The Future Of Managed Care Organization

Health care may be a local business, but managing that care is a national enterprise.

by James C. Robinson

PROLOGUE: For the past fifteen years the words "managed care" have been the shorthand label for a wide variety of health plans that, in one way or another, have combined the functions of delivering and financing medical care. Health plans have acquired and shed functions based on their calculations of how best to gain a larger share of the health insurance market. Initially, the not-for-profit group model, formed in the image of the Kaiser Permanente Medical Care Program with its closed physician panels, was dominant. As Americans demanded greater choice of doctors, broader network plans forged on a for-profit basis emerged rapidly.

In this lead paper James Robinson, a professor of health economics at the University of California, Berkeley, discusses what he regards as the currently ascending model of managed care: the multiproduct, multimarket health plan. His research is distinguished by his preference for combining the methods of health services research and, through extensive interviews with executives of health plans and other stakeholders, journalism, to determine the nature of change. His thinking also was influenced by a small group (see acknowledgment on page 23) of chief executive officers, system analysts and consultants, and other recognized individuals who gathered under the aegis of the California HealthCare Foundation and *Health Affairs* last fall to discuss his conclusions. The foundation also supported Robinson's research. In previous issues Robinson has written on the financial and intellectual capital of physician practice management (July/August 1998) and on the use and abuse of the medical loss ratio (July/August 1997).

ABSTRACT: This paper analyzes the transformation of the central organization in the managed care system: the multiproduct, multimarket health plan. It examines vertical disintegration, the shift from ownership to contractual linkages between plans and provider organizations, and horizontal integration—the consolidation of erstwhile indemnity carriers, Blue Cross plans, health maintenance organizations (HMOs), and specialty networks. Health care consumers differ widely in their preferences and willingness to pay for particular products and network characteristics, while providers differ widely in their willingness to adopt particular organizational and financing structures. This heterogeneity creates an enduring role for health plans that are diversified into multiple networks, benefit products, distribution channels, and geographic regions. Diversification now is driving health plans toward being national, full-service corporations and away from being local, single-product organizations linked to particular providers and selling to particular consumer niches.

WE ARE OBSERVING simultaneously the eclipse and expansion of the managed care organization. Health maintenance organizations (HMOs) and other insurers are hollowing out, yielding one function after another to purchasers and providers and thereby evoking questions about their future role and share of the premium dollar. Large employers and purchasing alliances are retaining insurance risk and specifying benefit packages; large provider organizations are accepting global capitation and responsibility for utilization management. Pundits daily announce the dawn of direct contracting and the squeezing out of the insurance middleman. Yet health plans everywhere are in rapid expansion, diversifying into new networks, benefit designs, distribution channels, and geographic markets. Every year brings mergers and acquisitions involving millions of enrollees and billions of dollars. Health insurance hardly seems to be an industry in decline.

This paper analyzes the transformation of managed care's central organization: the multiproduct, multimarket health plan. It examines vertical disintegration: the shift from ownership to contractual linkages between plans and provider organizations, and horizontal integration: the consolidation of erstwhile indemnity carriers, Blue Cross plans, HMOs, and specialty plans. Diversification into new managed care products, methods of marketing, and geographic regions is driving health plans toward national, full-service corporations and away from local organizations linked to particular providers and selling to particular consumer niches. The rapid growth in health care firm size results primarily from the need to achieve minimum efficient scale in each product, channel, and market and secondarily from attempts to achieve dominance in each sector.

The demand and supply sides of the medical marketplace are

fragmented, heterogeneous, and in a state of continual change. Purchasers differ widely in their preferences and willingness to pay for particular benefits and networks. Providers differ widely in their ability to bear capitation risk, manage utilization, and document quality. The diversity and complexity of health care create an enduring role for the multiproduct health plan, one that will not be displaced by corporate purchasing alliances or provider-based HMOs. Public policymakers and industry analysts often assume that there exists somewhere a truly efficient form of physician and hospital organization, an optimal benefit package, an evidence-based set of clinical protocols, and one best method of marketing and enrollment. But even a cursory examination of the medical marketplace quickly reveals that no one size fits all and that consumers do not agree on what they want, purchasers on what they are willing to pay for, and providers on what they are willing to deliver. The future of the health plan lies at the often conflict-ridden interface between consumers, purchasers, and providers, in the development, pricing, and distribution of managed care products that reconcile preferences with pocketbooks throughout the health care system.

Vertical Disintegration

Health plans assume an intermediate position on the chain of production and distribution, squeezed between physicians, hospitals, and other providers on one side and corporate benefits managers, governmental agencies, and consumers on the other. The boundaries of these industry segments have fluctuated continuously, with private purchasers establishing self-insured plans, public purchasers offering direct-service benefits, providers launching insurance products, insurers acquiring providers, and everyone dabbling with great enthusiasm and little success in the others' business. The most important efforts at downstream integration of purchasers into health plan functions have been the proliferation of self-insured corporate programs operating under federal Employee Retirement Income Security Act (ERISA) protection, the standardization of benefits and performance criteria by public and private purchasing alliances, and the extension of self-insurance into network management by large purchasers in the Minneapolis market.[1] The most important efforts at upstream integration of provider organizations into health plan functions have resulted from the acceptance of global capitation and the delegation of responsibility for credentialing, utilization management, and quality oversight.[2] Many provider organizations have developed insurance products, most of which have performed poorly but some of which have become market leaders. The rage of the moment is provider-sponsored organizations (PSOs), which

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will contract directly with Medicare. The public policy debate over direct contracting has been intense but has shed less light than heat. Each initiative needs to be evaluated soberly and with attention to general economic principles of vertical integration.

■ **Downstream integration by purchasers.** The unwillingness of the American polity to directly assure universal coverage has spawned innumerable state efforts to subsidize care of the poor by imposing premium taxes, regulations, and benefit mandates on commercial health plans. ERISA exempts from state control corporate health benefit programs that self-insure, thereby giving them a significant incentive to integrate downstream into insurance risk bearing. Once confined to the largest private corporations, the religion of self-insurance has converted many midsize firms and public employee benefit programs. Large purchasers move further into the roles conventionally played by health plans as they specify the details of their benefit packages, often standardizing designs across their multiple contracting plans and sometimes across multiple purchasers. The Pacific Business Group on Health (PBGH), for example, negotiates rates with twelve HMOs for twenty-one companies and 400,000 beneficiaries using a standard package of benefits. The California Public Employees Retirement System (CalPERS), with one million beneficiaries, negotiates rates for a standard benefit package with eleven insured HMOs and maintains two self-insured PPO plans. The Buyers Health Care Action Group (BHCAG) has developed a uniform benefit package and self-insured PPO product for 132,000 enrollees in Minneapolis, using a health plan to perform back-office functions based on negotiated fees.

The appropriation of insurance functions from health plans receives inordinate attention, since the corporate purchaser appears to be the only Godzilla big enough to grapple with the King Kong of managed care. In reality, large purchasers are wary of entering what they recognize to be a complex and risky business. Self-insurance was relatively easy in the indemnity context, especially when reinsurance for high-cost cases was available from commercial carriers without compromising the ERISA exemption. However, managed care requires developing networks of primary care, specialty, inpatient, outpatient, pharmacy, and ancillary services over a wide geographic region under continual excoriation from consumers and regulators. The federal Medicare and state Medicaid programs are

seeking to exit from their fee-for-service (FFS) plans, outsourcing responsibility wherever possible to private managed care organizations. The prototype public program of the future appears to be the Federal Employees Health Benefits Program (FEHBP), which owns no health plans but contracts with private plans offering indemnity, HMO, PPO, and point-of-service (POS) products.[3] Some large employers are turning to commercial carriers to manage their self-insured products using the networks, contracted provider rates, utilization management systems, and quality-oversight tools developed for the fully insured products. Many would be willing to go back to buying insured products if the states would desist from punishing with special taxes those employers that cover their employees in order to reward with special subsidies those employers that do not. The business mantra now is to focus on core markets and competencies. Manufacturers, banks, and software corporations should not be distracted into managing health care any more than health plans should be distracted into manufacturing drugs, underwriting consumer credit, or designing their computer networks.

■ **Upstream integration by providers.** In the early years of managed care many HMOs were sponsored by hospital systems and multispecialty medical groups as a way of marketing their services on a prepaid basis. Many of these early efforts failed, but some of the largest and most successful of contemporary carriers (including PacifiCare, Humana, and United) date their origins to upstream integration efforts by providers (as do, in a more distant sense, Blue Cross/Blue Shield plans). However, the most significant movement of health care providers into the roles once played by health plans has come with the recent rapid spread of capitation contracting and delegation of utilization management. Large provider organizations have begun to contract with health plans on a capitated basis for primary, specialty, and, increasingly, hospital and pharmacy services. The range of capitated services has broadened as providers have consolidated into integrated delivery systems and physician practice management (PPM) firms better able to absorb insurance risk.[4] Global capitation shifts the responsibility for network development and contracting, as the capitated provider organization takes on the chore of subcontracting with nursing homes, rehabilitation facilities, home health agencies, and out-of-area providers. A logical concomitant of capitation payment has been the delegation to provider organizations of responsibility for utilization management, including primary care referrals to specialists, hospital admission and length-of-stay, and authorization for high-cost procedures.[5] Medical groups are increasingly accountable for measurable aspects of quality, including patient satisfaction and provision of preventive

services. The PBGH, for example, now is measuring performance and cooperating on quality improvement programs at the level of the medical group and hospital system, in addition to its traditional efforts at the level of the health plan.[6] The National Committee for Quality Assurance (NCQA) is exploring credentialing and other quality oversight at the provider level.[7]

The appropriation of managed care functions from health plans has spurred some physician and hospital organizations to contemplate full upstream integration. Some provider systems, such as Kaiser Permanente in California and Intermountain in Utah, have gained regionally dominant positions by developing licensed HMOs and marketing directly to employers and public programs. Most provider-sponsored HMOs, however, have fared poorly when faced with direct competition from national health plans unless they have let go of their original provider linkages. Insurers have fared no better when they have tried to integrate in the other direction by acquiring hospitals and medical groups to establish staff-model HMOs. Almost all of the national plans that plunged into vertical integration during the heyday of managed competition have since divested their staff models. Nevertheless, the ideal of vertical integration between providers and plans remains vibrant, at least in hospital circles. Some large delivery systems are now gearing up to contract directly with Medicare as capitated PSOs.

Horizontal Integration

As they abjure ownership linkages with provider systems, health plans are not becoming merely vendors of back-office reinsurance and administrative services. On the contrary, they are expanding rapidly in both scale and scope, adding new functions, offering new services, attracting new clients, and penetrating new markets. Organizational enrollments and revenues are pyramiding as leading health plans merge with and acquire their rivals. The fundamental feature of the managed care marketplace is not its size, however, but its heterogeneity. Consumers differ in their preferences for breadth of physician and hospital panels, self-referral to specialty care, stringency of utilization review, and performance on quality indicators. Employers and governmental programs differ in the generosity of their premium contributions and their willingness to obtain lower premiums in exchange for higher deductibles, more significant consumer copayments, and thinner benefit coverage. The dynamics of marketing and enrollment differ dramatically across market segments, including individuals and small groups, midsize firms and large corporate accounts, public employee benefit programs, Medicare+Choice, and Medicaid managed care. States and metropolitan

areas differ in demographics and economics, in provider organization and consolidation, and in regulatory rules and purchasers' sophistication. This diversity in demand is generating a commensurate diversity in supply. Four dimensions of health plan diversification are to be emphasized: provider networks, benefit products, distribution channels, and geographic markets.

■ **Network diversification.** Until just a few years ago most health plans offered a single network structure, either any willing provider (indemnity) or closed panel (HMO). Those plan designs have mutated considerably, and each has borrowed liberally from the other. FFS plans now sell managed indemnity coverage, combining an open provider network with requirements for utilization review, or PPO insurance, supplementing a contracted network with limited out-of-network coverage. PPO products contract on a discounted FFS basis with individual physicians and impose top-down utilization review. They capitate no services and delegate no responsibilities to integrated delivery systems or PPM firms. PPOs offer choice but not efficiency; a broad network but little coordination; no gatekeeping but high deductibles. HMOs have responded to consumers' demand for choice by broadening their networks, adding POS coverage for nonnetwork services, and facilitating access within the network by reducing primary care gatekeeping and prior authorization for procedures. They differ fundamentally from PPOs, however, in relying heavily on independent hospital systems and physician networks to manage the actual delivery of care. Capitation contracting is spreading from primary to specialty, hospital, and pharmacy services and is accompanied by delegation of responsibility for utilization and quality management.[8] HMOs offer efficiency and coordination but run counter to the current trend toward consumerism, self-referral, and self-care.

PPOs and HMOs hold salient positions on a much broader spectrum of network designs, each with a different panel breadth, stringency of utilization management, and provider payment method. Unmanaged indemnity coverage, medical savings accounts (MSAs), exclusive provider organizations (EPOs), POS plans, partially insured products, and other hybrid arrangements attract particular customer segments. Separately structured subnetworks are proliferating underneath the health plans, including centers of excellence for tertiary care, capitated disease management panels, specialty PPM firms, carved-out mental health programs, complementary medicine providers, retail and wholesale pharmacy networks, ambulatory surgery chains, inpatient and outpatient rehabilitation centers, nursing homes and subacute care facilities, home health agencies, and durable medical equipment vendors.

Health plans can either focus on a single major network or develop a broad portfolio of network offerings. The dominant strategy is full diversification of services: the exploitation of scope economies in the design, marketing, and management of multiple networks. Many corporate functions necessary for the development of one network can be extended at low cost to others. Management information systems and actuarial capabilities required for an FFS, claims-driven product such as PPO or managed indemnity coverage can be applied to HMO products where it is important to evaluate capitation rates and document utilization profiles. Volume discounts with hospitals can be negotiated based on enrollment in all networks, allowing plans with large PPO enrollment to obtain attractive rates for their commercial POS or Medicare HMO products. In-house sales representatives and outside broker networks can cross-sell multiple networks to the same client base. Small and mid-size firms are particularly attracted to dual- and triple-option arrangements in which a health plan offers a PPO, an HMO, and perhaps a third network, allowing choice to employees without imposing high administrative costs on the employer. Health plans are playing the role assigned to purchasing alliances in the theory of managed competition. Rather than using a purchasing alliance to structure employee choice among multiple health plans, employers increasingly are contracting with a single health plan to structure employee choice among multiple provider networks.

■ **Benefit diversification.** Historically, health insurance offered two benefit structures, which balanced in different ways the desire for financial coverage in case of illness and the need for controls on cost inflation. Indemnity carriers, Blue Cross plans, and FFS Medicare relied heavily on deductibles, coinsurance, exclusions of preventive services, annual limits on hospital days, and maximum lifetime payment. HMOs offered comprehensive benefits without deductibles, coinsurance, and maximums but with modest copayments at the time of service. Recent years have witnessed partial convergence, as indemnity plans cover more preventive services and HMOs experiment with higher copayments for emergency room and hospital use. The dominant trend, however, has been toward the proliferation of benefit designs to accommodate the differences among consumers in preferences and ability to pay.

Health plans now design multiple benefit packages for off-the-shelf sale in the individual and small-group market and are willing to tailor benefits to suit large corporate purchasers, public employee programs, and public programs. Indemnity, managed indemnity, MSA, and PPO products now come with deductibles that range from zero up to $10,000 or more; with coinsurance rates that vary by

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provider, setting, and service; and with copayment rates that vary based on whether the service received prior authorization or was deemed an emergency. Cost-sharing provisions increasingly are tiered according to whether the service was received from a provider in the HMO network, in the wraparound PPO network, from a nonnetwork provider with POS prior authorization, from an out-of-area provider, or from a provider with which the plan has no contractual relationship. Benefit packages are increasingly differentiated, with mixes of full coverage, partial coverage, or exclusion for prescription drugs, mental health services, durable medical equipment, outpatient rehabilitation, and home health services. Some designs are covering nontraditional services such as long-term care, acupuncture, therapeutic massage, and holistic medicine.

The market demand for benefit diversity favors health plans with administrative capabilities in actuarial estimation, benefit pricing, and cross-marketing. It disadvantages plans that remain attached to a uniform benefit design and a community-rated pricing structure. Firms need to balance the attractions of a broad product portfolio against the need to communicate easily with sales agents, independent brokers, individual consumers, small proprietors, and corporate benefit managers. It is possible for a plan to offer too many benefit designs, but the more common tendency is to offer too few.

■ **Channel diversification.** Health plans traditionally focused on a few salient distribution channels. HMOs often served large public and private employers; commercial carriers favored the multistate corporations; Blue Cross plans dominated the individual, small-group, and midsize market; and Medicare and Medicaid operated their own FFS plans. Different strategies and structures reach these different customer populations. Marketing to Medicare beneficiaries and self-employed persons requires an in-house team adept at one-on-one outreach and "kitchen-table" sales. Independent brokers hold the keys to the small- and midsize-group market. Large corporate purchasers rely on consultants and human resources departments to impose detailed benefit and performance specifications. Large public employers and purchasing alliances favor nonexclusive contracting with multiple health plans. State Medicaid agencies try to stretch inadequate budgets by offering large but bottom-dollar contracts to plans. Self-insured employers, the Civilian Health and Medical Program of the Uniformed Services

(CHAMPUS), state programs for uninsured children, and other enrollee groups present new marketing challenges.

Despite the differences among customer niches, health plans have discovered that they cannot afford to ignore most distribution channels. A core investment in the creation of brand-name identity is useful for every niche, as is the development of in-house capabilities to analyze the marketing needs of particular segments and coordinate outreach across segments. Some differences in distribution remain important across plans, particularly with respect to their interest in or antipathy toward low-margin Medicaid business. But once they have a full portfolio of managed care products, health plans want to be able to market through a full range of distribution channels. Channel diversification is key to achieving the enrollment volumes necessary to obtain low prices from providers as well as for spreading the overhead costs of product development and regulatory compliance.

■ **Geographic market diversification.** The commercial indemnity carriers traditionally were national in breadth but shallow in local market depth; Blue Cross plans held large local shares but did not cross state lines; HMOs were concentrated in particular metropolitan areas. Now leading health plans are combining local market penetration with geographic diversification. New market entry offers enormous potential rewards for well-managed health plans. Corporate overhead expenses can be diluted, and core competencies deployed over ever-larger enrollee populations, only by expansion beyond familiar markets. Purchasing power for pharmaceutical products, computer systems, and other supplies via national contracts can be enhanced by enrollment growth without regard to its geographic locale. Wall Street looks favorably at firms whose risks are diversified across markets with different business climates and across states with different regulatory climates. Multimarket and multistate networks are useful for selling managed care products to national corporate purchasers and to the increasingly mobile business and leisure traveler. A strong presence in localities with distinct business cultures and clinical practice patterns affords the health plan the possibility to identify, internalize, and disseminate best practices. The ability to enter and exit local markets expeditiously is important as purchasing alliances and provider cartels organize to shut windows of profitability.

Regional markets reveal different mixes of national and local players, but the rapid pace of mergers and acquisitions is bringing the same names to the major metropolitan markets. The consolidation of commercial carriers is nearly complete, with only CIGNA and Aetna showing staying power for the long run. Traditional

HMOs, many now converted to investor ownership, are represented on the national scene by United, PacifiCare, Kaiser, Humana, and Foundation Health Systems. The heritage of the Blue Cross plans lies with WellPoint, Anthem, and a variety of regionally strong plans that could become national players if they overcome regulatory barriers to expansion.

The Economics Of Organization

It is important to emphasize, in this era of mind-boggling mergers and acquisitions, that larger scale and broader scope do not by themselves confer competitive advantages on managed care organizations.[9] Recent years have witnessed the dramatic decline of many formerly dominant health plans, particularly indemnity carriers and Blue Cross affiliates. Most of the multiline insurers have narrowed their product portfolios, exiting health care or divesting their nonhealth activities. Metropolitan, New York Life, Travelers, Massachusetts Mutual, John Hancock, and Lincoln are now of only historical interest from a health insurance perspective, and even Prudential is seeking to refocus on financial services. Similarly, vertical integration often confers disadvantages rather than advantages, a lesson apparently learned by CIGNA, Aetna, FHP, Foundation Health, Prudential, Humana, PacifiCare, PCA, and Blues plans in New Jersey and Massachusetts. Some of the most venerable staff- and group-model HMOs, including HIP, Harvard Pilgrim, and even Kaiser in some states, are moving toward nonexclusive relationships with their physician groups. In seeking to understand the fluctuating boundaries of the health plan, it is important to maintain a balanced view of both the economies and the diseconomies of scale and scope.

Economies of scale explain the comparative advantages that accrue from size itself, as distinct from intellectual property, market dominance, or scope of activities. Textbook examples accrue in manufacturing and transportation industries with large physical assets, the costs of which need to be spread over a large volume of production. In service industries such as managed care, fixed costs include core administrative functions and expensive computer systems. Additional size advantages derive from volume discounting with suppliers. Finally, many firms experience increasing returns to investments in marketing and brand-name recognition. Juxtaposed to these economies of scale are the disadvantages of large size, most of which can be conceptualized as forms of bureaucratization. Three dimensions stand out. First, large firms often suffer from the attenuation and distortion of incentives for individual participants, including managers and employees, compared with smaller firms and

particularly with owner-managed entities.[10] Second, large firms are subject to internal influence politics, as individual groups and subunits struggle for control of and access to the organizational surplus; these struggles typically increase with the internal heterogeneity of the firm.[11] Finally, large and diversified economic organizations are required to develop internal "transfer prices" that dictate how resources are allocated between subunits; transfer prices are subject to internal manipulation and are notoriously less efficient than external market prices are in indicating true resource costs.[12]

Economies of scope explain the advantages of diversified over focused firms, after taking account of scale effects. Textbook examples highlight physical or intellectual assets that can be used for multiple products without being fully exhausted by any one.[13] Joint physical assets include chemical facilities that can produce paints, dyes, and solvents or metal stamping facilities that can produce many shapes of cars and trucks. Joint assets in distribution include relationships with clients that permit the cross-selling of multiple products and brand-name recognition that confers a marketing advantage on one product because of consumer trust in another. Intellectual assets such as special know-how in a particular line of business explain diversification by customer segment or geographic locale, as when hotel corporations maintain multiple chains of facilities (such as economy, resort, and business) across many geographic areas. Diseconomies of scope explain why most firms are focused on a particular set of products, customer segments, and geographic markets, with only a few being able to sustain a conglomerate organizational form. Multiproduct and -market diversification exposes the firm to loss of scale economies in each of its particular operations, including economies in production, supplier contracting, and marketing. It leads to a loss of focus and to overload on senior management, who cannot keep abreast of rapidly changing consumer preferences and production technologies in their far-flung operations. Excess diversification can undermine brand names by spreading them across too many products of uncertain vintage, confusing the firm's image in the mind of the consumer, and encouraging competition among its products rather than with products of other firms. The boundaries of the health plan can usefully be illuminated with reference to these economies and diseconomies.

■ **The economics of vertical disintegration.** Two sets of problems afflict vertically integrated organizations and explain why systems incorporating both insurance and delivery are to be found more frequently in health policy proposals than in the managed care marketplace. Vertical integration between production and distribution sacrifices the economies of scale available to firms that serve up-

stream suppliers and downstream distributors. With the exception of some highly concentrated markets, no health plan has enough enrollment to support a broad exclusive network. Staff-model HMOs failed to convince consumers to limit their choices to a narrow range of employed physicians and have broadened their networks. Conversely, few hospital systems can fill their beds solely with patients from their in-house insurance plan; most are forced to take patients from independent plans as well. Vertical integration does not help the health plan to spread its core overhead expenses over a broader base of operations, since it adds new administrative functions and costs as rapidly as it adds to the base of operations. The administrative, information, and clinical competencies required for an organization that actually delivers health care are quite distinct from those of an organization that develops, markets, and monitors contractual networks.

The second set of difficulties stem from the attenuation of physician incentives and aggravation of internal bureaucratic politics afflicting health plans that employ rather than contract with physicians. Physicians and other providers simply work less hard when they are employed by large insurance corporations than when self-employed or part of a physician partnership. Vertically integrated insurers often created staff clinics that were larger and more elaborate than the offices of the private-practice physicians with whom they competed. Private-practice physicians understand that they are paying personally for the extra examining room, nurse assistant, and continuing medical education course, while staff-model HMO physicians believe that the corporate parent bears these costs. Vertically integrated systems also suffer from the politics of transfer pricing, with the hospital and clinic divisions wanting rates to be based on their average costs while the insurance division wants rates to be based on marginal costs. In the context of excess hospital and specialty capacity, marginal costs fall well below average costs. The most successful group-model HMOs, such as Kaiser Permanente, have attenuated these problems by contracting exclusively with quasi-independent physician organizations. But most health plans have found their staff clinics to experience higher costs and lower productivity than their contracted networks experience. Incentive attenuation and influence costs also explain the failure of partial integration. Some health plans structured themselves around a core of wholly owned clinics and then extended their reach through contractual means, only to find that their clinics were the costliest rather than most efficient component of their networks.

The enthusiasm in health policy circles for organizational unification of insurance and delivery is so fervent that it is useful to note

that the broader economic literature on markets and organizations views vertical integration as the exception to the rule, as the governance mechanism of last resort.[14] Life-cycle theories of vertical integration emphasize that integration by producers upstream into distribution or downstream into supply has occurred primarily in the early phases of industry development when independent distributors and suppliers are not available.[15] Independent distributors and suppliers emerge as efficient alternatives to the internally owned units, which are divested or restructured as joint ventures or franchises. Transaction cost and principal-agent theories emphasize that vertical integration is efficient in mature markets only where specialized equipment, skills, or geographic locations reduce the number of available contract partners.[16] Absent these special circumstances, contractual relationships can provide adequate coordination without sacrificing scale economies and individual incentives. These conditions held in most health care markets prior to the 1980s, since health plans interested in creating capitated HMO products could not find independent medical groups and needed to build their own. Conversely, medical groups and hospital systems interested in prepayment often found it easier to launch their own HMO than to work with local insurers who remained wedded to FFS practices. In the 1990s, however, many markets have multiple managed care plans and multiple provider organizations, and vertical ownership relationships are disintegrating.

■ **The economics of horizontal integration.** Two forms of scale economy are important for understanding the diversification of health plans into multiple networks, benefit products, distribution channels, and geographic markets. First and most obviously, health plans need to spread product development and pricing, finance, utilization and quality management, and computer information systems over large numbers of enrollees to hold down the administrative expense per enrollee. High patient volumes also are important for obtaining significant discounts or attractive capitation rates from physicians, provider organizations, pharmaceutical manufacturers, and other suppliers. Diversification into multiple benefit products and distribution channels is central to the pursuit of these scale economies, since they bring in new volume without adding significantly to the costs of managing care. Diversification into multiple provider networks brings in greater volume but also increases overhead costs and raises the minimum efficient scale for provider contracting. The competencies required to manage a hands-on PPO product are very different, for example, from those needed for a capitated and delegated HMO product. A large volume of enrollment passing through the capitated independent practice associa-

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tion (IPA) and medical-group networks may not help the health plan in its fee policies with individual providers in the PPO network, although common rates covering all networks can often be negotiated for hospitals, nursing homes, and ancillary providers. These factors explain why so few health plans have successfully maintained multiple market-leading networks. Most plans have a leading network design—either PPO, HMO, or POS—and then offer other options to fussy purchasers. True network diversification will be an increasingly important comparative advantage in coming years, however, given the irreducible variation in consumers' and purchasers' preferences. WellPoint, United, CIGNA, and Aetna are well positioned in this regard, whereas Kaiser, PacifiCare, Oxford, Foundation Health Systems, and many Blue Cross plans remain largely nondiversified.

Economies of scale do not explain the dramatic mergers and acquisitions that are creating nationally diversified health plans. Geographic expansion does not help health plans to cover any but their most general forms of administrative expense and adds nothing to plans' bargaining power with suppliers in particular markets. This explains why carriers that once held shallow positions in many localities have been replaced by firms that expand only into markets where they can achieve significant penetration. The scale economies achieved from inputs from national sources, such as drugs and computer systems, are not significant enough to justify new geographic expansion unless substantial local market share can be achieved. Expansion needs to follow upon rather than precede the reduction in core cost structure if it is not to court disaster, as was proven in the transportation and communication industries after deregulation and in the PPM industry more recently.[17]

Scale economies in marketing and brand-name recognition to date have been limited, with many managed care plans using different distribution networks and brand names for different products and in different regions. WellPoint, for example, uses the same name for all networks, products, and channels but different names in different states (Blue Cross in California, Unicare elsewhere).[18] PacifiCare uses one name for its commercial products and another (Secure Horizons) for its Medicare product. Plans built from many mergers and acquisitions, such as Foundation Health Systems, struggle along with many different brand names (for example,

HealthNet, QualMed, and Physicians Health Services). In coming years, however, common branding across networks, products, distribution channels, and geographic markets will become ever more important as plans compete on quality and service as well as on price.

Economies of scope in marketing and distribution are the key determinants of health plan diversification into multiple provider networks and benefit packages, while contributing little to diversification by distribution channel and geographic market. The ability to combine HMO, PPO, and hybrid networks into one package at one price is extremely valuable in the small- and midsize group market, where employers shun the administrative complexity and adverse selection risks of contracting with multiple plans. The ability to cross-sell medical, dental, and life insurance and other services is important for large corporate accounts, which typically offer richer benefit packages but want to simplify their administrative responsibilities. The ability to design and price multiple benefit packages is essential for all segments of the commercial market, since employers vary widely in the generosity of their premium contributions and benefit coverage. Ironically, scope economies explain little of the decision to diversify into multiple distribution channels, since the mechanism for reaching individuals (direct advertising and brokers), small groups (brokers), corporate accounts (consultants), Medicare beneficiaries (direct advertising and physicians), and Medicaid (safety-net providers and community organizations) are quite distinct. Scope economies in distribution are a secondary aspect of geographic expansion, although broad network coverage is important for multistate employers and Medicare "snowbirds." For example, plans with heavy enrollment in the New York region, such as HIP and Oxford, have sought to follow their vacationing and retiring members to Florida.

THE FUNDAMENTAL FEATURE of health care is the heterogeneity of both consumers' preferences and providers' capabilities. Consumers differ in their ability and willingness to pay for broad provider networks, thick benefit packages, and direct access to specialty care. Purchasers differ in their size and bargaining leverage, interest in tailoring benefits versus buying designs off the shelf, generosity in premium contributions, and understanding of quality accreditation. Physician organizations and hospital systems differ in their ability to take on the insurance risk of capitation and the utilization management responsibilities of delegation. Some provider systems seek to coordinate the full range of services, while others focus on particular clinical conditions, specialties, technolo-

gies, or facilities.

The continual flux in demand and supply creates an enduring role for the multiproduct health plan as the nexus of contracts that links, coordinates, and gives incentives to the many buyers and sellers of health care. Niche analysis has become a core competency as health plans strive to understand and accommodate each market segment. Health plans have little to fear from the rhetoric of cutting out the middleman. Neither the individual consumer armed with an MSA nor the corporate purchaser armed with a self-insured benefit program can achieve provider rates and utilization efficiencies comparable to those offered by large health plans. The heterogeneity among providers similarly creates an enduring role for health plan networks that cover every ZIP code and are uniformly credentialed, contracted, and accredited. Health plans have little to fear that medical groups and physician/hospital systems will integrate into insurance and marketing, once the regulatory demands for financial solvency and the marketplace demands for network access are understood. Joint ventures between particular plans and provider organizations certainly are to be expected, as are long-term relationships between particular plans and purchasers, but the diversified health plan will always participate in more networks, products, and markets than even the largest provider or purchaser. Health care is a local business. But managed care—the development, pricing, and marketing of multiple provider networks and benefit designs through multiple distribution channels in multiple geographic regions—is a national business.

This paper was prepared for a policy roundtable on the future of the multiproduct health plan, sponsored by the California HealthCare Foundation and Health Affairs, *in Oakland, California, in October 1998.*

NOTES

1. J. Maxwell et al., "Managed Competition in Practice: 'Value Purchasing' by Fourteen Employers," *Health Affairs* (May/June 1998): 216–226; J. Christianson et al., "Managed Care in the Twin Cities: What Can We Learn?" *Health Affairs* (Summer 1995): 114–130; and J.C. Robinson, "Health Care Purchasing and Market Changes in California," *Health Affairs* (Winter 1995): 117–130.
2. See, for example, M.R. Gold et al., "A National Survey of the Arrangements Managed-Care Plans Make with Physicians," *New England Journal of Medicine* 333, no. 23 (1995): 1678–1683; S.M. Shortell, R.R. Gillies, and D.A. Anderson, "The New World of Managed Care: Creating Organized Delivery Systems," *Health Affairs* (Winter 1994): 46–64; and J.C. Robinson and L.P. Casalino, "Growth of Medical Groups Paid through Capitation in California," *New England Journal of Medicine* 333, no. 25 (1995): 1684–1687.
3. S.M. Butler and R.E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs* (Winter 1995): 47–61.
4. Shortell et al., "The New World of Managed Care;" J.C. Robinson, "Consolida-

tion of Medical Groups into Physician Practice Management Organizations," *Journal of the American Medical Association* 279, no. 2 (1998): 144–149; and J.C. Robinson, "Financial Capital and Intellectual Capital in Physician Practice Management," *Health Affairs* (July/August 1998): 53–74.

5. E.A. Kerr et al., "Managed Care and Capitation in California: How Do Physicians at Financial Risk Control Their Own Utilization?" *Annals of Internal Medicine* 123, no. 7 (1995): 500–504; E.A. Kerr et al., "Quality Assurance in Capitated Groups: Where Is the Emphasis?" *Journal of the American Medical Association* 275, no. 15 (1996): 1236–1239; and Robinson and Casalino, "Growth of Medical Groups Paid through Capitation in California."
6. Details and data are available at www.healthscope.org.
7. For information on the provider credentialing program, see www.ncqa.org.
8. Some HMOs continue to contract with individual physicians on a fee-for-service basis and retain utilization review in house, rather than contracting with physician organizations on a capitation basis and delegating utilization management.
9. Power theories, according to which firms with significant economic and political assets cannot be displaced even if they lack production efficiency and sensitivity to consumers' preferences, do offer high explanatory power in contexts where competition has been eliminated or severely constricted by regulation. In such contexts, political connections and perceived institutional legitimacy play predominant roles in ensuring organizational success.
10. M.C. Jensen and W.H. Meckling, "Theory of the Firm: Managerial Behavior, Agency Costs, and Ownership Structure," *Journal of Financial Economics* 3, no. 7 (1976): 305–360; and E.F. Fama and M.C. Jensen, "Agency Problems and Residual Claims," *Journal of Law and Economics* (June 1983): 327–349.
11. P.R. Milgrom, "Employment Contracts, Influence Activities, and Efficient Organizational Design," *Journal of Political Economy* 96, no. 1 (1988): 42–60; and H. Hansmann, *The Ownership of Enterprise* (Cambridge, Mass.: Harvard University Press, 1996).
12. R. Eccles, *The Transfer Pricing Problem: A Theory for Practice* (Lexington, Mass.: Lexington Books, 1985); and J. Rotenberg, "A Theory of Inefficient Intrafirm Transactions," *American Economic Review* 81, no. 1 (1991): 191–201.
13. J.C. Panzar and R.D. Willig, "Economies of Scope," *American Economic Review* 71, no. 2 (1981): 268–272; D.J. Teece, "Economies of Scope and the Scope of the Enterprise," *Journal of Economic Behavior and Organization* 1, no. 3 (1980): 223–247; and A.D. Chandler, *Scale and Scope: The Dynamics of Industrial Capitalism* (Cambridge, Mass.: Harvard University Press, 1990).
14. O.E. Williamson, *The Economic Institutions of Capitalism* (New York: Free Press, 1985); and M.K. Perry, "Vertical Integration: Determinants and Effects," in *Handbook of Industrial Organization*, vol. 1, ed. R. Schmalensee and R.D. Willig (New York: North Holland, 1989).
15. G.J. Stigler, "The Division of Labor Is Limited by the Extent of the Market," *Journal of Political Economy* 59, no. 3 (1951): 185–193; and A.D. Chandler, *The Visible Hand: The Managerial Revolution in American Business* (Cambridge, Mass.: Harvard University Press, 1977).
16. B. Klein, R.G. Crawford, and A.A. Alchian, "Vertical Integration, Appropriable Rents, and the Competitive Contracting Process," *Journal of Law and Economics* (October 1978): 297–326; and Williamson, *The Economic Institutions of Capitalism*.
17. R. Vietor, *Contrived Competition* (Cambridge, Mass.: Harvard University Press, 1994).
18. If the acquisition of BlueCross BlueShield of Georgia is consummated, as planned, WellPoint will use the name BlueCross BlueShield rather than Unicare in Georgia.