

Managed Care

General Discussion

What Is Managed Care?

Managed care is any health care arrangement that includes cost-containment strategies; risk allocation among insurance entities, providers and employers; and the claims administration and reporting thereof. The term applies to an HMO, PPO, EPO, POS, PHO and also to direct contracting and utilization review. Managed health care has developed as a response to the rapidly rising medical costs in the last decade.

Problems With Name Managed Care

Many people would prefer that the name *managed care* be changed to *coordinated care* because the latter name is more user-friendly.

Historical Perspective

Many years ago employers provided managed care, capitation and integrated health care in the following ways:

- Employers where a labor force was so isolated or detached that it could not conveniently obtain medical care own its own; e.g., Hawaii plantations, lumber camps in the Northeast, iron ranges in Minnesota, and railroads generally.
- To provide care, the employer hired physicians, started hospitals or contracted for beds, used visiting nurses and owned clinics. Note: state-sponsored anti-corporate medicine legislation resulted from the evils of such practices; also the IRC §501(c)(9) trust came into being to give special tax status to railroad hospitals.

The Kaisers, with their wide range of activities in the West (dams and roads, primarily), developed these managed care techniques for their *far flung* workforce; such was carried over by the Kaisers into their shipbuilding activities during World War II. Kaisers' ideas were adopted after WWII by Ford Motor Company. The Mayo Clinic in Rochester, Minn. developed using managed care principles from its outset and continues to follow such practices to this day.

The success of such managed care described above was successful because the workers, most of whom were *old world*, were familiar with such medical practices. This made acceptance thereof easy. The *old world* includes both the geographical (England had its

medical cooperatives and friendly societies, e.g.) and religious (catholic charity care, e.g.).

Development

Not long ago, the options for a managed care initiative were fairly simple. The choices were to bring in some fairly simple benefit management programs such as mandatory second surgical opinions, utilization management, outpatient services and preadmission certification, or add an HMO. Unfortunately, in certain environments, the addition of HMOs actually accelerated costs through adverse selection. The traditional indemnity plans had been adversely selected because younger employees, or employees with no physician relationships, gravitated toward the HMOs while the older employees or those employees with pre-existing conditions or ongoing physician/hospital relationships remained in the indemnity program. This all started to change as HMO members grew older and physician participation in managed care plans rapidly increased. Today, an employer has the option of selecting a managed care program to best fit its philosophies and needs. It is generally felt that a true managed care plan should have five basic characteristics:

1. It is difficult to control costs if participants have unrestricted access to physicians and hospitals. Managed care plans attempt to encourage or force participants to use predetermined providers. Because a major portion of medical expenses results from referrals to specialists, managed care plans tend to use primary care physicians as gatekeepers to determine the necessity and appropriateness of specialty care.
2. Comprehensive case management and utilization review is needed at all levels.
3. Managed care plans should encourage preventive care and the attainment of healthier lifestyles.
4. Managed care plans are most successful if providers share in the financial consequences of medical decisions. Newer managed care plans have contractual guarantees to encourage cost-effective care. For example, a physician who minimizes diagnostic tests may receive a bonus. Ideally, such an arrangement will eliminate unnecessary tests, not discourage tests that should be performed.
5. A managed care plan will not be well received and selected by participants if there is a perception of inferior or inconvenient medical care. In the past, too little attention was paid to this aspect of cost containment. Newer managed care plans not only serve providers more carefully, but also monitor the quality of care on a continuing basis.

The four most popular types of managed health programs available today are:

- Managed indemnity plans
- Preferred provider organizations or PPOs

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- Point-of-service plans
- Health maintenance organizations, or HMOs.

These options differ based upon the amount of freedom that participants have in choosing physicians to provide care. The greater the degree of managing the control of choices, the more cost-effective the plan becomes. The traditional managed indemnity programs are the least cost-effective and provide the most choices, while the HMO plans are the most restrictive and cost effective. The PPO and Point of Service plans fall somewhere in between.

Managed Care Strategy

The proportion of patient care controlled by managed care organizations is increasing dramatically, and students of the business should study managed care trends and understand their implications. Many opportunities exist for providers that offer their own managed care programs if they can avoid mistakes. An effective tool in developing managed care programs is a strategy that includes cooperation with other providers, the development of an internal risk management organization and direct contracting arrangements.

Managed Care And Market Share (Dog Eat Dog Environment)

A group of physicians (approximately 20% of whom were primary care) recently initiated an ad campaign accusing one of the state's large IPA-HMOs of acting unethically and violating patient confidentiality.

The patients of the aggrieved physicians received a postcard from a competing clinic that offered free back-to-school physicals. In its ads, the group described the clinic as HMO-controlled and claimed that the only way it could have gotten the aggrieved physician's patient list was through the insurer that owned the HMO, since all of the patients targeted were covered by the insurer.

The ads encouraged patients to pressure their employers to switch to another health plan. And they recommended that patients who were concerned about the carrier's actions let their employee benefits manager know they didn't want to deal with a company that does business the way the HMO does. The insurer-HMO sponsor, meanwhile, counterattacked with ads explaining it was rebuilding its physician network.

Managed Care Source of Growth

Managed care growth has been as follows:

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- Many insurers do not offer a straight indemnity plan anymore.
- High choice managed care (dual option indemnity-HMO, e.g.) is enjoying growth; low choice managed care (rented PPO, e.g.) growth is fairly flat.

Increasing Effectiveness of Managed Care

These rules would help.

- Employers should set practice guidelines or standards of care to be followed by the physicians.
- Employer's managed care program should not be dominated by a single person or authority.
- Tools of employer's managed care programs should be these:
 1. Networks
 2. Case management
 3. Utilization review
 4. Quality assurance
 5. EAPs.

Employer-dominated authority to keep these tools at maximum effectiveness is needed.

- Participant communications should be practiced.
- Quality data to measure effectiveness should be stressed.
- Wellness and behavioral changing products/services should be offered.
- Anti-fraud audits are needed as well as close monitoring of noninvasive diagnostic testing and laboratory charges.

Managed Care Win-Win Posture With Players

Provider Perspective

Large providers will typically consist of hospitals, a PPO, a home health company and a clinic management firm, that is, the full range of providers. To make a win-win solution, the following factors, from the provider's perspective, are essential:

- Don't be too greedy.
- Care must be cost-effective and qualitative.
- Providers must be willing to capitate and/or discount.
- Good numbers will bring good results.
- Primary care must be basic to any solutions.
- Provider-sponsored PPOs are essential to the *big games*.

- Providers must be willing to do direct contracting.
- Utilization review is needed.
- Managed care remains, for most providers, the squeezing of profits and the loss of independence.

Payer Perspective

Many insurers are involved in a major way with managed care:

- Buying or creating HMOs
- Sponsoring PPOs

Insurers usually are aware of five truths with the country's health care system:

- Participants want full freedom to get health care anywhere, anytime, at any price with no restrictions whatever, all as a matter of right.
- Employer can steer covered persons toward managed care by plan design.
- Insurers must influence provider toward thrifty and prudent care.
- Single payer plan is not part of our national ethos. Health care costs continue out of control. Insurers must accommodate to managed care: Different data bases.
- Modified marketing
- Changed philosophy (indemnity and managed care are dramatically different)
- Acceptance of one-stop shopping
- Networking and joint-venturing alone are not workable; there must be strong control.
- Claims, administration and marketing must be specifically crafted for managed care.

Employer Perspective

Employers approach managed care with several basic philosophies in place:

- Services must be both qualitative and cost-effective.
- Preventive care must be provided.
- Flex-plans are deemed essential.
- Care has to be quality-based.
- Behavior modification should to be factored in with managed care.
- There must be strong utilization controls.
- Centers of excellence must be analyzed and set.
- Better data has to be delivered.

- New providers have to be recognized (nurse practitioner and physician assistant, e.g.).

Downside of Managed Care

Introduction

Generally, managed care means the alternative to fee-for-service; examples: HMO, PPO, EPO, utilization review or combination thereof. In whatever guise, managed care violently attacks the traditional physician-patient relationships.

A long, complicated but all-inclusive definition of managed care is:

- Comprehensive approach that involves planning, education, monitoring, coordinating and controlling quality, access and cost; plan design, financing, utilization controls are involved.
- Such intrusion may be done either retrospectively or prospectively but the end result must be to reduce freedom of choice.
- Choices, once the right of the providers, have been assigned to others to the end of controlling costs.

Managed Care and Cost Containment

That managed care is worthwhile or effective is not *totally* proven to be the case. It may well be merely an intrusion into medical economics; its salutary effect on health care costs is not *totally* accepted.

Businesses are vocal in demanding cost-containment action because, without it, they are unable to compete in the global economy. Businesses either demand managed care or government takes over.

Historical Perspective of Managed Care

Employer and government-sponsored health care plans with no choice limitations disguised from the employers the true costs of the plans. As costs grew to unacceptable levels, demand for control grew. As shifts in public attitudes occurred, the option of managed care took hold. Utilization review has been and will continue to be an important part of the managed care process.

Consequences of Managed Care

Savings will result; all of the credible studies so indicate. Quality will be neither helped nor harmed but anxiety, inconvenience, administrative burdens and reduced physician autonomy and satisfaction will result. Access, choice, freedom will suffer.

Savings. Hospital inpatient days have been reported to be decreased from 5% to 10% with utilization review.

Quality. The overwhelming response has been negative to managed care by most patients and physicians.

Access. The access to certain types of providers is dramatically limited when a gatekeeper is put in place: dental hygienists, physical therapists, medical specialists, chiropractors all are hurt in some way. Gatekeepers also restrict access to mental and substance abuse care providers. Large case management has been offensive to many persons. Mechanics of certain programs have also been met negatively by many patients: point-of-service, exclusive providers, out-of-network cutbacks, e.g.

Miscellaneous Negatives With Managed Care

- Some of what is called managed care savings is nothing more than cost shifting to the patient or employer in other forms.
- Managed care, oddly, may be as antipreventive and antiprimary care as fee-for-service.
- The causal relationship between the increase of managed care and the increase of uninsureds must be noted; it is perhaps, most significant.
- Managed care has failed to come up with any significant cost-effective delivery system changes.
- Managed care leaves untouched the catastrophic illness problems; managed care has done nothing to solve the occasional *job lock* from preexisting condition provisions.
- Managed care where providers *are on the risk* (as with HMO capitation) can go from discouraging overtreatment to encouraging undertreatment.
- Precertification *sentinel* effect is as achievable through *sample checks* as with every admission check.
- Where primary care physicians have a financial interest in not referring, the potential for bad care and patient dissatisfaction exists.
- Mechanics and composition of many review panels are questionable.
- Providers object as their autonomy and authority are challenged; they bristle from the *hassle* factor.
- Expecting compliance with complicated managed care rules from an emotionally and/or physically stressed person is not realistic.
- Patients believe that managed care imposes on them the philosophical perspective of the gatekeeper (hostility to chiropractic care, holistic medicine, physical therapy, e.g.) which is perceived to be unjust.
- Managed care is so complex and burdensome that many people, in despair, sometimes choose not to seek care at all.

Physicians' Concerns With Managed Care

While physicians do not get the majority of health care dollars, they control the majority of such dollars. Physicians are dramatically involved in managed care:

- Affiliated with a PPO: 64%
- Affiliated with an IPA HMO: 26%

Notwithstanding, physicians worry about the following:

- They want and need clinical autonomy and control. Managing care and costs doesn't mean micromanaging every aspect of the physician's practice.
- By encouraging primary physicians, specialists should not be made subclass citizens.
- The physician-patient relationship is sacrosanct. It should not be intruded upon lightly.
- Patient choice is a financial issue for physicians. But patients also believe freedom of choice will produce the best care.
- Physicians deserve to make a good living.
- Physicians are worried and angry that more of their income is at the mercy of contracts and managed care contracts and affiliations which may be terminated at any time.
- Physicians should be allowed to form partnerships that give them clout in the new market.

Physicians React to Managed Care

The general reaction of physicians to managed care is negative:

- Quality care is being denied.
- Managed care is profit-driven.
- Managed care will bring on a single payer national plan.
- Physicians get hassled and burdened with paperwork.
- Traditional physician-patient relationship is poisoned.
- Physicians' income is reduced.
- Managed care induces physicians to be manipulators.