or it may be contracted out to either a third party review specialist or to the hospital providing the service. [14]

Second Opinion Program

Second opinion refers to the practice of a second physician evaluating the patient for the same medical problem to give another opinion on the diagnosis or the proposed plan of care. The patient, the physician or the insurance company may seek a second opinion. The patient may be apprehensive about a suggested invasive procedure, or discontented with the care being provided. The primary physician and the consultant may have differing opinions. A consultant may seek another opinion in a complicated condition, or where the patient is perceived as demanding or arguable. The prevalence of 'second opinion' is difficult to determine accurately: often the patient may not let the consulting physician know, for a variety of reasons, that a second opinion is being sought and accurate data on referral source are rarely maintained. In the USA, a high number of malpractice lawsuits and lately cost containment issues have led to increased use of second opinion programs particularly for invasive procedures. Thus, improved quality of care, cost containment and increased patient satisfaction are the major reasons for establishing a second opinion program.[15]

Clinical Pathways

Clinical Pathways are structured, multi-disciplinary plans of care designed to support the implementation of clinical guidelines and protocols. They consist of four main components: A timeline that provides an approximate guideline for the different stages of treatment; the categories of care or activities and their interventions; an intermediate and long term outcome criteria; and finally the variance record that documents possible deviations from the guideline. Clinical Pathways provide explicit and well-defined standards for care supporting the introduction of evidence-based medicine. As they limit the freedom of doctors and nurses in the application of treatment procedures, they also limit the risk of potential misjudgments and neglected care. Thus they support clinical risk management and clinical audit which help establish an effective quality management.[16]

[14] Oberlander, Jonathan, "The US health care system: On a road to nowhere? " CMAJ 2002;167(2):163-8 pp. 166

[15] Mamdani, Meenal , Indian Journal of Medical Ethics, Jul-Sep 1997, Issue, 5(3) , http://www.ijme.in/053mi075.html

[16] Thiemann, H., Voss, H. (1998): Clinical Pathways: Hilfsmittel für ressourcenschonendes Handeln in der Medizin, in: Eichhorn, S., Schmidt-Rettig, B. (Hrsg.): Chancen und Risiken von Managed Care, Stuttgart, S. 175-186

History of Managed Care

Why did it come about?

As health-insurance costs rose during the 1970s and 1980s—driven both by improving medical technology and by the growing inefficiencies of the health-care system—health maintenance organizations, which had been around since the beginning, began to proliferate, along with other managed-care schemes. In 1971, the Nixon Administration announced a new national health strategy: the development of health maintenance organizations (HMOs). The federal government would establish planning grants and loan guarantees for HMOs, towards a goal of increasing the number of HMOs from 30 in 1970 to 1,700 by 1976, enrolling 40 million people, and 90 percent of the population by 1980. The HMO Act of 1973 authorized $375 million in federal funds to help develop HMOs; preempted state laws that banned prepaid groups; and required companies with at least twenty-five employees to offer a federally qualified HMO.[17]

Managed care continued to grow throughout the 1970s, 1980s. Employers came to look upon managed care as a less expensive yet comprehensive and high quality form of insurance to offer their employees. State governments also increasingly turned to managed care to help with the Medicaid program, and the federal government has implemented managed Medicare.[18] Ronald Reagan was the first mainstream political leader to take deliberate steps to reform American health care from its longstanding not-for-profit business principles into a for-profit model that would be driven by the insurance industry. Twelve percent of the market was served by for-profits in 1981; by 1997, that was more like 65 percent.[19]

What caused the managed care backlash?

As the private health insurance market turned away from the indemnity health insurance system to embrace the more restrictive and cost-conscious managed care system, patients worried that they would be denied needed medical services. [20] This phenomenon was particularly dominant throughout the 1990's and became known as the managed care backlash. However, even nowadays there is a growing body of evidence that patients distrust managed care organizations (MCOs) and believe that MCOs are unlikely to provide necessary care should they become seriously ill. One example is the statistic below (Exhibit 1), where American's who were surveyed ranked HMO's in close vicinity to tobacco and oil corporations, which classically have a bad public standing. Another study found that only 30% of MCO members trust their health plan to provide the right level of care, as opposed to 55% of people in traditional plans, and that 61% of MCO members believed their health plan was more concerned with saving money than with giving patients the best treatment, as compared with 34% of people in traditional plans. [21]

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[17] Tufts Managed Care Institute "A Brief History of Managed Care" 1998 http://www.tmci.org/downloads/BriefHist.pdf

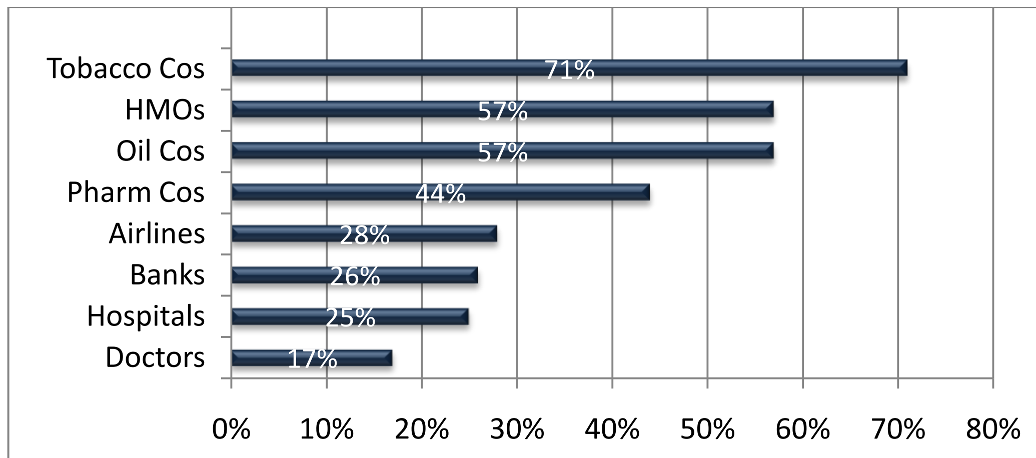
[18] Ibid

[19] Cohn, Jonathan, Sick: The Untold Story of America's Health Care Crisis--and the People Who Pay the Price, Harper and Collins, New York, 2007, p. 33

[20] Titlow , Karen and Bethesda, Ezekiel Emanuel "Employer Decisions and the Seeds of Backlash", Maryland Journal of Health Politics, Policy and Law, Vol. 24, No. 5, October 1999. p.143

[21] Miller, Nolan, "Insurer-provider integration, credible commitment, and managed-care backlash" Journal of Health Economics, Volume 25, Issue 5, September 2006, pp. 861-876

Exhibit 1: Percent of Groups with "Unfavorable" Rating



Source: Kaiser Family Foundation, National Survey of Prescription Drugs 2000

Particularly unpopular were the utilization review, out-of-pocket expenses and the steering of patients to more cost effective providers. During the managed care backlash of the 1990's the most annoying of these features had been removed from plans as insurers responded to pressure from enrollees and employers. But with premiums rising at double-digit rates, some plans have now begun reintroducing these strong cost-control measures. [22] Insurance companies have argued that the backlash never occurred, citing the positive enrolment figures in managed care plans over the last decades.[23] However, one might safely argue that patients did not have a choice and had to enroll in managed care plans as their employers increasingly opted for these plans and indemnity plans became increasingly scarce.

Managed Care and the US Health Care System

The US Health Care System

The health care system in the United States remains a "paradox of excess and deprivation." The United States spends more on medical services than any other nation, and US physicians earn more than their counterparts in Canada, Europe and Japan. Americans with insurance have access to the latest in sophisticated medical technology and innovative medical procedures; rates of diffusion for many medical technologies, such as magnetic resonance imaging, are generally higher in the United States than in other industrialized democracies. Indeed, the availability of these resources is so widespread that some analysts believe that well-insured Americans are receiving too many medical services. At the same time, millions of Americans receive too little medical care.[24]

80 Million Americans are insured by the government. They are either beneficiaries of the Medicare plan or the Medicaid plan. Although their names are similar, Medicaid and Medicare

[22] Anonymous, "Managed care plans dust off practices that triggered 1990s Backlash" Hospitals and Health Networks, Spember 2004 p. 96

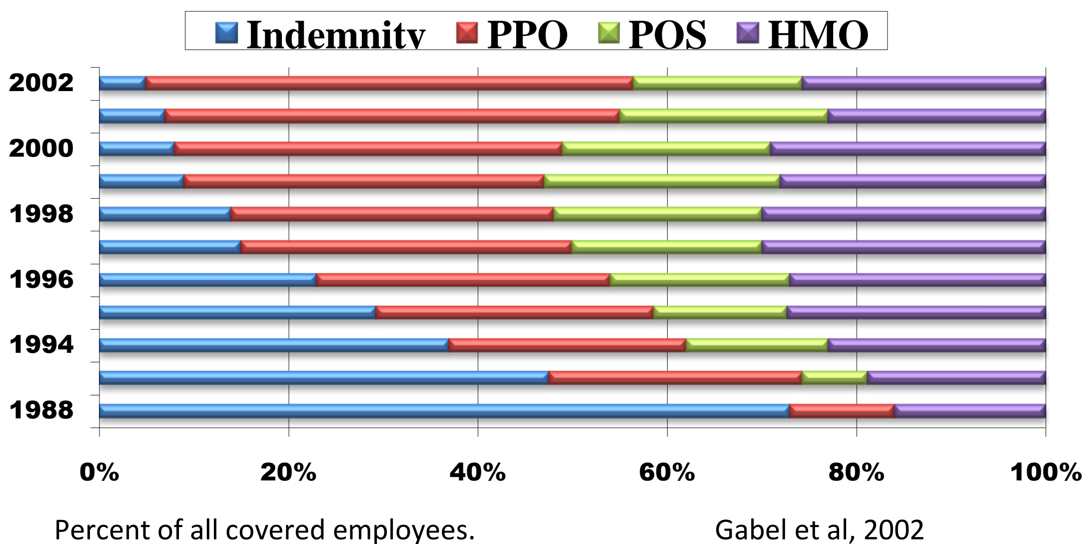
[23] Marquis et al . "The Managed Care Backlash: Did Consumers Vote with Their Feet?", Inquiry, Winter 2004/2005

[24] Oberlander, Ibid.

are very different programs. Medicare is an entitlement program funded entirely at the federal level.[25] It focuses primarily on the older population.[26] Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end stage renal disease.

Medicaid is not an entitlement program, and it is not solely funded at the federal level. Medicaid is a needs-based program: eligibility is determined by income. States provide up to half of the funding for the Medicaid program. In some states, counties also contribute funds. The main criterion for Medicaid eligibility is limited income and financial resources, a criterion which plays no role in determining Medicare coverage. 170 Million Americans get covered by their employer's benefit plan. Over 40 million Americans do not have health insurance, which makes the United States the only democratic country in the world with a substantial uninsured population. In the United States, only 45.1% of health spending is funded by government revenues, well below the average of 72.5% in OECD countries.[27] As Exhibit 2 shows, most Americans today are enrolled in some sort of managed care plan.

Exhibit 2: Enrollees per insurance system in percent



Percent of all covered employees. Gabel et al, 2002

Let us now focus on the financial situation of the US health care system in comparison to other advanced health care systems. According to a recent OECD study, total health spending accounted for 15.3% of GDP in the United States in 2005, the highest share in the OECD, and more than six percentage points higher than the average of 9.0% in OECD countries. The United States also ranks far ahead of other OECD countries in terms of total health spending per capita, with spending of 6,401 USD (adjusted for purchasing power parity), more than twice the OECD average of 2,759 USD in 2005. Between 2000 and 2005, health spending per capita in the United

[25] US Department of Health and Human Services, The Official Government Website for People with Medicare http://www.medicare.gov/LongTermCare/Static/Home.asp Page Last Updated: January 22, 2007

[26] US Department of Helath and Human Services, Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/MedicareGenInfo/ Page Last Modified: 12/14/05

[27] Oberlander, Ibid.

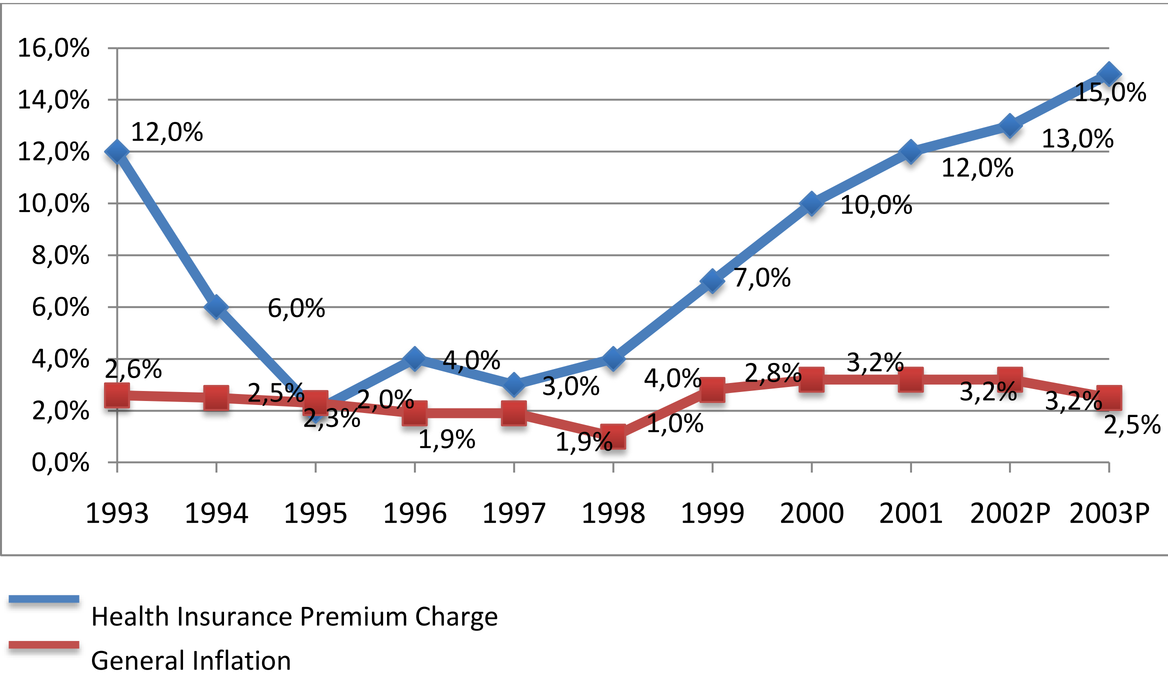
States increased, in real terms, by 4.4% per year on average, a growth rate slightly higher than the OECD average of 4.3%.

In spite of the relatively high level of health expenditure in the United States, there are fewer physicians per capita than in most other OECD countries. In 2005, the United States had 2.4 practicing physicians per 1 000 population, below the OECD average of 3.0. There were 7.9 nurses per 1 000 population in the United States in 2002 (latest year available), which is slightly lower than the average of 8.6 across OECD countries. The number of acute care hospital beds in the United States in 2005 was 2.7 per 1 000 population, also lower than the OECD average of 3.9 beds. These facts raise the question of how managed care relates to these high expenditures.[28]

Managed care and rising health care costs

Since the advent of managed care in the early 1990s, health care spending in the United States has slowed. From 1993 to 1998, the share of gross domestic product (GDP) devoted to national health expenditures declined from 13.7% to 13.5%, and premiums for employer-sponsored health insurance actually grew more slowly than the per capita GDP.[29] However, as we can see in Exhibit 3 in 1998 the cost saving trend reversed and since then health insurance premium charges have skyrocketed. This seems to indicate that the introduction of managed care initially helped to reduce costs but that the cost savings were weathered down over time and cannot be realized anymore today. Let us now look at the factors that could explain the rise in health care costs.

Exhibit 3: Health Insurance Premium charge versus general inflation



Sources: Towers Perrin (red) and the Department of Labor (blue)

[28] OECD, Health Data 2007How Does the United States Compare www.oecd.org/health/healthdata.

[29] Obelander, Ibid

A Study by PricewaterhouseCooper reveals a differentiated picture of the price increase. Firstly, there are the exogenous factors such as a large increase in costs related to drugs, medical devices and medical advances or demographic changes. And indeed, findings from various studies confirm the notion that US health care makes relatively intensive use of technology, e.g. the United States had more MRI units and CT scanners per person in 1999 than nearly three-fourths of OECD countries reporting data. Furthermore, a study comparing care for heart attack patients in 17 countries over the past decade showed that, while treatment in all countries has become more intensive in the use of medications and cardiac procedures, the United States had a pattern of early adoption of new technologies and fast diffusion.[30] This seems to indicate that Americans are paying more because their doctors have access to the most innovative treatments.

Exhibit 4: Factors Fueling Rising Health Care Costs

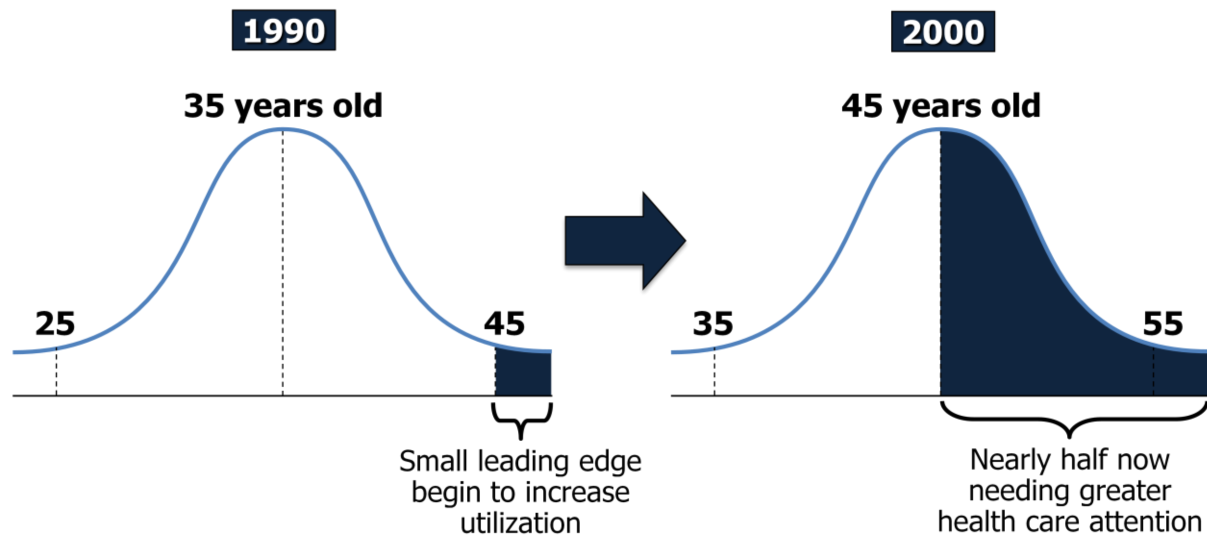
	Percentage Points	Percent of
Medical Trend	13.7%	100%
General Inflation (CPI)	2.5%	18%
Scien. and tech.	3.0%	22%
Rising Provider Expenses	2.5%	18%
Government Mandates	2.0%	15%
Increased Consumer	2.0%	15%
Litigation and Risk Man.	1.0%	7%
Other Categories	0.7%	5%

Source: PricewaterhouseCooper Commissioned by America's Health Insurance Plans, 2002

Similarly, the increased consumer demand for health care is a strong exogenous factor which can largely be traced back to the demographic developments in the United States. As Exhibit 5 indicates, this trend is becoming a major factor in the increase of expenditures.

[30] Technological Change in Health Care (TECH) Research Network. "Technological Change around the World: Evidence from Heart Attack Care." Health Affairs. 2001;20(3):25–42.

Exhibit 5: Demographic change



Source: US Census Bureau

However, very important elements of the rising costs are also endogenous factors such as the rising costs through government mandates or litigation and risk management that can largely be attributed to the managed care backlash. Patients become suspicious of health care organizations that have strong profit incentives. Throughout the backlash the government began to address these concerns by imposing stricter laws on hospitals to ensure that the quality of health care would not deteriorate due to the efficiency measures undertaken by the managed care organizations. On the other hand, patients were more motivated to start lawsuits if they perceived wrong doings by the managed care organizations. Both led to a higher quality control and risk management which, in turn, increased the costs of health care provision. If you take the liberty of adding both factors, they account for a rise in costs similar to that induced by technological and scientific advances (22%).

More importantly, though, among the endogenous cost increasing factors are the rising provider expenses. Indeed, since most managed care organizations are managed on a private basis, they have to make profits. In a competitive market they can make profits through costs leadership. As the market becomes more monopolized, however, it increasingly becomes a monopoly rent. In fact, during the 1990's there was a wave of hospital consolidations. What, then, drove these consolidations? Quantitative studies show mixed evidence of managed care being the driver for consolidations, which seems to indicate a more indirect affect of managed care on the rising expenditures as managed care is particularly conducive to for-profit strategies in the health care sector.[31]

It is not surprising, then, that hospital CEOs most commonly cite the promise of efficiency gains and opportunities to consolidate services and strengthen their financial position as reasons for

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[31] Keeler E et al. "The Changing Effects of Competition on Non-Profi t and For-Profi t Hospital Pricing Behavior." Journal of Health Economics, vol. 18, no. 1, Jan 1999.

consolidating.[32] On the one hand consolidations assure better economies of scale, and on the other hand they secure more market power. Research suggests that hospital consolidation in the 1990s raised inpatient prices by at least five percent and likely significantly more. Prices increase 40 percent or more when merging hospitals are closely located.[33]

Beyond just the issue of consolidation, studies indicate that privatization is a major cost driving factor. An article by the Harvard Medical School scholars Steffie Woolhandler and David U. Himmelstein argues that the excess payments for care in private for-profit institutions were substantial: 19%. This figure implies that the US$37 billion that Americans paid for care at investor-owned acute care hospitals in 2001 would have cost only US$31 billion at not-for-profit hospitals — a difference of US$6 billion. But higher acute care (and rehabilitation) hospital payments are not the whole story on investor-owned care. For-profit hospitals and dialysis clinics have higher death rates. Investor-owned nursing homes are more frequently cited for quality deficiencies and provide less nursing care, and investor-owned hospices provide less care to the dying, than non-for-profit facilities. [34]

Conclusion

Finally, it must be concluded that the direct short term consequences of managed care lead to significant cost saving, however, over the long run, managed care may neither guarantee lower costs nor better quality, not to mention patient satisfaction. Having examined the elements, organizational features and instruments of managed care, we should now have a clear picture of what the concept of managed care encompasses. Exploring the history of managed care and taking a closer look at the managed care backlash, we have been able to analyze under which circumstances managed care developed over time. Ultimately, we explored the US health care system and unveiled exogenous and endogenous factors that lead to the rise in costs in the US despite the cost saving purpose of managed care. It remains to be seen whether managed care will take a similar path in Europe. This paper should serve as a note of caution.

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[32] Ibid

[33] Gaynor M, Vogt W. "Competition Among Hospitals." RAND Journal ofEconomics, vol. 34, no. 4, Winter 2003

[34] Woolhandler and Himmelstein "The high costs of for-profit care" From the Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass: CMAJ, June 8, 2004; p. 170

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