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4 ORGANIZATIONAL VARIATION IN
5 THE MANAGED CARE INDUSTRY
6 IN THE 1990S: IMPLICATIONS FOR
7 INSTITUTIONAL CHANGE
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16
17 **ABSTRACT**
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19 *Despite continuing debate about costs and benefits, managed care became*
20 *an integral part of the health care sector during the 1990s. In this paper,*
21 *we examine the organizational and practice variation in the managed care*
22 *industry at two points in the 1990s using a national census of organizations*
23 *operating in those years. We use a definition of managed care that captures*
24 *the increased diversity within the industry while still distinguishing it*
25 *from traditional indemnity, fee-for-service care. We draw on institutional*
26 *theory to begin to formulate a framework for understanding why certain*
27 *organizational forms and practices emerged when and where they did.*
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29
30 **INTRODUCTION**
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32 In the last quarter of the 20th century, the social organization of health care
33 delivery in the U.S. changed dramatically with the introduction and growth of
34 managed care (MC). In a nutshell, MC is comprised of both organizations and
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1 organizational practices that manage as well as finance the delivery of health care.
2 MC organizations are prevalent in all health care markets (Wholey et al., 1992) and
3 managed care is the dominant form of health coverage for privately-insured indi-
4 viduals (Gabel, 1999; Gabel et al., 1994). MC has achieved what neo-institutional
5 theorists label a “taken-for-granted” status (DiMaggio & Powell, 1983; Meyer &
6 Rowan, 1977; Zucker, 1977). In other words, MC is now a social institution in the
7 United States.

8 During its early development in the 1970s and 1980s, MC was synonymous with
9 the organizational form of group-staff model health maintenance organizations or
10 HMOs (e.g. Group Health of Puget Sound and Kaiser-Permanente), which con-
11 sisted of a clear and finite set of practices through which health care was managed:
12 physicians paid by salary or “capitation” (i.e. annual lump-sum pre-payment) with
13 primary care gatekeepers and frequently, utilization review (Miller & Luft, 1994;
14 Strang, 1995). These and other features of MC were a direct challenge to the
15 dominant paradigm of fee-for-service (FFS) medicine, but had little impact on the
16 structure of health care initially. It was not until the cost-presures from dramatic
17 health care inflation in the 1980s, coupled with an economic recession, that the
18 “logic” of FFS medicine was threatened by the alternative logic offered by MC. It
19 was at that time, in the late 1980s, that states began to create regulatory incentives
20 to promote MC (Strang, 1995; Strang & Bradburn, 2001; see also Light, 2001).

21 By the early 1990s, the paradigm shift away from FFS health care toward MC
22 was in full swing, and by the mid-1990s MC had replaced FFS as the dominant
23 organizing principle in health care insurance (Gabel et al., 1994), with widespread
24 implementation of MC practices such as capitation, gatekeeping and utilization
25 review. The widespread diffusion of MC forms and practices might appear to be
26 the end of a story about the institutionalization of MC in health care. Indeed, the
27 vast majority of analyses of MC over the past twenty years have been concerned
28 with how MC *differs* from FFS health care, not how MC itself varies. We, however,
29 take this period as our point of departure. As we show in this paper, the extent
30 of organizational variation within MC indicates that the process of institutional
31 change in health care financing and delivery is still very much underway. Scholars
32 have described this as a period of profound institutional change in the health
33 care industry (Scott et al., 2000; see also Mechanic, 2002). Though all forms of
34 MC differ in important ways from FFS health care, the variation within MC has
35 implications for understanding current and future effects of health care delivery
36 for patients, for providers and for society as a whole.

37 In this paper, we explore the organizational composition of the managed care
38 industry by describing the demographic distribution of organizational forms and
39 practices across the U.S. at two points during the 1990s. Our goal here is threefold:
40 (1) to determine the extent of organizational variation in managed care during

1 the period of institutionalization in the 1990s; (2) to compose a new working
2 definition of managed care that captures the increased diversity within the industry
3 while still distinguishing it from traditional fee-for-service health care; and (3) to
4 begin to formulate a framework for understanding why certain forms and practices
5 emerged when and where they did, by drawing on theories of institutional and
6 organizational change. We raise more questions than we answer in this paper, in
7 part because our primary goal is to illustrate the variation within MC and discuss its
8 implications, rather than to fully analyze why we see the variation when and where
9 we do. MC, however, offers an opportunity to both illustrate and further develop
10 theoretical models of institutional change, and this study is the first part of a larger
11 project that will further analyze the dynamics of change within this industry.
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14 **INSTITUTIONAL CHANGE**

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16 Despite the increasing prevalence of MC throughout the 1990s, there is a great
17 deal of variation in management rules and practices, while the prevalence and con-
18 centration of different forms of MC organizations varies considerably across local
19 markets. As we will show below, by the end of the 1990s, the initially quintessential
20 form of MC, the staff-model HMO had declined significantly, while new organi-
21 zational forms, such as the individual practice association (IPA) and the preferred
22 provider organization (PPO), emerged and grew rapidly throughout the decade.
23 Thus, ironically, during the period of apparent institutionalization in which MC
24 became the predominant form of healthcare delivery, the organizational features
25 of managed care became more rather than less diverse.

26 Institutionalization often implies uniformity because it is a process through
27 which institutions, resilient and stable social structures, are formed. As [Scott](#)
28 [\(2001\)](#) makes clear, however, institutions operate at multiple levels as well as via
29 multiple mechanisms (see also [Campbell, 1997](#)). Institutional change is a broad
30 set of processes entailing both the adoption and evolution of new organizational
31 forms and practices (what is often termed “institutionalization,” [DiMaggio &](#)
32 [Powell, 1983](#)), as well as the discontinuation or abandonment of other forms
33 and practices (termed “deinstitutionalization,” [Oliver, 1992](#)) ([Jepperson, 1991](#)).
34 So while “changes in practice co-evolve with changes in legitimating logics”
35 during institutional change ([Scott, 2001](#), p. 190), they do not do so uniformly.
36 Organizational change may begin with uncertainty about what practices an
37 organization should adopt as previous norms and practices are deinstitutionalized
38 but new standards are not yet established ([Oliver, 1992](#); [Strang & Soule, 1998](#)).
39 Organizations may innovate new rules or practices over a relatively short period of
40 time, only to discard or radically alter those procedures if they do not become the

1 institutionalized practices in the field (Dowell & Swaminathan, 2000). Innovation
2 itself can be a catalyst for further organizational innovation, leading to increasing,
3 rather than decreasing rates of organizational change (Greve & Taylor, 2000).
4 Alternatively, organizations may adopt new practices only after they have become
5 commonplace among peer organizations (DiMaggio & Powell, 1983), or mandated
6 from the state or some other regulatory body (Edelman, 1992; Fligstein, 1990).

7 Even under strong institutional pressure, organizational variation may increase
8 (Edelman, 1992; Lounsbury, 2001; Ruef & Scott, 1998). Organizational variation
9 in response to normative and/or regulative pressures occurs partly because
10 ecological and competitive pressures affect organizational responses to the insti-
11 tutional environment (Dacin, 1997; Haveman & Rao, 1997) and more specifically,
12 because competitive and institutional environments vary in intensity at the local
13 level (Hannan et al., 1995; Wade et al., 1998). At the same time, differential
14 access to resources across firms leads to organizational variation in response
15 to institutional pressures (Lounsbury, 2001; Suchman, 1995). Organizational
16 practices inconsistent with dominant institutional logics, however, will not be
17 readily incorporated across organizations (Biggart & Guillen, 1999).

18 Recognizing that institutions are multi-layered, and that institutional change is
19 a multi-dimensional process, makes the increasing organizational diversity in the
20 MC industry less perplexing because uniformity at one level may hide diversity
21 at other levels. Further, it suggests that examining institutional change in the
22 MC industry requires attention to multiple aspects of the organizational entities
23 comprising it (Ruef, 2000; Scott et al., 2000). Figure 1 very simply illustrates insti-
24 tutional change across multiple organizational dimensions, including *institutional*
25 *logics*, the broad organizing principles that indicate (and define) what is considered
26 appropriate, normal and reasonable for organizations (Biggart & Guillen, 1999;
27 Friedland & Alford, 1991); *organizational forms*, the set of authority structures
28 and technological systems used across a population of organizations (Hannon &
29 Freeman, 1989; Stinchcombe, 1965); and *organizational practices*, the rules,
30 guidelines and routines that govern organizational tasks (DiMaggio & Powell,
31 1991; Nelson & Winter, 1982). Changes in institutional logic will be causally
32 linked to changes in organizational forms and at a more micro level to changes
33 in organizational practices, procedures and guidelines. Change however, may
34 occur first at any level, and lead either to significant changes at the other two
35 levels, resulting in what can be termed institutional change. For example, in
36 their historical review of long-term care in the United States, Kitchener and
37 Harrington (2003) show that institutional change in the long-term care sector
38 requires multi-dimensional change including changes in *care practices* used with
39 individual residents, development of new *organizational forms* of care delivery,
40 and shifting *societal norms* (and institutional logics) of how to treat the elderly.

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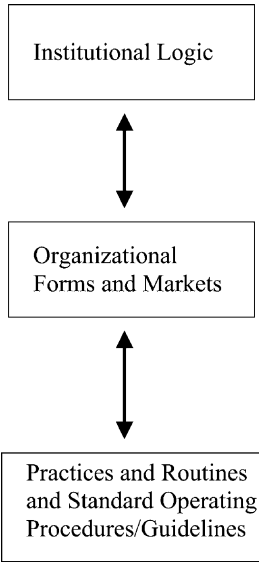


Fig. 1. Levels of Institutional Change.

Alternatively, change at one level may lead to no further change at the other levels, resulting in organizational change but not significant institutional change. Many of the more interesting dynamics in organizational and institutional change occur because change across levels is not fully uni-directional and may occur at different speeds. A closer study of variation in MC can contribute to our understanding of the dynamics of institutional change across levels of analysis and can address many questions regarding the future of the health care industry.

Diversity in Managed Care Organizational Forms and Practices

From an institutional perspective, the “logic” of MC is the *idea* that both the clinical practice and the financing of health care should be managed together, typically by insurance plans. As noted above, this was a direct challenge to the logic of FFS medicine, in which financing and clinical practice are managed separately. Under FFS, insurance plans paid fees charged by physicians who provided clinical care; physicians did not share the risk of health insurance, and physicians managed clinical care via professional rules, relationships and norms. Under MC, physicians are expected to share risk as well as submit to oversight of their clinical practice by insurance plans. The stark difference in organizing principles alone

1 has caused deep-seated resistance to the institutionalization of MC ([Mechanic, 1996, 2002](#)).

2
3 When institutions are indeterminate, such as when a dominant logic is
4 challenged, or multiple logics exist, as is currently the case in health care, there is
5 uncertainty regarding appropriate organizational forms and practices. Currently,
6 HMOs and PPOs are the two major organizational forms of MC, but they differ
7 significantly in the practices they use to pay providers and to manage care delivery
8 ([Gold et al., 1995](#)). Previous research has found substantial differences in the
9 survival and growth of different types of HMOs and of PPOs ([Christianson
10 et al., 1991; Gold et al., 1995; Wholey et al., 1992; Wholey & Burns, 1993](#)). A
11 substantial literature exists on the practices and historical trends among HMOs,
12 including research on physician payment ([Sleeper et al., 1998](#)), insurance premium
13 structures ([Wholey et al., 1995](#)), organizational forms ([Wholey & Burns, 1993](#))
14 and state oversight of HMOs ([Christianson et al., 1991](#)). In contrast, though a
15 number of studies analyze the organizational features of PPOs (e.g. [Dalton, 1987;
16 Gold et al., 1995; Gold & Hurley, 1997](#)), and the effects of PPOs on health costs
17 and utilization (e.g. [Hellinger, 1995; Smith, 1997](#)), PPOs have been relatively un-
18 studied despite their increasing prevalence in the last ten years. Here, we compare
19 the ecological trends in both HMOs and PPOs simultaneously to determine how
20 the larger population of MC firms more generally has evolved. Consequently,
21 we determine and compare the prevalence and practices of both PPO and HMO
22 forms of managed care in 1993 and 1998, and in so doing, explore the relative
23 differences and similarities within and between these two organizational forms.

24 25 26 *Data* 27

28 We examine MC organizational forms and practices using data reported in the
29 Medical Economics Company (MEC) HMO/PPO Directory for the years 1993
30 and 1998. The directories provide comprehensive information on the organiza-
31 tional characteristics for all MC health plans operating in each state in the U.S.
32 Comparison to the more familiar InterStudy HMO (1998) and PPO Directories
33 (2001), identify similar numbers of organizations for comparable years. The MEC
34 Directories provide detailed information on specific organizational practices, such
35 as clinical care oversight mechanisms and provider payment structures. While
36 cross-sectional, these data provide valuable first insights into population level
37 changes in MC during the last decade.

38 Health plans are categorized as HMO or PPO. HMOs are defined as health
39 plans offering prepaid, comprehensive health coverage for both hospital and
40 physician services, in which members are required to use participating providers

1 and are enrolled for a specified period of time. PPOs are defined as plans in which
2 beneficiaries receive care from a selected panel of providers who agree to some
3 form of discounted fee schedule when contracting with the PPO.

4 Model types within plans are categorized as one of three possible types. The
5 *group or staff* model is one in which a contracted or salaried physician group
6 provides health services to a health plan's members. An Independent Practice
7 Association (*IPA*) or *network* model is a plan that contracts directly with one or
8 more independent physician practices, of which the practices may be all or some
9 combination of solo, single-specialty or multi-specialty group practices. Models
10 classified as *other* are plans that did not specify a model type.

11 We document differences in a number of organizational-level characteristics
12 of MC plans including whether the organization is for-profit or is nationally
13 accredited. For the 1998 data, we also have information regarding whether the
14 organization issues a report card.

15 A central focus of this paper is to understand not only the variation in orga-
16 nizational forms and characteristics, but also the variation in practices across and
17 within forms. The directories provide information on whether the plan implements
18 a variety of MC practices, including methods of clinical care oversight: utilization
19 review, required second surgical opinions and case management, whether patients
20 are required to select a primary care provider, as well as provider-payment
21 methods (i.e. salary, capitation or discounted-fee-for-service). Data on payment
22 methods are available for 1998 only. The directories list whether plans respond
23 "yes" to using any of these practices. The data we report are percentages of plans
24 that reported "yes," compared to all other plans, including both those that said
25 "no," as well as those that reported "not applicable."

26 27 28 FINDINGS

29 30 *Describing the MC Organization Population*

31
32 **Table 1** shows that the number of MC organizations continued to increase during the
33 1990s, although the distribution of types of MC forms changed during the decade.
34 Overall, HMOs were still the predominant organizational form of managed care
35 in 1998, but during this period PPOs increased dramatically in both number and
36 as a proportion of all MC organizations. Comparing the general categories of PPO
37 to HMO (shaded rows in **Table 1**), the number of PPOs increased by 40% while
38 HMOs increased 21% between 1993 and 1998. In 1998, PPOs comprised 46%
39 of all MC organizations compared to about 39% in 1993. PPOs also have much
40 higher numbers of enrollees than HMOs.¹

Table 1. Characteristics of Different Forms of Managed Care Organizations in the 1990s.

	Mean Year Started	Total Number Organizations		% Change	Mean Number Enrollees	
		1993	1998	1993–1998	1993	1998
HMO	1981	517	654	+21	89,300	521,800
Group/Staff	1976	93	64	–45	107,178	498,405
IPA/Network	1982	412	528	+22	78,047	523,227
Other	1983	12	62	+81	336,235	553,453
PPO	1984	335	561	+40	249,800	794,600
IPA/Network	1983	238	438	+46	250,882	865,825
Other	1985	97	123	+21	247,157	357,767

Source: Medical Economics Company HMO/PPO Directory, 1993 and 1998.

Comparing in more detail by type of HMO or PPO shows a more complex picture (see the unshaded rows in Table 1). The earliest form of managed care, the HMO-Group/Staff model, declined dramatically during the 1990s, although newer types of HMOs increased in number. Note that the IPA/Network model of both HMOs and PPOs is the predominant type within each form, in both number of organizations and number of enrollees.

Table 2 shows that the general pattern of declines in HMO-Group/Staff models, and increases in IPA/Network models in both forms, as well as the dramatic increase in PPOs overall, holds true for every region across the country. Consistent with the idea that MC is becoming institutionalized, we see convergence in the

Table 2. Regional Distribution of Managed Care Organizations.

	North East		South		Mid-West		West	
	1993	1998	1993	1998	1993	1998	1993	1998
HMO	68.1%	52.2%	62.1%	56.3%	64.9%	56.8%	51.4%	49.9%
Group/Staff	12.8	4.5	13.3	3.9	11.2	6.9	7.8	5.5
IPA/Network	51.8	40.2	48.3	47.3	52.6	45.3	42.4	40.3
Other	3.5	7.6	0.5	5.1	1.2	4.5	1.2	4.0
PPO	31.9%	47.8%	37.9%	43.7%	35.1%	43.2%	48.6%	50.1%
IPA/Network	20.6	33.5	26.1	34.4	26.7	34.5	34.6	40.6
Other	11.3	14.3	11.8	9.3	8.4	8.7	14.0	9.5

Source: Medical Economics Company HMO/PPO Directory, 1993 and 1998.

Table 3. Managed Care Practices by Organization Type.

	Patient Selects Primary Care Provider		Capitated Payment	Discounted-FFS Payment
	1993	1998	1998	1998
HMO	48.9%	58.9%	53.8%	44.0%
Group/Staff	50.5%	56.3%	42.2%	14.1%
IPA/Network	50.0%	64.8%	60.0%	45.1%
Other	0%	11.3%	12.9%	8.1%
PPO	27.8%	34.2%	29.1%	50.6%
IPA/Network	33.6%	39.0%	33.1%	51.8%
Other	13.4%	17.1%	14.6%	23.6%
HMO-PPO	$X^2 = 37.792$ $p < 0.000$	$X^2 = 73.543$ $p < 0.000$	$X^2 = 75.9$ $p < 0.000$	$X^2 = 5.3$ $p < 0.01$

Source: Medical Economics Company HMO/PPO Directory, 1993 and 1998.

distribution of MC forms across regions of the country. The greatest decline in HMO prevalence occurred in regions where penetration was previously high, and the highest growth in PPOs occurred in those regions where HMOs were previously predominant.

Next we compare specific managed care practices in the different organizational forms. Table 3 shows that, overall, both HMOs and PPOs experienced growth in the use of primary care providers (PCP) although HMOs are much more likely than PPOs to require patients to select a primary care provider (PCP) (comparing the shaded rows of Table 3). This is only one measure of gatekeeping, in which the primary care provider is the source for referral to any specialty care. Managed care organizations may also require approval for referrals even when patients see a variety of providers – a practice most common in Group/Staff HMOs. Hence, the difference between HMOs and PPOs may be more attenuated if we had a better measure of gatekeeping practices.

Overall, HMOs are more likely to pay physicians through capitation, while PPOs are more likely to use discounted-fee-for-service to pay providers (compare shaded rows of columns three and four in Table 3). The HMO-IPA/Network model appears to be a hybrid form of MC by using both payment forms. Similar to PPOs, they have a relatively high use of discounted-fee-for-service, but like traditional HMOs, they also have a relatively high frequency of using capitation. These similarities and differences make sense if we consider, as others have (Sleeper et al., 1998), that health care provider organizations fall along a continuum, with traditional fee-for-service (indemnity-insurance) delivery at one end, and traditional staff HMOs at the other,

Table 4. Provider Oversight in Managed Care Organizations in the 1990s.

	Case Management		Second Opinion		Utilization Review	
	1993	1998	1993	1998	1993	1998
HMO	52.8%	56.7%	24.0%	36.5%	54.2%	57.3%
Group/Staff	52.7%	59.4%	23.7%	29.7%	51.6%	56.3%
IPA/Network	53.6%	61.9%	24.5%	40.9%	55.6%	62.9%
Other	25.0%	9.7%	8.3%	6.5%	25.0%	11.3%
PPO	42.1%	47.6%	24.5%	34.2%	47.2%	52.2%
IPA/Network	52.1%	55.5%	30.7%	40.6%	57.6%	60.7%
Other	17.5%	19.5%	9.3%	11.4%	21.6%	22.0%
HMO-PPO	$\chi^2 = 9.3$	$\chi^2 = 10.1$	$\chi^2 = 0.03$	$\chi^2 = 0.071$	$\chi^2 = 3.9$	$\chi^2 = 3.2$
	$p < 0.001$	$p < 0.001$	n.s.	n.s.	$p < 0.05$	$p < 0.05$

Source: Medical Economics Company HMO/PPO Directory, 1993 and 1998.

with IPA/Network HMOs and PPOs in the middle. These hybrid forms account for some of the variation in managed care practices across markets, as the institutional pressures associated with operating as a hybrid form may be conflicting.

In Table 4, we compare the prevalence of provider oversight practices across years and organizational forms. Overall, provider oversight practices have increased in prevalence between 1993 and 1998. However, HMOs are more likely to use case management, somewhat more likely to do utilization review, and no more likely to require second opinions for surgery than PPOs (compare shaded rows in Table 4). Looking at the variation within models again reveals a slightly more complex picture. The IPA/Network PPOs look similar to various HMO models, but the newer, unspecified types (HMO-Other and PPO-Other) are much less likely to use provider oversight and case-management practices.

In Table 5, we compare general organizational characteristics of the various managed care forms. Overall, PPOs are more likely than HMOs to be for-profit firms. This finding stems primarily from the fact that only a little more than one-third of Group/Staff HMOs are for-profit firms. In contrast, HMO-IPA/Network models are nearly as likely as PPOs to be for-profit.

Overall, PPOs are much less likely to be nationally accredited or to issue consumer “report cards” with information about quality measures (compare shaded rows in columns two and three in Table 6). The variation on these two measures holds across model types and across years. Nearly 50% or more of the two dominant HMO models (Group/Staff and IPA/Network) are nationally accredited in both 1993 and 1998, compared to only about 13% of IPA-Network PPOs in each of those years. Similarly, approximately two-thirds of all HMO

Table 5. Organizational Features of Managed Care Organizations.

	% For-Profit		% Accredited		% Issue Report Card
	1993	1998	1993	1998	1998
HMO	65.2	64.8	60.1	55.5	67.0%
Group/Staff	45.1	37.1	66.7	57.8	63.8%
IPA/Network	69.0	68.2	55.6	49.4	66.8%
Other	90.0	64.5	0	19.4	77.3%
PPO	66.5	75.9	18.4	17.5	36.0%
IPA/Network	67.4	77.6	13.9	12.8	36.2%
Other	64.2	67.2	5.2	5.7	34.8%
HMO-PPO	$X^2 = 0.150$	$X^2 = 15.9$	$X^2 = 101.4$	$X^2 = 130.2$	$X^2 = 87.6$
	n.s.	$p < 0.000$	$p < 0.000$	$p < 0.000$	$p < 0.000$

Source: Medical Economics Company HMO/PPO Directory, 1993 and 1998.

Table 6. Clinical Managed Care Practices in MC Organizations, 1998.

	Mean Number of Clinical MC Practices (0–4)	% with 2 + Clinical MC Practices
HMO	2.1	58.1
Group/Staff	2.0	59.4
IPA/Network	2.3	63.6
Other	0.4 ^a	9.7
PPO	1.7	49.6
IPA/Network	1.96 ^b	58.0
Other	0.7 ^a	19.5
HMO-PPO	$F = 19.3$	$X^2 = 8.9$
	$p < 0.000$	$p < 0.002$
Model Types	$F = 43.0$	$X^2 = 131.3$
	$p < 0.000$	$p < 0.000$

Source: Medical Economics Company HMO/PPO Directory, 1998.

^a Significantly less than all other model types ($p < 0.05$).

^b Significantly less than Group/Staff-HMOs and IPA/Network-HMOs ($p < 0.05$).

model types issue a quality report card, compared to only about one-third of PPOs.

What Do We Mean by Managed Care Anyway?

Essentially, MC introduced the management of health care delivery primarily along two dimensions. One dimension introduced alternative methods for the payment of health services, moving from fee-for-service payment to mechanisms

1 in which providers share risk (Luft, 1999). Some of the earliest HMOs paid
 2 providers by salary. More typically, MC organizations used capitation, as well as
 3 various forms of bonuses or penalties tied to utilization rates. Today, some plans
 4 now include discounted fee-for-service as a form of MC payment. The second
 5 dimension of MC introduced oversight of the clinical decisions of providers.
 6 Clinical management has included practices such as gatekeeping, utilization
 7 review, case management, and required second opinions. It is also possible to
 8 think of a third dimension by which MC “manages” delivery of health services, the
 9 dimension of managing patient care-seeking by introducing patient co-payments
 10 for services, but we do not address this dimension here.

11 In the section above, we presented descriptive statistics of individual MC prac-
 12 tices in different MC organizational forms. Here we present composite variables
 13 from the 1998 data measuring two dimensions of MC, payment mechanisms
 14 and clinical management, to assess the extent to which different organizational
 15 forms of MC actually “manage” health care delivery. Our first composite variable
 16 measures the clinical dimension of MC and includes whether an organization
 17 uses any of the following four practices of clinical oversight: case management,
 18 utilization review, second opinions or gatekeeping.

19 Table 7 shows that, in general, HMOs use more clinical oversight practices
 20 to manage care than PPOs (compare shaded rows). A post-hoc Sheffe test reveals

21
 22
 23 **Table 7.** Payment Management Practices in MC Organizations, 1998.

	Payment Mgmt 1: Salary or Capitation		Payment Mgmt 2: Salary, Capitation or DFFS	
	Mean	% No Payment Mgmt	Mean	% No Payment Mgmt
HMO	0.65	41.4	1.0	33.9
Group/Staff	0.91 ^a	25.0	1.1 ^a	25.0
IPA/Network	0.68 ^b	38.1	1.1 ^a	29.4
Other	0.13	87.1	0.21	82.3
PPO	0.33	69.3	0.78	42.8
IPA/Network	0.37	65.8	0.88	36.5
Other	0.20	82.1	0.43	65.0
HMO-PPO	$F = 99.2$	$X^2 = 94.8$	$F = 26.7$	$X^2 = 10.0$
	$p < 0.000$	$p < 0.000$	$p < 0.000$	$p < 0.001$
Model Types	$F = 47.1$	$X^2 = 166.6$	$F = 32.9$	$X^2 = 111.4$
	$p < 0.000$	$p < 0.000$	$p < 0.000$	$p < 0.000$

38 *Source:* Medical Economics Company HMO/PPO Directory, 1998.

39 ^aSignificantly more than all other types ($p < 0.05$).

40 ^bSignificantly less than Group/Staff-HMOs, but significantly more than other types ($p < 0.05$).

1 that this comparison holds even when comparing HMO-IPA/Network models with
2 IPA/Network-PPOs (compare unshaded rows). Unspecified model types (HMO-
3 Other and PPO-Other) use significantly fewer clinical MC practices than all others.

4 We analyze different forms of payment management, measured by two different
5 composites, in Table 8. The first composite variable includes only the standard MC
6 payment mechanisms of salary and capitation. The second payment composite
7 includes discounted-fee-for-service (DFFS), as well as salary and capitation. Well
8 over half of all HMOs use either salary or capitation to pay providers, compared
9 to less than one-third of all PPOs (compare shaded rows in column 3 of Table 8).
10 IPA/Network-HMOs are more likely to use salary or capitation than either type
11 of PPO, but are less likely than Group/Staff HMOs to use them. When we include
12 DFFS as a form of MC payment, the percent of PPOs with no MC payment
13 mechanism declines, but PPOs are still less likely than HMOs to use payment
14 management (see column 2 in Table 8).

15 Overall, HMOs have significantly more MC practices, including both clinical
16 oversight and payment mechanisms, than PPOs. Both Group/Staff and
17 IPA/Network HMOs have significantly more managed care practices than
18 IPA/Network PPOs. On a continuum of “managedness,” IPA/Network PPOs
19 appear to fall between HMOs, on the one side, and traditional fee-for-service on
20 the other, as a “less managed” type of care. What is unclear, however, is whether
21 and in which direction further change will occur. Increasing numbers of PPOs
22 suggest that managed care is becoming less managed over time.

23 24 25 **DISCUSSION** 26

27 The increasing prevalence of managed care has changed a number of the practices
28 for the provision of health care, including restructuring payments for health
29 care services, reorganizing providers and services in health care markets, and
30 introducing new practices that shape the relationships between and among health
31 care providers and patients. Our results demonstrate that managed care currently
32 consists of several distinct organizational forms that differ dramatically in their
33 use of MC practices. PPOs use fewer MC practices and offer greater autonomy
34 for providers than HMOs. PPOs also are less likely to be accredited and less likely
35 to issue report cards. Some of these differences may exist because PPOs are a
36 newer organizational form than HMOs. These differences, however, indicate that
37 PPOs have distinctly different relationships to key stakeholders in the health care
38 system than do HMOs.

39 The evidence also shows, however, that a substantial number of what are
40 considered traditional HMOs do not use “traditional” MC practices, including

1 utilization review and case management. This raises the question, are PPOs and
2 HMOs more alike or different? Future research needs to look more closely at
3 local markets to determine whether competition among the different forms of
4 MC occurs within local markets or whether local markets are dominated clearly
5 by one form or another. Institutional theory suggests that competition among
6 different forms in the local market is the major way in which institutional logics
7 are questioned (Ingram & Clay, 2000; Knight, 1992). Subsequently, we must
8 consider how competition among HMOs and PPOs is defining the future of
9 managed care.

10 Those markets where HMOs and PPOs go into direct competition for consumers
11 will be in turmoil institutionally. We may expect that within these markets, both
12 types of organizational forms will have some change in their use of MC practices,
13 as the social norms within the market are not clearly defined. In contrast, if
14 PPOs have spread into markets where HMOs were never strong competitors,
15 it would suggest that the strong managed care practices of HMOs were never
16 fully accepted by the population and there will be little incentive (or institutional
17 pressure) for either HMOs or PPOs to use strong MC practices. MC organizations
18 may be highly susceptible to local variation for a number of reasons: because
19 the relatively recent institutional development of its “logic” makes it more
20 susceptible to regulatory pressure, because health care plans are “tightly coupled”
21 with aspects of the local environment (e.g. supply of physicians, community
22 employment level), or because norms within MC conflict with “traditional” values
23 and practices of (fee-for-service) medicine.

24 25 26 CONCLUSION

27
28 A closer examination of the changes in organizational practices used across MC
29 forms will help us gain a better understanding of how resource demands made
30 by external stakeholders shape institutional processes. Institutional theorists
31 have argued recently that bargaining among parties is a critical component of
32 institutional change (Ingram & Clay, 2000). Many of the facets of patient-provider
33 and provider-provider relationships are affected by the practices of managed care
34 firms. For example, physicians’ professional networks are often disrupted by
35 MC rules such as closed specialist panels for referrals (Anthony, 2003). While
36 MC practices clearly affect consumers and medical professionals, we have little
37 understanding of how these groups respond to changes in managed care practices –
38 for example, by switching insurance as a consumer or switching practice locations
39 as a physician (cf. Jiang & Begun, 2002). Such analyses require longitudinal data
40

1 on how individual organizations change practices and lose or gain memberships.
2 This study is part of a larger project to collect the organizational data necessary
3 for addressing these questions.

4 The policy implications of the findings presented here depend more generally
5 on how one views managed care. Some may conclude that the increasing number
6 of PPOs is positive for consumers since PPOs entail less risk-sharing among
7 providers and less gatekeeping of patients. In addition, PPOs typically offer a
8 larger number of providers, thereby offering increased consumer choice and
9 flexibility. Some will also believe that less clinical oversight more typical in
10 PPOs is beneficial for both patients and providers. Others, however, may be
11 worried that PPOs are throwing the managed care baby out with the bathwater.
12 They may caution that the findings that PPOs are more likely to be for-profit,
13 less likely to be nationally accredited, and less likely to issue report cards could
14 signal quality differences between PPOs and HMOs. Moreover, it is not clear that
15 PPOs yield the same cost savings as HMOs. While we presented no data on cost-
16 differences, other studies have found that PPOs do not have the same savings as
17 HMOs (Smith, 1997).

18 The data presented here illustrates how the institution, forms and practices
19 of managed care have changed in the last decade. It reveals a complexity in
20 organizational change at the levels of organizational form and practice that
21 is sometimes obscured by considering more macro changes in institutional
22 logic. The multiple organizational levels at which change occurs contribute
23 substantially to the complexity of institutional change. Our study provides clues
24 to the institutional processes that may be driving the industry to change and at the
25 same time, demonstrates growing diversity and complexity in the social definition
26 and acceptance of managed care practices in health care. Social scientists
27 attuned to the multidimensional features of institutional and organizational
28 change can determine when, where and why the MC industry is changing
29 in order to better understand the profound impact of MC on the delivery of
30 health care.

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NOTE

36 1. At least part of this difference can be explained by the different techniques for
37 estimating enrollment between HMOs and PPOs. Unlike HMOs, in which “covered lives”
38 equals the number of members, PPOs estimate the number of covered lives based on
39 assumptions about the number of dependents per subscriber, and this “dependent factor”
40 varies widely across plans (Smith & Scanlon, 2001).

40

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