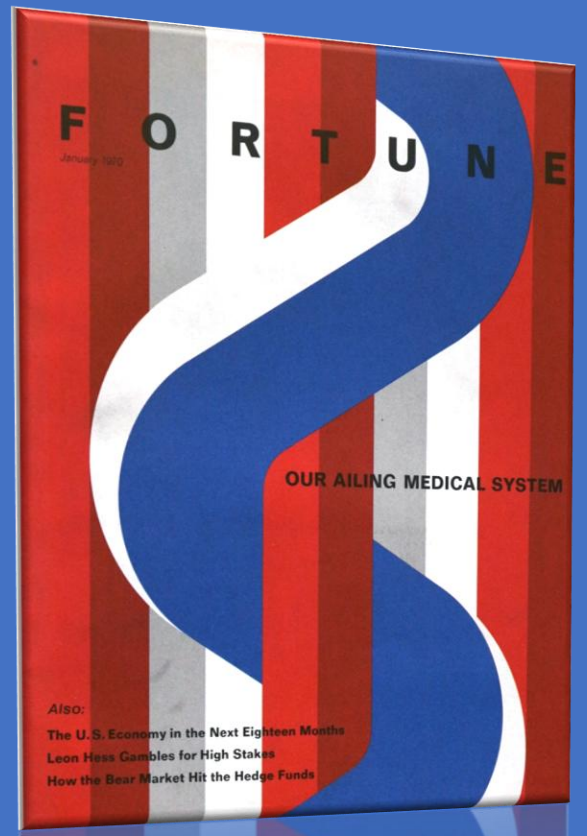
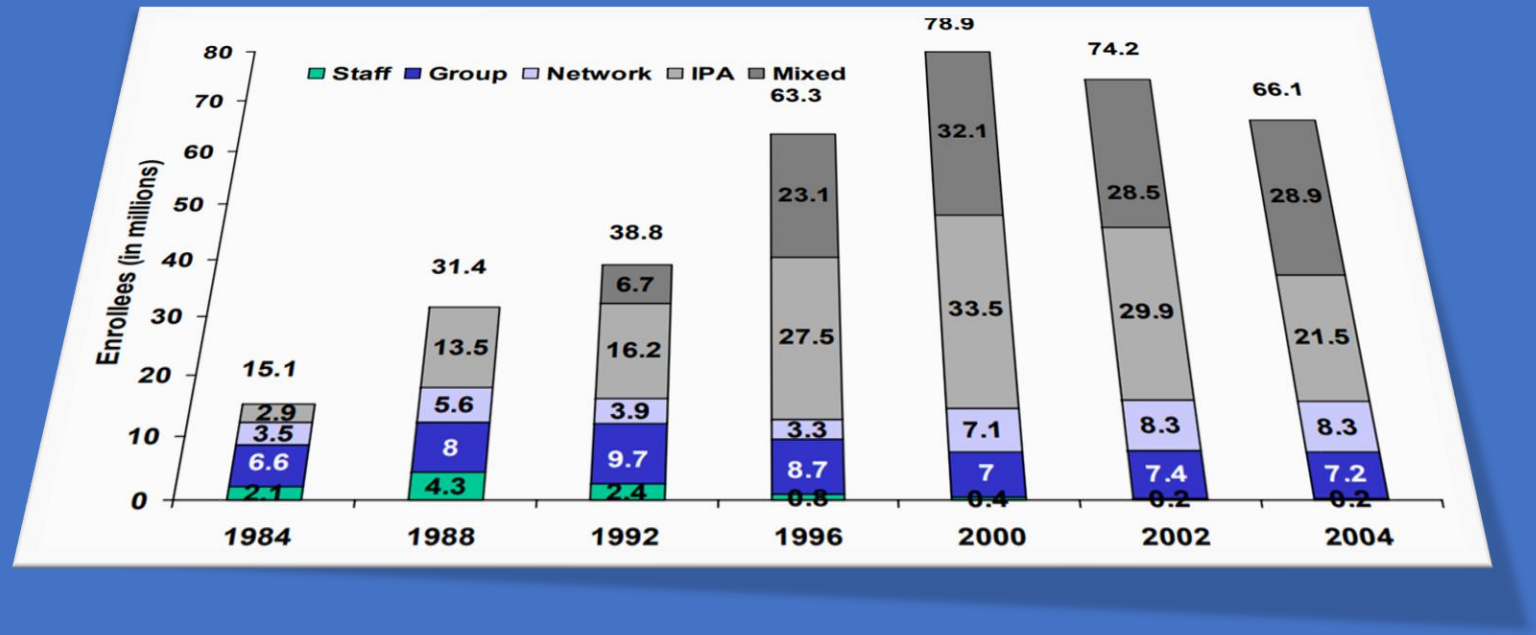
A Brief History of Managed Healthcare: 1970 to Present





Healthcare Issues in 1970

Fee-for-service Reimbursement

- Physician and hospital behavior driven by volume and revenue rather than by health outcomes.
- Incentives rewarded doing more procedures and hospitalizations, not keeping people well.

Weak management and governance.

- lack of accountability for performance
- absence of systematic measurement of outcomes, efficiency, or equity
- minimal consequences for poor results.

Rapidly Rising Costs unsustainable,

- healthcare spending already high % of national income
- poised to grow faster than the economy

U.S. healthcare spending has risen from 7% of GDP in 1970 to nearly 18% today

Fortune Solution: Staff model HMOs

KAISER PERMANENTE®

- founded during WW II to serve 200,000 employees in underserved areas.
- Became available to the public in 1945
- Largest HMO in the country in 1970 and today

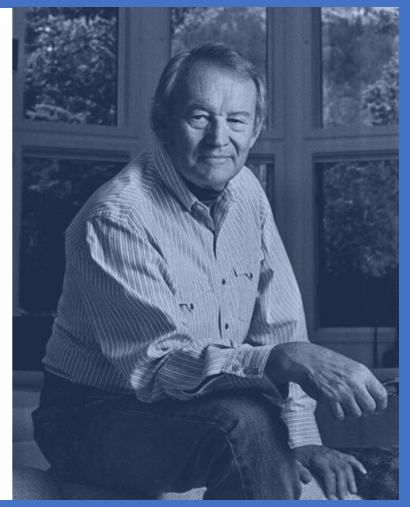
Members	Hospitals	Medical offices[1]
12.6M	40	618

Physicians[2]	Nurses[3]	Employees+
23,982	68,218	215,932

Fortune's Solution: Dr. Paul Elwood

Dr. Paul Ellwood, Pediatrician

- Conceived & coined the term "HMO"
- Sold the concept to Nixon admin.
- Founded Interstudy & Jackson Hole Group



"**large <u>nonprofit</u> organizations** would compete for patients by providing the best care at the lowest price and **… contain costs by keeping patients healthy ,,, with an emphasis on preventive medicine**."
Fortune Jan. 1970

HMO & Managed Care Timeline

1970s: Government Support of HMOs

- Non-profit Group & Staff Model HMOs
- Federal Grants & loans enabled startups & growth.
- HMO Act of 1973 gave access to employer market

1980s: Rapid Expansion of HMOs fueled by Equity Investment

- Reagan ended Federal Grants; encouraged equity investment
- For-profit IPA & Network HMOs outgrew non-profit Group & Staff model HMOs

1990s: Further Expansion of HMOs, Consolidation, Consumer Backlash

- Acquisitions led to consolidation and reduced competition
- Consumer backlash due to overly zealous claims denials
- HMO enrollment peaked in the late 1990s and declined thereafter

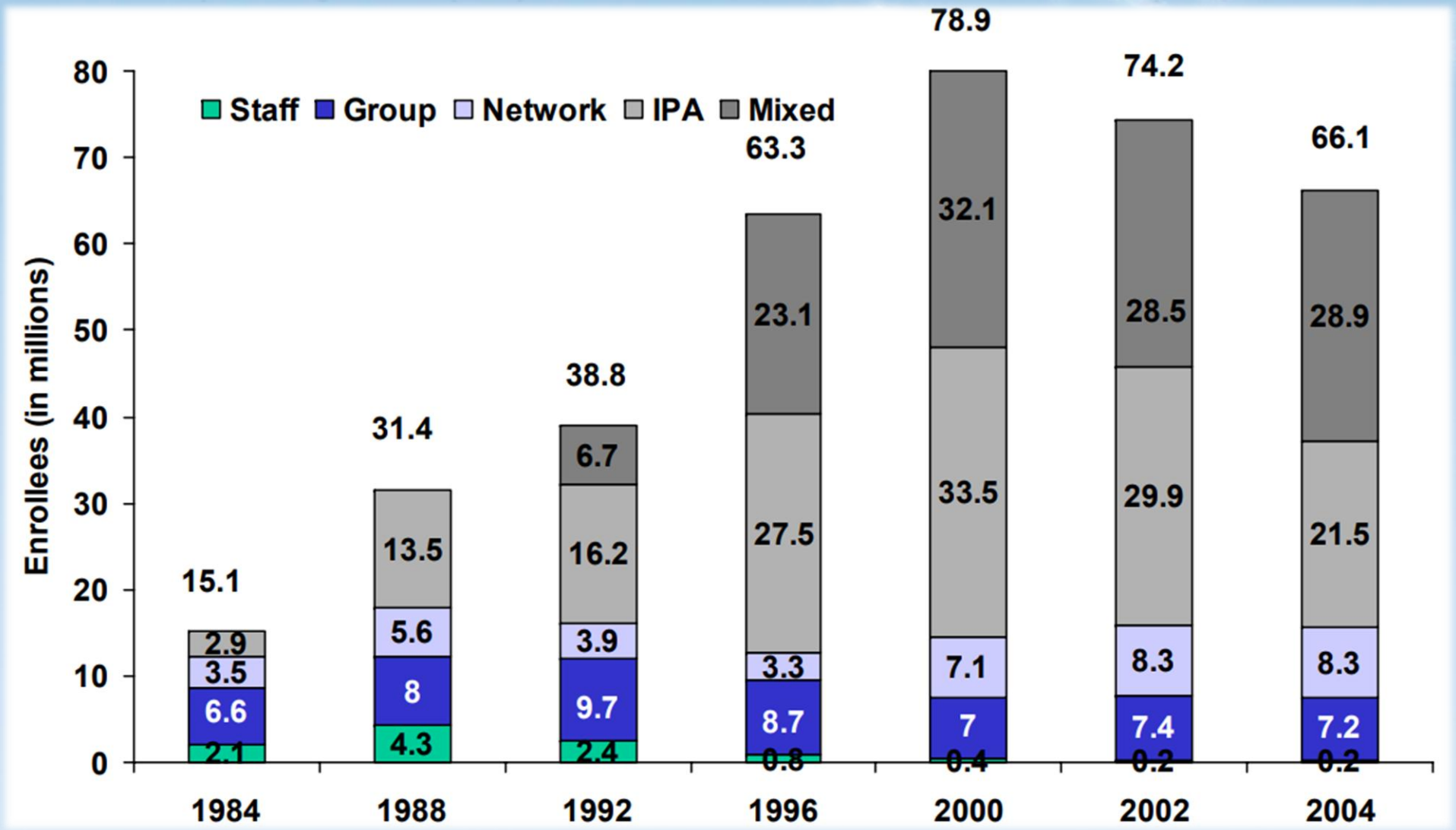
2000s: Managed Medicare & Medicaid (RomneyCare)

2010 – present: Expanded Coverage, New Care Models

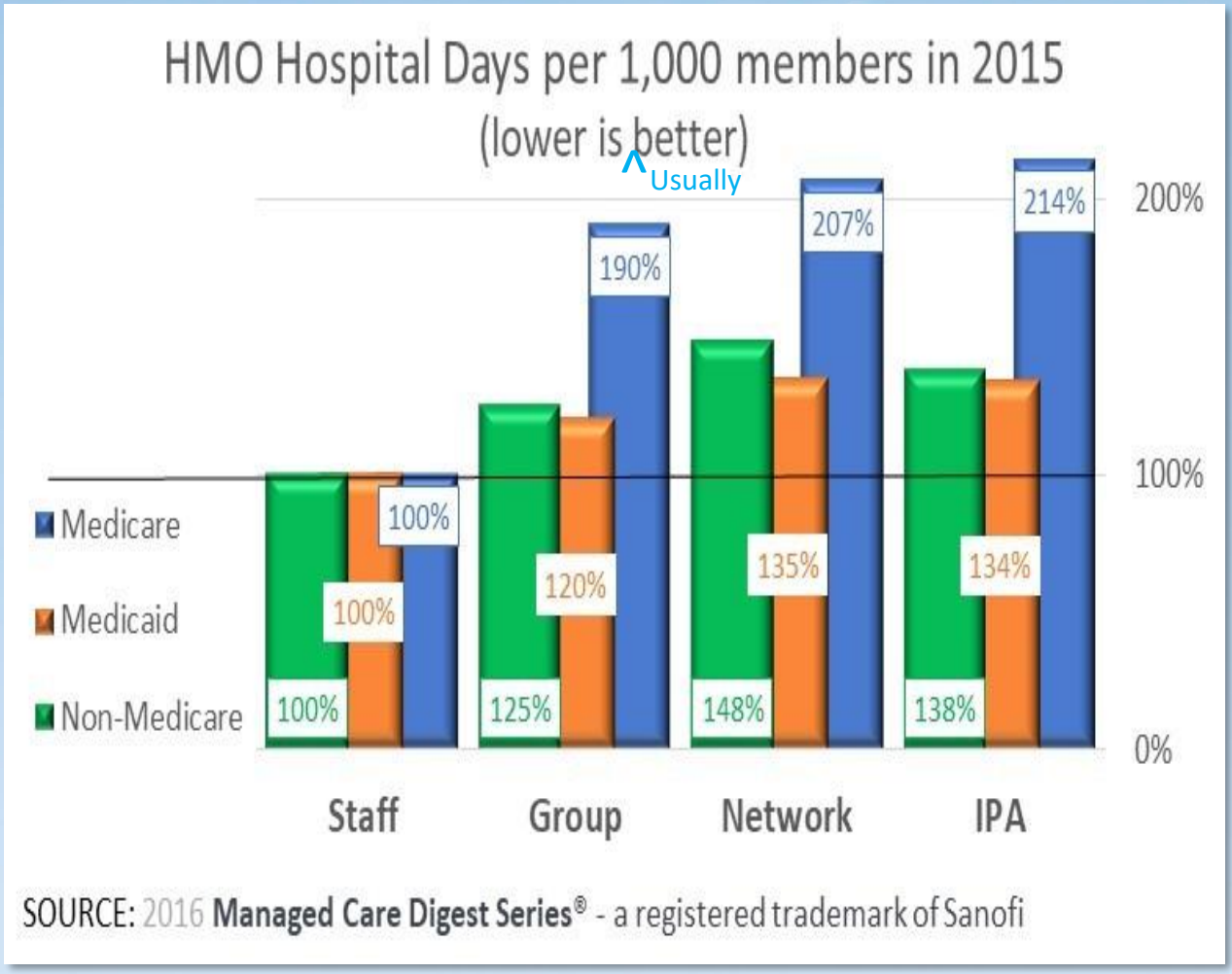
- Affordable Care Act (2010)
- Medicare Advantage (MA) replacing Medicare FFS
- Accountable Care Organizations (ACOs)

HMO Enrollment Peaked in the 1990s

IPA & Network HMOs outgrew staff & group HMOs in the 1980s



What we learned: Group & Staff HMOs Typically outperform IPA & Network HMOs



GROUP & STAFF MODEL HMOS: employ or contract exclusively with providers.

- Salary plus bonus
- No financial incentive to provide more care rather than better care
- Culture of quality, peer review, etc.

IPA & NETWORK MODEL HMOS: non-exclusive contracts with many providers.

- Less capital intensive, ergo faster growth.
- Rely heavily on **Utilization Review**, which can result in claims denials.

What went wrong?

Dr. Paul Ellwood, AHA interview, 2011

"Political expediency … to promote HMO growth led to … three mistakes:

- *for-profit plans,*
- *independent practice associations,*
- *failure to include outcome accountability."*

A Brief History of Medicare Advantage

1970s–1980s – Early HMOs in Medicare

- Medicare allowed to contract with HMOs on a capitated basis as alternative to FFS.

1982 – TEFRA Risk Contracts

- formalizes risk-based HMO contracts within Medicare.

1997 – Medicare+Choice Created

- Balanced Budget Act establishes Medicare+Choice
- expanding private plan types (HMOs, PPOs, PSOs, PFFS).

2003 – Medicare Advantage (Part C)

- Medicare Modernization Act renames Medicare+Choice to Medicare Advantage
- revises bidding/payment
- links many MA plans with new Part D drug coverage.

2010s–2020s – Growth and Refinement

- ACA adjusts payments and adds star-rating bonuses;
- MA enrollment grows to a large share of beneficiaries
- ongoing debates over risk adjustment, overpayments, and quality.

Medicare Advantage Today

The Managed Care Alternative to traditional Medicare

- **2025 enrollment: about 54–56% of eligible Medicare beneficiaries.**
  - HMO enrollment 54%
  - PPO enrollment 45%.
- **Savings vs Medicare Fee-for Service (Milliman)**
  - $1,362 PMPM total costs for MA vs.
  - $1,520 for Medicare FFS
- **Over 70% fewer hospital readmissions, 25% fewer preventable inpatient admissions.** (Harvard-Inovalon Medicare Study)
- **48 Studies show that MA outperforms FFS in various Quality of Care metrics** (HealthAffairs – 6/7/2021)
- **Nearly 2/3 of Medicare Advantage enrollees pay No Supplemental Premium** other than the Part B premium in 2021 (Kaiser Family Foundation 6/21/2021)
- **Yet the MA Program continues to experience accusations of fraud & excessive costs**

ACOs: Origins & Early Development

- Elliott Fisher coins the term "Accountable Care Organization" at MedPAC (2006)
- Affordable Care Act authorizes Medicare Shared Savings Program (2010)

- *"modeled on … quality leaders in health care, e.g.* ***Kaiser Permanente HMO****, Mayo Clinic, Cleveland Clinic, and Geisinger Health."*
- *"highly integrated providers, generally with* ***staff models*** *where* ***physicians are employees*** *of the health care organization."* - Congressional Research Service 4/25/11 -

2012

- First Medicare Shared Savings Program ACOs go live
- CMS also launches Pioneer ACO Model

ACOs: Current Status/ Medicare Shared Savings Program

- **476 ACOs:** ~11.2 million beneficiaries (18% of Medicare)
- **$2.4B net savings**: 75% earned shared payments ($4.1B)
- **$241 net savings per capita** (up 16% from 2023)
- **Better Quality:** BP control, A1c levels, depression screening follow-up
- **Physician-led outperform hospital-led** (($316/capita vs. $175/capita)
- **Two-sided risk ACOs** generated **2/3 of all savings**

Yet the ACO movement lacks momentum!

hampered by mixed results, lack comprehensive data to properly evaluate alternative models

Current Trends with Managed Care Origins

These trends informed by past managed care successes & failures

Clinically Integrated, Team-based Primary Care: the foundation of Better Care

- Traceable to the success of group and staff model HMOs, physician-led ACOs
- Momentum: Advanced Primary Care and state–based Primary Care Investment initiatives.

Measurable Quality, Equity, Value & Transparency essential to Better Care

- Value-based contracts increasingly tie payment to quality, patient experience, and equity metrics, reflecting lessons from early managed care.

AI, Interoperability, and other IT Innovations essential to Continuous Improvement

- AI-supported coding, risk prediction, decision support, and interoperable data exchange (e.g., FHIR/TEFCA) are becoming critical enablers of quality, equity, value and transparency.

Will Multi-Payer ACOs expand the reach of Better Care?

- Multi-payer and all-payer initiatives (e.g., Vermont's All-Payer ACO Model) aim to align Medicare, Medicaid, and commercial incentives around common accountable-care structures.
- Is there sufficient support for further development of ACOs?