1990s Revolution of Care

Posted on January 25, 2020

Introduction

The “1990s revolution of care” refers primarily to the rapid expansion of managed care in the United States and the temporary slowdown in health-spending growth that accompanied it. Employers, insurers, and public programs increasingly moved people away from traditional fee-for-service coverage toward health maintenance organizations, preferred provider organizations, utilization review, negotiated payment, and restricted networks. The original essay correctly observes that this change reduced spending growth for a period and generated dissatisfaction among patients and clinicians. Its dates and expenditure figures are confused, however, and it treats managed care as one unified plan. A clearer history separates the cost crisis that preceded the shift, the mechanisms managed-care organizations used, the one-time nature of some savings, the political backlash, and the system that emerged afterward. The 1990s did not solve American healthcare costs. They demonstrated that payment and organizational design can alter spending, access, clinical autonomy, and public trust simultaneously. (Centers for Medicare & Medicaid Services, 2015)

The Cost Problem Before the 1990s

U.S. health expenditure grew rapidly during the 1970s and 1980s. New technology, expanded insurance, hospital growth, specialist care, population change, inflation, and payment systems all contributed. Traditional fee-for-service arrangements generally paid providers for each service delivered, creating weak direct incentives to limit volume. Patients with comprehensive employer coverage were often insulated from the full price at the point of care, while employers received favorable tax treatment for health benefits. By 1989, health spending consumed about 11.6 percent of national output, according to federal expenditure accounts. Policymakers and employers feared that continued growth would reduce wages, strain government budgets, and make insurance unaffordable. (Centers for Medicare & Medicaid Services, 2015, 2026; Levit et al., 2000)

What Managed Care Meant

Managed care describes organizational and payment arrangements intended to coordinate services and control utilization. Health maintenance organizations commonly combined financing with a defined provider network and emphasized primary-care coordination. Preferred provider organizations negotiated discounted rates and encouraged use of contracted providers while allowing some out-of-network care at greater cost. Point-of-service plans mixed features of both. Insurers also used prior authorization, utilization review, case management, formularies, and selective contracting. These

tools differed in restrictiveness and clinical rationale. Managed care was therefore not one policy but a family of mechanisms that shifted decision-making from independent transactions toward organized networks. (Miller & Luft, 2002)

Employer-Led Enrollment Changes

Employers played a central role because employment-based insurance covered a large share of nonelderly Americans. Faced with premium increases, firms offered managed-care plans, changed contributions, or limited the amount they would pay toward more expensive options. Some used fixed contributions that made employees responsible for the difference between plans. This approach created stronger price sensitivity but also shifted cost and complexity onto workers. Employees who valued unrestricted choice could face substantially higher premiums. The change was especially significant because health benefits are part of total compensation: rising employer spending can reduce the money available for wages, hiring, and other benefits even when workers do not see the tradeoff directly. (Miller & Luft, 2002)

From Fee-for-Service to Network Care

Enrollment moved rapidly away from conventional indemnity insurance. By the end of the 1990s, only a small minority of workers with employer-sponsored coverage remained in traditional plans, while preferred provider organizations and other managed arrangements became dominant. The transition was large because purchasers did not wait for gradual consumer choice; they redesigned the menu of available plans. Network care could improve coordination and negotiate lower prices, but it also meant that the value of insurance depended on which clinicians and hospitals were included. A low premium offered little reassurance if a trusted physician or necessary specialist was outside the network. (Miller & Luft, 2002)

How Managed Care Slowed Spending

Managed-care organizations used several routes to lower expenditure growth. They negotiated payment rates, reduced hospital admissions and lengths of stay, reviewed high-cost services, encouraged outpatient care, and required authorization for selected procedures. Competition among plans also put pressure on premiums during a period when employers were willing to switch carriers. The shift coincided with broader economic growth and other policy changes, so the exact contribution of each mechanism is difficult to isolate. Federal historical analysis nevertheless describes 1993–1999 as a managed-care era in which health-spending growth moderated and the health share of gross domestic product remained unusually stable. (Centers for Medicare & Medicaid Services, 2015, 2026; Levit et al., 2000)

A Temporary Success

The slowdown was real but largely temporary. CMS historical analysis reports average annual health-spending growth of about 6 percent from 1993 through 1999, followed by faster growth in the early 2000s. Several early savings could not be repeated indefinitely. Once hospital use had been reduced and provider prices compressed, further cuts became harder without threatening access or provoking resistance. Plans also relaxed restrictions as employers competed for workers in a strong labor market and consumers demanded broader choice. Prescription-drug spending, technology, provider consolidation, and other pressures accelerated. Managed care changed the level and timing of spending, but it did not eliminate the underlying drivers. (Centers for Medicare & Medicaid Services, 2015, 2026; Levit et al., 2000)

Patient Backlash

Patients often objected when authorization rules delayed care, networks excluded preferred clinicians, or plan representatives appeared to make decisions primarily for cost reasons. Highly publicized denials became symbols of a system that placed an insurer between patient and physician. Some criticism reflected misunderstanding, because not every requested intervention is beneficial and appropriate utilization review can protect patients from unnecessary treatment. The larger problem was legitimacy. Plans frequently failed to explain criteria, appeal rights, or the clinical basis for decisions. When people believe that an organization profits by refusing care, secrecy and inconsistent processes destroy trust quickly. (Miller & Luft, 2002)

Clinician Dissatisfaction

Physicians and other clinicians experienced increased administrative review, negotiated fees, network rules, and documentation requirements. Some valued coordinated systems and prevention, while others saw managed care as an intrusion into professional judgment. Financial incentives could also create ethical tension when payment arrangements appeared to reward lower utilization. The appropriate question is not whether clinicians should have unlimited autonomy. Unnecessary or low-value care can harm patients and waste resources. Oversight must instead be transparent, evidence-based, timely, and designed with clinical participation. Administrative control that adds burden without improving decisions creates cost in another form. (Miller & Luft, 2002)

Primary Care and Gatekeeping

Many HMOs used primary-care physicians as gatekeepers for specialty referrals. In principle, this model could coordinate fragmented care, reduce duplication, and strengthen prevention. In practice, it sometimes placed primary-care clinicians in the uncomfortable role of both advocate and resource

controller. Gatekeeping also functioned poorly where primary-care capacity was inadequate or patients had complex needs requiring frequent specialty input. Later models retained coordination while using broader networks, standing referrals, disease-management programs, and team-based care. The lesson is that coordination requires resources and relationships; an authorization form alone does not create integrated care. (Miller & Luft, 2002)

Quality: More Than Cost Control

The public debate often treated managed care as a conflict between cost and quality, but quality varied across plans and fee-for-service systems. Organized plans could measure preventive services, identify gaps, manage chronic disease, and create accountability for a population. They could also underprovide, fragment networks, or discourage high-cost enrollees. Quality assessment expanded through accreditation, reporting, and measures such as the Healthcare Effectiveness Data and Information Set. Measurement improved visibility but also encouraged attention to what was easiest to count. A complete evaluation includes outcomes, patient experience, equity, access, continuity, and administrative burden. (Centers for Medicare & Medicaid Services, 2015)

Medicare Managed Care

Medicare had long allowed participation in private plans, and the Balanced Budget Act of 1997 created the Medicare+Choice program. Policymakers hoped that plan competition would expand options and produce savings. Payment changes and market conditions led some plans to withdraw from counties, disrupting beneficiaries and revealing the difficulty of maintaining choice while controlling public expenditure. The program later evolved into Medicare Advantage under different payment policies. The 1990s experience showed that private-plan participation is sensitive to government rates, local provider markets, benefit design, and the ability to attract favorable risk. (Miller & Luft, 2002)

Medicaid Managed Care

States also expanded managed care for Medicaid beneficiaries to improve budget predictability and coordinate services. The population includes children, pregnant people, people with disabilities, older adults, and individuals needing long-term services, so one plan design does not fit all. Capitated payment can encourage prevention and efficient care, but inadequate rates or weak oversight can restrict access. States need network standards, encounter data, quality monitoring, grievance systems, and protections for continuity. Cost predictability for government is not sufficient evidence that beneficiaries receive appropriate care. (Miller & Luft, 2002)

The Uninsured During the Managed-Care Era

Managed care addressed how insured care was organized; it did not provide universal coverage. Millions remained uninsured because they lacked eligible employment coverage, could not afford premiums, or fell outside public programs. The original essay cites approximately forty-three million uninsured people, a figure consistent with the broad scale of the problem around the turn of the century but requiring a specific year and source. Cost control can make coverage more affordable, yet restrictive plans do not solve eligibility gaps. The persistence of uninsurance demonstrated that delivery reform and coverage policy are related but separate problems. (Robinson, 2004; Centers for Medicare & Medicaid Services, 2015)

Cost Shifting to Workers

Employers responded to premium pressure not only by selecting plans but by increasing employee contributions, deductibles, copayments, or dependent costs. Cost sharing can discourage low-value use, but patients often cannot distinguish low-value from necessary care. Higher out-of-pocket costs may cause people to delay medication, preventive services, or evaluation of serious symptoms. The distribution matters: the same deductible imposes a far greater burden on a low-income worker. A sustainable system should make patients aware of cost while protecting high-value care and limiting financial harm. (Centers for Medicare & Medicaid Services, 2015, 2026; Levit et al., 2000)

Consolidation and Bargaining Power

Managed-care purchasing initially relied on plans' ability to negotiate with hospitals and physicians. Providers responded partly through mergers, employment arrangements, and larger systems that could bargain more effectively. Consolidation can support integrated records and coordinated investment, but it can also increase prices when local competition declines. The cycle demonstrates that cost-control strategies change market behavior. A plan that gains leverage in one decade may face dominant hospital systems in the next. Policy must therefore examine both insurer and provider concentration rather than assuming that one side represents competition automatically. (Robinson, 2004; Centers for Medicare & Medicaid Services, 2015)

From Tight HMOs to Looser Management

Public resistance encouraged employers and insurers to favor less restrictive products, especially preferred provider organizations. These plans preserved negotiated networks but offered greater apparent choice and fewer gatekeeping requirements. The change reduced some dissatisfaction while weakening certain utilization controls. Management did not disappear; it moved into prior authorization, formularies, case management, payment contracts, and increasingly data-driven

review. The contemporary system still contains managed care even when patients do not use that label. (Robinson, 2004; Centers for Medicare & Medicaid Services, 2015)

Managed Care's Lasting Institutional Effects

The 1990s normalized network contracting, quality measurement, disease management, pharmacy benefit design, utilization review, and purchaser comparison. It also changed expectations about accountability. Insurers and delivery systems were increasingly expected to manage the health and cost of defined populations rather than pay every claim passively. Later accountable-care organizations, value-based payment, and population-health models inherit parts of this logic. They attempt to align payment with quality and total cost, though they face similar risks involving measurement, selection, consolidation, and administrative complexity. (Robinson, 2004; Centers for Medicare & Medicaid Services, 2015)

What the 1990s Did Not Resolve

The managed-care revolution did not settle how much the United States should spend, how prices should be set, who should be insured, or how administrative costs should be reduced. It also did not remove variation in practice or guarantee equitable access. The temporary slowdown revealed that aggressive purchasing and organizational change can affect expenditure growth. The rebound revealed that cost pressure returns when technology, prices, labor, market power, and public expectations continue to expand. No single insurance design can resolve all these forces. (Centers for Medicare & Medicaid Services, 2015)

Lessons for Contemporary Reform

First, cost control must be evaluated alongside quality and access. Second, restrictions need transparent clinical criteria and meaningful appeal. Third, savings that depend on one-time price compression should not be mistaken for permanent productivity improvement. Fourth, primary-care coordination needs investment rather than gatekeeping alone. Fifth, competition can be weakened by consolidation among either insurers or providers. Sixth, patients require understandable information about networks and financial exposure. Finally, coverage expansion and delivery reform should be planned together so that efficiency gains do not leave large groups outside the system. (Robinson, 2004; Centers for Medicare & Medicaid Services, 2015)

Conclusion

The 1990s revolution of care was a rapid transformation in the organization and financing of American healthcare. Employers and public programs shifted enrollment from traditional fee-for-service

insurance toward managed networks that negotiated prices, reviewed utilization, shortened hospital care, and emphasized coordination. Spending growth moderated during much of the decade, making the change a temporary cost-control success. The same mechanisms generated backlash when patients lost choice, clinicians faced opaque restrictions, and plans failed to establish trust. Growth accelerated again as restrictions loosened and deeper cost drivers persisted. Managed care did not disappear; its tools became embedded in modern insurance, Medicare Advantage, Medicaid plans, pharmacy management, and value-based care. The central lesson is not that management should be abandoned or intensified without limit. It is that cost control is sustainable only when clinical legitimacy, transparency, access, equity, and long-term system incentives are addressed together. (Centers for Medicare & Medicaid Services, 2015, 2026; Levit et al., 2000)

References

Centers for Medicare & Medicaid Services. (2015). *History of health spending in the United States, 1960–2013*.

Centers for Medicare & Medicaid Services. (2026). *National Health Expenditure Accounts: Historical data*.

Levit, K., Smith, C., Cowan, C., Lazenby, H., Sensenig, A., & Catlin, A. (2000). National health expenditures in 1999. *Health Care Financing Review, 22*(1), 77–110.

Miller, R. H., & Luft, H. S. (2002). HMO plan performance update: An analysis of the literature, 1997–2001. *Health Affairs, 21*(4), 63–86.

Robinson, J. C. (2004). Reinvention of health insurance in the consumer era. *JAMA, 291*(15), 1880–1886.