Tufts Managed Care Institute

A Brief History of Managed Care

The structure and system of care that are known today as "managed care" trace their history to a series of alternative healthcare arrangements that appeared in various communities across the country as early as the 19th century. The goal of these arrangements was to help meet the healthcare needs of select groups of people, including rural residents and workers and families in the lumber, mining, and railroad industries; the enrollees paid a set fee to physicians who then delivered care under the terms of their agreement. In urban areas, such groups often were paid by benevolent societies to provide care to their members or charges. These prepaid group practices were a model for later entities that came to be known as Health Maintenance Organizations.

A frequently cited managed care pioneer is Dr. Michael Shadid, who started a rural farmers' cooperative health plan in Elk City, Oklahoma in 1929. Although he met with significant opposition from other physicians, with help from the Oklahoma Farmers' Union he succeeded in enrolling several hundred families. These members paid a predetermined fee and Dr. Shadid rendered his patient care.

Also in 1929, the Los Angeles Department of Water and Power contracted with Drs. Donald Ross and H. Clifford Loos to provide comprehensive services for about 2,000 workers and their families. Within 5 years, this doctor-owned and controlled group practice prepayment plan at the Ross-Loos Clinic enrolled 12,000 workers plus 25,000 dependents, at a cost of $2.69 per subscriber per month.

In 1933, also in LA, Dr. Sidney Garfield and several associates were providing medical care on a prepaid basis for 5,000 workers on an aqueduct construction project. The workmen's compensation insurance companies paid Garfield a percentage of their premium income to take care of accident cases; the men contributed 5 cents out of their wages for other medical services. Five years later, Garfield did the same for workers at the Grand Coulee Dam for Henry J. Kaiser.

Henry Kaiser, whose name became synonymous with prepaid healthcare, was impressed with Dr. Garfield's program. During World War II, he set up two medical programs on the West Coast to provide comprehensive health services to workers in his shipyards and steel mills. When the war ended, Kaiser opened his plans to the public. Kaiser believed he could reorganize medical care to provide millions of Americans with prepaid and comprehensive services at prices they could afford. Ten years after the war, the Kaiser Permanente health plan had a growing network of hospitals and clinics and a half million people enrolled.

Several other prepaid group practice plans developed in the 1930s and 1940s and became precursors to the modern HMO. Group Health Association in Washington, DC, was organized in 1937 as a nonprofit cooperative by employees of the Federal Home Loan Bank. Group Health Cooperative of Puget Sound in Seattle, Washington, was established at the end of the war by members of the Grange, the Aero-Mechanics Union, and local supply and food cooperatives. The Health Insurance Plan (HIP) of Greater New York was launched in 1947 with the support of Mayor Fiorello La Guardia to provide care to city employees after a study found that the major source of their financial distress was indebtedness caused by illness.

These early prepaid group practice plans, or medical service plans, differed in their corporate structures: Group Health Cooperative was owned

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by its enrolled members who elected trustees. At Kaiser, the Kaiser family and its company executives held the power, and subscribers had no governing role. At HIP, decisions were made by a self-perpetuating board with representatives from business, labor, medicine, and government. Yet they all shared a commitment to comprehensive and coordinated health care. In fact, their premiums were as expensive or more expensive than other insurance, but their coverage and benefits were superior, including a major emphasis on preventive care, outpatient care, well-child care services, immunizations, and other services not covered by other insurance. Members were subject to relatively few exclusions, limits, or copayments. Group practice plans, especially if they owned hospitals, could create an environment and incentives for physicians that reinforced cost-effective and high quality care.

In some locations prepaid group practice plans were quite successful at attracting members. Other local physicians became concerned about their own patient base. In 1954, the San Joaquin County (California) Medical Society formed the San Joaquin Medical Foundation in response to competition from Kaiser. The foundation accepted capitation payments from subscribers, and it paid the affiliated independent physicians and hospitals according to a relative value-based fee schedule. The foundation heard grievances against physicians, developed peer review procedures, and monitored quality of care. This plan is considered the earliest example of an independent practice association (IPA) model prepaid health plan.

The other important side to the story of managed care's development was the staunch opposition of organized medicine and the American Medical Association (AMA). With regard to the prepaid cooperative plans, the AMA was opposed to any form of lay control (i.e., non-physician control) over medical professionals. It rejected anything resembling the "corporate practice" of medicine. On the other hand, when prepaid plans were controlled by physicians, the AMA considered them a form of "unethical" contract practice. During the 1930s and 1940s, the AMA did what it could to suppress the growth of prepaid plans and cooperatives. Organized physician groups expelled participating physicians from local medical societies, prevented them from obtaining consultations and referrals, and persuaded hospitals to deny them admitting privileges. As a result of actions like these, the AMA was indicted and convicted of violating the Sherman Antitrust Act in its efforts to suppress the new plans. In 1947 the Supreme Court rejected the AMA's claims that medicine was a profession, not a trade, to which antitrust laws did not apply. In spite of this, the AMA's campaigns largely succeeded, as the organization's lobbying efforts resulted in numerous state laws that barred consumer-run medical service plans, required plans to allow members free choice of physician, granted authority to state medical societies to approve or deny new plans, or otherwise limited prepayment plans. By the 1950s, prepayment plans were a small presence in healthcare, and the AMA changed its position from official sponsorship of reprisals against prepaid group practice to watchful coexistence.

Prepaid health care remained a minor phenomenon until the 1970s. In the late 1960s and early 1970s, politicians and interest groups of all stripes promoted various proposals for reforming the nation's healthcare system. Issues of cost containment, coverage for the uninsured, access to services for the poor and minorities, consumer rights, efficient delivery systems, and more were all on the agenda. 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 is the HMO asked to be offered. In adopting this policy, the Administration was influenced by Paul Ellwood, MD of Minneapolis, who argued that the structural incentives of traditional fee-for-service medicine had to be reversed in order to achieve positive reform. Dr. Ellwood coined the phrase "health maintenance organization" to refer to prepaid health plans that enrolled members and arranged for their care from a designated provider network.

While the initial growth and enrollment goals have not been met, managed care, as it has come to be called, has continued to grow throughout the 1970s, 1980s and 1990s. Employers came to look upon managed care as a less expensive yet comprehensive and high quality form of insurance to offer their employees. More recently, state governments have turned to managed care to help with the Medicaid program, and the federal government has implemented managed Medicare. By the end of 1996, there were over 600 HMOs in operation, enrolling about 65 million members, or close to one-fourth of the U.S. population. All indications are that the number of people receiving care through managed care arrangements will keep on climbing.