COMMENTARY SECTION

Organizational and management strategies in response to US market trends

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Abstract *This paper describes major trends in the health care market. They include increased health care costs, the growth of managed care, emphasis on quality of care, consumer choice and the growth of the elderly and uninsured populations. The relationship between cost, quality, managed care and choice are explored in the Medicare and Medicaid programs. A clearer understanding of these trends enables managers in health care organizations to make strategic decisions resulting in organizations' survival and growth.*

Introduction

The health care system in the USA is undergoing turbulent changes. Major trends include increased health care costs, the growth of managed care, emphasis on quality of care, consumer choice, and the growth of the elderly and uninsured populations. In government-financed programs, such as Medicare and Medicaid, policies have shifted to the increased use of managed care to control high costs. This is especially necessary considering the rising number of elders who are Medicare beneficiaries and also the large numbers of medically indigent enrolled in Medicaid. As managed care penetration increases, monitoring quality in managed care plans is equally critical for policymakers, organizational management and consumers. Consumers not only worry about quality, but also cost and choice. Some are willing to forgo less expensive plans in exchange for higher quality. However, in other cases, many consumers lack finances and options. A major trend is the movement toward greater access to information for consumers to make informed choices about their plans and providers.

While trends affect all stakeholders, the intention of this paper is to describe the impact of these trends on organizations and managers. In particular, senior level management is responsible for strategically positioning their organizations for survival and success (Guo, 2001). As they counter pressures in the environment, health care managers must be prepared to make strategic decisions. The objectives of this paper are to:

(1) Briefly explain the history of the US health care system, particularly focusing on managed care.

(2) Discuss major trends in the health care environment. Here, Medicare and Medicaid programs will be reviewed to illustrate linkages among cost, quality, and managed care. Further, expanded consumer choice will be explained in connection with quality and coverage options in health plans.

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(3) Describe strategic goals of health care organizations.

(4) Outline strategies of senior level managers to counter these environmental pressures.

Brief history of the US health care system

Medical expenditures have risen rapidly in the past 40 years. Prior to 1965, the private sector was predominately responsible for spending in the medical sector. That is, private health insurance and individuals paying out of pocket comprised 80 percent of all health expenditures or $27.7 billion in 1965. The federal government only contributed the remaining 20 percent or $7.1 billion (Feldstein, 2003). In 1965, two major government programs, Medicare and Medicaid were created, which increased the role of the government in the financing and delivery of health care. Medicare provides coverage for the aged, those 65 and over, and Medicaid is for the categorically or medically needy. As a result of these two programs, national health expenditures escalated dramatically. Managed care came about as a market response to rising health care costs.

Traditional indemnity health insurance paid physicians and hospitals based on fee-for-service. This form of health insurance dominated 71 percent of the market in 1988 (KPMG Peat Marwick, LLP, 1998). In this model, patients are permitted to go to any provider and the provider is paid for each service. The patient pays a small annual deductible plus 20 percent of the provider's charge up to an annual out-of-pocket limit of $3,000. Since traditional fee-for-service plans lacked incentives to contain costs, government sought to reduce rising costs through the creation of the Health Maintenance Organization (HMO) Act of 1973 which encouraged the use of HMOs. An HMO is an organization that provides comprehensive health care services to a voluntarily-enrolled group for a pre-paid fee. Therefore, HMOs are able to control costs through utilization management, payment incentives to physicians, and restricted access to providers. The emergence of HMOs began in the early 1980 s and grew to its highest in the 1990 s. The peak period for HMO enrollment was in 1999, in which 81.1 million members were enrolled (Feldstein, 2003). However, HMOs were too restrictive, since they only reimbursed for networked providers. Patients who desired to seek care outside of the HMO network were responsible for full costs. Furthermore, in the HMO model, the primary care physician serves as a gatekeeper for referring patients to specialists. As patients demanded quality and choice among health plans, traditional HMOs began to evolve by offering point of service (POS) options. A POS is an HMO that permits its enrollees to use non-participating providers if enrollees are willing to pay a higher co-payment each time they use out of network providers. Although POS plans did not exist in 1988, a decade later, it controlled 20 percent of the market share (KPMG Peat Marwick, LLP, 1998).

To further provide patients with more options, managed fee-for-service indemnity insurance offered a preferred provider organization (PPO) option (closed provider panel) or access to all providers (open provider panel). Providers were paid based on fee-for-service, and enrollees have the financial incentive (pay a lower premium) to use the PPO providers or out of the network providers. PPOs captured only 11 percent of the market in 1988. By 2001, PPOs led the health care market at 48 percent, while HMOs represented 23 percent of market shares. POS were at 22 percent, and traditional fee-for-service were only 7 percent of the market (Feldstein, 2003). Today, managed

care continues to dominate the US health care system. Enrollment in HMOs and less restrictive managed care plans continues to grow. Hybrid managed care models are evolving to focus more on consumer choice, quality of care, preventive care, evidence-based medicine, clinical guidelines, and better coordination of care.

Increased health care costs and managed care

Health care expenditures cost containment remains one of the greatest areas of concerns in health care today. The national health spending as a percentage of the gross domestic product was 13.2 percent in 2000 and this is projected to increase. The cost of health care is expected to increase for several reasons including: the growing elderly population needing more access to health care, growing pressures from insurance company shareholders to improve their financial performance and underpriced health care products are attempting to regain market share by increasing costs to recoup losses. Health insurance premiums are expected to grow in all categories of health plans, including conventional fee-for-service, HMOs and PPOs. These premium increases will be especially high in the northeast regions (3.9 percent increase from 1996 to 1997), and 1.1 percent in the both south and west regions (also from 1996 to 1997) (KPMG Peat Marwick, LLP, 1997).

As a result of rising premium costs, many Americans are without health insurance coverage. Kuttner (2001) examined the state of health insurance and found that in 1995, 14.2 percent of the population were without insurance. This increased to 16.1 percent in 1997. Despite many government efforts to expand coverage, in 1997, 43.4 million Americans are still without insurance. The percentage of children younger than 18 without insurance increased from 13.8 percent to 14.8 percent from 1995 to 1996. Reforms to reduce the number of children without insurance resulted in a number of state block grants to the amount of $24 billion in 1998. Kuttner (2001) also noted that children are not the only ones likely to be uninsured. The near elderly, those aged 55-64 also lack insurance, primarily due to high costs of insurance for this age group. Other trends in eroding insurance coverage include:

- the movement toward temporary and part-time workers without health care coverage;
- reduction in benefits, especially pharmaceutical benefits;
- greater limitations in covered care, especially for HMOs, shift from traditional HMOs to POS and PPOs, which require more out-of-pocket payments; and
- loss of Medicaid coverage due to welfare reform (Kuttner, 2001).

These trends continue to pose widespread systemic problems. Although spending has been increasing for all programs, government still remains the largest provider and payer of health care services totaling 46.4 percent, with Medicare at 19.6 percent, Medicaid at 14.6 percent and other government programs at 12.2 percent (Centers for Medicare and Medicaid Services, 1998). Of the nation's health care expenditures, 32 percent comes from private health insurance payments, while out-of-pocket payments total 17.2 percent (Centers for Medicare and Medicaid Services, 1998). Spending in health care is divided into five categories, with hospital care being the most expensive at 34 percent, physician services at 19.9 percent and nursing home care at 7.5 percent (Centers for Medicare and Medicaid Services, 1998).

Medicare

In 1990, about 32 million Americans were over the age of 65 and 13.5 million were over 75. By 2020, those over 65 are projected to be 52.7 million (Longest, 2001). The number of Medicare beneficiaries is 39,620,000 as of 2000 (American Association of Retired Persons, 2001). As the population ages, government policy reforms will emphasize increasing access to health care, affordable health care, and quality of care for the aged. To accomplish these goals, government has sought solutions in managed care.

The growth of managed care is especially notable in government-financed programs. The Balanced Budget Act of 1997 drastically reduced Medicare spending. With the Medicare program in financial trouble as its expenditures rise at a rate of approximately 8 percent per year, the Centers for Medicare and Medicaid Services (CMS) determined that managed care will play a major part in the long-term solution for Medicare's plight. Thus, the goal of CMS is to enroll approximately half of all Medicare beneficiaries in managed risk/managed care programs by the year 2007.

The percentage of enrollees in Medicare risk programs has increased from 3.7 percent of the total enrollment in 1990 to 13.3 percent in 2001 (American Association of Retired Persons, 2001). The top ten HMOs for Medicare enrollees account for 42 percent of all Medicare HMO enrollment in 1997. PacifiCare of California is ranked number one for Medicare HMO enrollment with 395,699 enrollees and Kaiser Foundation Health Plan in northern California is ranked number two with 284,225 enrollees (InterStudy, 1997).

In a survey of Medicare risk plan enrollees, 47 percent of enrollees identify the most important reasons for enrolling in Medicare risk plans are lower costs and increased benefits (Centers for Medicare and Medicaid Services, 1997). On the other hand, the most important reasons for disenrolling from Medicare risk plans are problems with physicians (31 percent), financial issues (23 percent) and involuntary disenrollment (20 percent) (Centers for Medicare and Medicaid Services, 1997).

One of the major financial problems for the elderly is the cost of prescription drugs. These costs have risen faster than the costs of other components of health care. Total expenditures for prescription drugs increased by 85 percent between 1993 and 1998, with an estimated 17 percent increase from 1997 to 1998 alone (Kuttner, 2001). These expenditures were more than four times the rate of increase of the national health spending.

Although the elderly heavily depend on prescription drugs, more than 19 million, about half of all Medicare enrollees, lack drug coverage. With drug expenditures accounting for 34 percent of all medical expenditures for the elderly, many prescription drugs are unfilled, due to inability to pay for these drugs. Those elderly with pharmaceutical benefits received them from HMOs (12 percent), Medicaid (6 percent) and employer provided supplemental policies for retirees (26 percent), or privately purchased through Medigap insurance to supplement out-of-pocket costs not covered by Medicare (9 percent) (Lewin Group, 1998).

A further attempt by government to expand choices for Medicare beneficiaries is the implementation of Medicare + Choice. This plan allows beneficiaries more choice of products, including access to PPOs and POS plans. In 2001, 13.7 percent of Medicare beneficiaries are enrolled in Medicare + Choice (see Table I).

Medicaid

There are 40.3 million Medicaid beneficiaries (American Association of Retired Persons, 2001). Although low-income families account for 72 percent of all Medicaid enrollees, they spend a total of 33 percent of total Medicaid expenditures. The blind and disabled make up 17 percent of beneficiaries, yet, they spend the largest portion of Medicaid expenditures (38 percent). The elderly make up 11 percent Medicaid enrollees; they spend 30 percent of all expenditures (Kaiser Commission on the Future of Medicaid, 1997). More than one-third of Medicaid spending is for long-term care services. These services include home health (6 percent), mental health (2 percent), intermediate care facility (7 percent), and nursing facility care (19 percent) (Kaiser Commission on the Future of Medicaid, 1997).

State and local policymakers struggle with two major policy objectives. On the one hand, they seek alternative mechanisms to hold Medicaid cost down. On the other, they must extend coverage to growing numbers of uninsured populations. In 1997, there were 43.4 million persons (16.1 percent) without health insurance coverage (Kuttner, 2001). Thus, as with Medicare, Medicaid has begun to rapidly expand toward managed care risk plans. The nation's first mandatory Medicaid managed care program began in 1982 in Arizona (Solomon, 2001). Under this structure, Medicaid recipients are able to establish formal connections with health care providers, resulting in better and more coordinated care. In this way, managed care can be seen as an opportunity for Medicaid enrollees to receive higher quality of care (Torrens and Williams, 1999). Even in markets with voluntary Medicaid managed care programs, results have shown stronger alliances among providers and the ability to better manage patients along the continuum of care (Solomon, 2001). Consequently, the numbers of enrollees in Medicaid managed care have risen steadily. At the end of 2000, 55.8 percent of Medicaid beneficiaries were enrolled in managed care (American Association of Retired Persons, 2001).

Consumer choice

Consumers are a major force in shaping the health care market through their ability to make decisions about their health care needs. Consumers voice their demands for provider responsiveness, expect better services from insurers, desire more choices, availability, alternative therapies and more electronic access to information (VHA Inc., 1997). While most consumers believe that information about quality, as well as cost and satisfaction are relevant data that enable consumers to make informed choices, only 39 percent of consumers report that they actually have received such information.

In general, consumers are unhappy with the health care system. They believe that health insurers have more control over their medical care than providers. In a survey of consumers, 49 percent of respondents agree that quality of care is often compromised

Medicare beneficiaries	39,620,000
Medicare enrollment in Medicare + Choice, 2001	13.7%
Medicaid beneficiaries, 2000	40,380,979
Medicaid enrollment in managed care	55.8%

Source: American Association of Retired Persons (2001)

Table I.
Medicare and Medicaid, 2000

by insurance companies to save money; thus, 52 percent agree that "there is something seriously wrong with the health care system" (National Coalition on Health Care, 1997). When Americans chose a health plan, their number one concern is quality of care. However, consumers often judge quality differently from health care providers. Consumers rank quality by easy access to specialists (68 percent), range of health benefits (66 percent), percentage of physicians who have a complaint filed against them by patients (64 percent) (Robinson and Brodie, 1997). In fact, 75 percent of consumers are willing to pay for a more expensive plan with more benefits than a less expensive plan with fewer benefits (National Coalition on Health Care, 1997). Moreover, consumers believe that patient involvement with their treatment decisions is a key quality indicator. Indeed, there is a communication gap between patients and physicians. A total of 66 percent of patients want physicians to ask them questions about their general health, whereas, only 29 percent of physicians rate this as an important issue (Bayer Institute of Health Care, 1996).

Moreover, consumers argue that few health plans offer choices that they value. For example, one out of three Americans use alternative medicine, yet alternative medicine is seldom covered by their health plans (Eisenberg, 1997). One of the first managed care plans to offer alternative medicine was Oxford Health Plans of Connecticut in January 1997 (Leonard, 1997). More than 120 companies signed up for this managed care rider, even though premiums are slightly higher than a plan without alternative medicine.

To increase consumer choice, many health plans are responding to consumer demands by offering more diverse health coverage options. For instance, only 19.8 percent of managed care organizations offered POS plans in 1990. By 1994, 74 percent offered this option.

Organizational strategies

The trends described above are increasingly difficult issues for every health care organization. In fact, the health care industry is becoming more goal-oriented. At the same time, the goals of these organizations are very complex. Greater complexity demands prioritizing strategies. For example, cost containment is still the number one priority among health care providers (49 percent), while the second strategic priority is care management (VHA Inc., 1997). Care management is a cross functional endeavor in health care which involves clinical, economic, organizational, and behavioral elements. Consequently, organizations must be prepared to deal with economic pressures and care management issues. Managing these strategic priorities lies in the realm of knowledgeable management. As the market calls for lower prices, higher quality, and responsive services, to meet these demands, managers must adapt their organizations for long-term survival. There are a variety of strategic issues that drive the decision-making process of senior level managers in health care organizations. In surveys with organizational hospital executives, managed care leaders, and group practice administrators, their top five strategic goals are very similar (Greene, 1997). For example, hospital executives rank commitment to mission as their number one strategic goal and information technology as number two. On the other hand, managed care organizations and group practice administrators reversed the order of those two strategic goals, yet they remain as the two top choices. Furthermore, only managed care organizations

and group practices noted the importance of quality of care and outcomes in their top five strategic goals (Greene, 1997) (see below):

(1) *Hospitals' top five strategic goals*:
- commitment to vision;
- information technology;
- Medicare and Medicaid managed care contracting
- board education; and
- partnering and integration.

(2) *Managed care organizations' top five strategic goals*:
- information technology;
- commitment to vision;
- competitive pricing strategies;
- Medicare and Medicaid managed care contracting; and
- measuring quality of care and outcomes.

(3) *Group practices' top five strategic goals*:
- information technology;
- commitment to vision;
- measuring quality of care and outcomes;
- expanding physician networks; and
- availability of qualified senior managers.

Key strategies of senior level managers

In a survey of chief operating officers, they identified many forces in the health care environment as crucial to their organizational goals and progress. These environmental forces include: increased growth of managed care, competition from for-profit and not-for-profit organizations in the market, relationships with primary care physicians, and mergers and acquisitions (Guo, 2001; VHA Inc., 1997) (see Table II). For instance, 88 percent of all chief operating officers cite managed care as the highest area of concern. Thus, to survive under these conditions, senior level managers implement a variety of strategies to achieve their organizational goals (VHA Inc., 1997).

Table II.
Environmental and organizational conditions that chief operating officers believe influence their organization's progress toward their goals

	Percent
Increased growth of managed care	88
Competition from not-for-profit health care organizations	75
Relationships with primary care physicians	75
Ability to provide care outside the hospital	58
Mergers and acquisitions by your organizations	42
For-profit competition in market	40

Source: VHA Inc. (1997)

Guo (2002) found that senior level managers must make more timely and precise decisions under complex environmental conditions. Furthermore, managers must perform proactive roles including entrepreneur, resource allocator, liaison and monitor roles. These four roles are especially important for the managed care environment as organizations concentrate on strategies for long-term survival. As managers perform these roles, they develop strategies to enhance organizational goals. The four roles of managers (Guo, 2002) are:

(1) Liaison-role for networking and building contacts.

(2) Monitor-role for scanning the environment for opportunities and threats.

(3) Entrepreneur-role of creating strategies and innovations.

(4) Resource allocator-role for allocating resources to enhance organizational goals.

The top strategic priority ranked by 97 percent of chief operating officers is cost reduction. In second place is the concentration of clinical and operational benchmarking (88 percent). Alliance formation (84 percent), improving community health (77 percent) and marketing strategies for patient recruitment and retention (75 percent) are among the top five strategies (VHA Inc., 1997) (see Table III).

As a result of environmental pressures, chief operating officers must prioritize their areas of focus (VHA Inc., 1997) (see Table IV). The number one area of focus is to enhance financial conditions in their organizations (68 percent). Furthermore, partnering or merging to decrease competition is also vital. Other areas to be addressed include increasing market share, focusing on customer and patient care, enhancing physician relations, emphasizing quality, improving community care and focusing on managed care (VHA Inc., 1997).

	Percent
Cost reduction	97
Clinical and operational benchmarking	88
Alliances with health care organizations	84
Improve overall community health	77
Marketing strategies for patien recruitment and retention	75
Eliminate or add services based on competency and market needs	75

Source: VHA Inc. (1997)

Table III.
Key strategies that chief operating officers use to achieve their organizational goals

	Percent
Financial condition	68
Partnering or merging	30
Market share	28
Consumer and patient care	26
Physician relations	23
Quality	22

Source: VHA Inc. (1997)

Table IV.
Areas of focus for the top goals of chief operating officers

Conclusions

To gain a clearer picture of the forces affecting health care organizations, this paper has presented facts and findings describing a number of key trends in the health care market. Although many other forces may act on the health care industry, the selection of these major trends reflects the author's perspective, specifically addressing issues to target the long-term survival of organizations through identification of management strategies and priorities. The future of health care organizations depends on crucial decisions made by capable and knowledgeable managers. This paper has taken a step in the direction of recognizing the need for greater understanding of managerial decision-making authority in health care organizations.

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