Lesson Objectives

• To describe historical origins of managed care
• To explain the rationale for developing managed care
• To understand the evolution of managed care
• To understand the international models of managed care
• To understand the mechanisms by which managed care operates
• To understand the merits and demerits of managed care

Lesson Overview

• What is managed care?
• Reasons for rapid growth in managed care?
• What are the tools of managed care?
• Topology of managed care organizations?
• Advantages and disadvantages?
• What are the impacts of managed care?
• How is managed care regulated?
What is Managed Care?

- “the variety of organizational and financial structures, processes, and strategies designed to monitor and influence treatment decisions so as to provide service in the most cost-effective way” (Mechanic et. al., 1995).

Operational Definition

- “integrating and coordinating the financing and delivery of services across what previously were fragmented provider and payer entities” (Weiner, J.P. & de Lissovoy, G., 1993)
- “enrollees obtain care from a network of participating health care providers who contract with the managed care organization and abide by the organization’s rules” (Hughes and Luft, 1998)
- “Managed care may be defined as a variety of methods of financing and organizing the delivery of comprehensive health care in which an attempt is made to control costs by controlling the provision of services” (JK Iglehart, NEJM 1994;331:1167-71)
Objectives of Managed Care

- Restructuring the organization of health services, focusing on
  - cost containment, quality, and management of patient care needs
  - realignment of the relationship between payers, providers and consumers
- Key objectives:
  - Cost containment, rationing, patient care efficiency, less duplication, administration efficiency, contracting efficiency, managing care, appropriateness of care

Who Invented Managed Care?

- The employers invented managed care
- Rationale for managed care?
  - Traditional FFS lacks incentive for cost containment
- Historical development
  - 1945: The Kaiser Health Care System and Group Health Cooperative of Puget Sound in Seattle
  - 1929: Ross Loos establish pre-paid plans

An International View

- The British NHS is, in essence a large, national, prepaid health care delivery system modeled on the principles of regionalization (Roemer 1985)
  - the concept on a regional basis for the entire nation
  - Regionalization is at the heart of many managed care concepts
- Diversity both in U.S. and internationally
Beginnings in the United States

- Early prepayment programs were *closed panel*, complete delivery systems
  - Antithetical to the principles of capitalism within the context of provision health care
  - Physicians employed in prepaid settings were often viewed with suspicion by their colleagues
- Changes in the power structure of health care and Nixon’s support for HMOs
- Patient distrust of HMO motives!
  - Health care services provided are “*medical losses*”

Managed Care Phases

- Socially motivated affordable care (1940s)
- Cost-containment alternative to FFS (1960s, 1970s)
  - HMO, IPA
- Preferred Provider Organizations or PPOs (1980s)
  - PPOs and POS have higher copayments for out-of-network
- Multi-tiered plans offered to employees (current)
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Reasons for Rapid Growth in Managed Care

**Managed Care’s Explosion**

- Originally a private sector phenomenon
- Government involvement
  - Managed care and relevant regulation evolved.
  - FFS has adopted practices of managed care.
- The attraction to managed care:
  - Reduce the incentive to over-treat / overuse
  - Greater incentive for prevention
  - Improve coordination of care

**HMO Plans**
Tools of Managed Care

- Financial arrangements
  - Capitation
  - Withholds / bonuses

- Utilization controls
  - Gatekeeping / limits on access
  - Utilization review
  - Case management
Types of Managed Care Organizations (MCOs)

- PPO – Preferred Provider Organization
- HMO – Health Maintenance Organization
  - Direct contracts with providers (IPA Model)
  - Exclusive contractual arrangements
    - Staff-model
    - Group-model
- POS – Point of Service
- PCCM – Primary Care Case Management

MCO Definitions

- The distinguishing feature relates to the method of reimbursing providers
  - Capitation or other financial incentives to restrict quantity (not quality, in theory)
  - Negotiated discounted rates in return for large patient bases
  - Patients who go out of network have to pay more

HMO Penetration
Summary MCO Cost Control Strategies

1. PPO
   - Price control, Utilization management, Patient cost sharing

2. IPA-Network HMOs
   - Price controls, Utilization Management, Gatekeeping, Changing unit of payment to capitation, Regulating supply via selective contracting

3. Group/Staff Model HMO:
   - Changing unit of payment to salary and global budget, Supply control, Administrative simplicity

4. Canada
   - Price controls, global budgets for hospitals, expenditure caps for physicians, supply controls, administrative simplicity

Advantages and Disadvantages of Managed Care

**Advantages**
- Better coordination of care
- Better access (broader benefits package, including preventive services)
- Lower patient cost-sharing
- More cost-effective care

**Disadvantages**
- Stinting (or under-treatment)
- Management of services => barriers
- Select most health clients
Managers in Managed Care

• A manager intervenes to monitor and control the transaction between provider and consumer

• An outside party identifies care that is potentially at par with accepted clinical practice
  • Examines process of care
  • Theoretical objective is efficiency in care
  • Balance between cost and quality

How Managed Care Reduces Total Cost

Cost = ((Price*Quantity) + Overhead)

• Reducing price
• Reducing quantities
• Substituting cheaper types
• Organizational
• Withholds
  • Projected cost – actual cost

Other Manager Tools to Lower Cost

• Second opinion
• Precertification
• Pre-admission testing
• Concurrent review
• Database profiling
• Intensive case management
• Generic substitution
• Discharge planning
• Retrospective view
• Audits
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**Impacts of Managed Care**

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**Problems with Research**

- Managed care is changing rapidly
- Voluntary enrollment
- Measurement
  - Health status
  - Quality

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**Impact of Managed Care**

- Access
  - Privately insured – reduced
  - Medicaid – depends on payment structure
- Use of services – inpatient
  - Privately insured – some reduction (less for adults)
  - Medicaid – no consistent effect
- Use of services – ER
  - Privately insured – unknown
  - Medicaid – reduction
- Use of services – ambulatory care
  - Privately insured – increased
  - Medicaid – mixed
- Use of services – Specialists
  - Privately insured – unknown
  - Medicaid – reduction
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Regulation of Managed Care

Laws

• State Level:
  1. Access to care:
     – No-drop laws to protect those who get sick
     – Non-exclusion of adopted children concerning specialist or emergency care
  2. Quality of care:
     – credentialing and data quality assurance medical audits
  3. Financing:
     – proof of fiscal responsibility and adequate working capital
  4. Consumer protection:
     – plans for resolving grievances / both within the plan and an external mechanism as well
Quick Recap

• Recent rapid growth (1980s & 1990s)
• Managed care promises low prices and high quality care
• Evolution is continuing
• Some Managed Care Related Terms (Alphabetically)

Terminology

• Fee-For-Service
  — specific payment for specific services rendered
• Formulary
  — An approved list of prescription drugs
• Gag Clause
  — Restriction of information providers share with a beneficiary
• Gatekeeper
  — A PCP or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for.
• Global budgeting
  — Limits placed on categories of health spending.
  — A method of hospital cost containment in which participating hospitals must share a prospectively set budget.

• Health Maintenance Organization (HMO)
  — prepaid, comprehensive coverage for hospital and physician services
  — Charges monthly premiums or capitated rates by the payers
  — Adhere to the federal HMO act
  — There are 4 basic models:
    1. group model,
    2. individual practice association,
    3. network model, and
    4. staff model.
**Terminology**

- Indemnity Plan (Indemnity health insurance)
- Managed Care Organization (MCO)
- Managed Care Plan
- Medical Services Organization
- Point of service (POS) plan
- Preferred Provider Organization (PPO)
- Premium

**Terminology**

- Participating physician or Participating provider
- Primary Care Physician (PCP)
- Pre-existing condition
- Prior authorization

**Remainder of Presentation**

- HMO membership and enrollment
- Impact on cost, quality and access
- Medicaid managed care
- UK on future health care
- Future impacts
The United States has spent far more on health care than any other country in the world.

Did the extra money purchase substantially more?
- The U.S. ranks poorly in life expectancy and child mortality
- Clearly, cost was and is a problem.

Did managed care help?
Most states have adopted aspects of managed care for their Medicaid programs, particularly for the largest groups of beneficiaries: low-income women and children.

Close to half of all Medicaid beneficiaries were enrolled in managed care in 1997, more than double the percentage enrolled three years earlier.

This trend mirrors the shift to managed care in the general population and conveys the same mix of benefits and risks.
Medicaid Managed Care Enrollment

Benefits of managed care include:
- enhanced continuity of care
- better provision of preventive and screening services
- fewer emergency room visits and hospital admissions.

Risks:
- Reduced access
- Reduced freedom of choice of provider; and
- Poorer health outcomes for individuals with chronic diseases, high-risk medical conditions, or special needs.
The Future

Future Uncertainty

- Market instability
- Aging population
- Costs
- Consumerism
- Privacy and security
- Government regulations

Provider Problems
Top Business Priorities

<table>
<thead>
<tr>
<th>Rank</th>
<th>Business initiatives</th>
<th>Respondents mentioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Expand markets</td>
<td>34%</td>
</tr>
<tr>
<td>2</td>
<td>Patient/customer care/satisfaction</td>
<td>33%</td>
</tr>
<tr>
<td>3</td>
<td>Revenue cycle improvement</td>
<td>31%</td>
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<td>4</td>
<td>Cost reduction</td>
<td>23%</td>
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<tr>
<td>5</td>
<td>Clinical automation improvements</td>
<td>19%</td>
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<tr>
<td>6</td>
<td>Operation efficiency</td>
<td>18%</td>
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<tr>
<td>7</td>
<td>Patient safety/error reduction</td>
<td>14%</td>
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<tr>
<td>8</td>
<td>Facility improvement</td>
<td>13%</td>
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<tr>
<td>9</td>
<td>Patient/physician recruitment</td>
<td>11%</td>
</tr>
<tr>
<td>10</td>
<td>Employee satisfaction/relations</td>
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### Payer Problems
#### Top Business Priorities

<table>
<thead>
<tr>
<th>Rank</th>
<th>Business Initiatives</th>
<th>Respondent mentioning</th>
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<tbody>
<tr>
<td>1</td>
<td>E-business</td>
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<tr>
<td>2</td>
<td>Growth/expand markets/products</td>
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<td>3</td>
<td>HIPAA</td>
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<td>4</td>
<td>Core managed care system</td>
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<tr>
<td>5</td>
<td>Financial health/cost control</td>
<td>22%</td>
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<tr>
<td>6</td>
<td>CRM/customer service/satisfaction</td>
<td>16%</td>
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<tr>
<td>7</td>
<td>Data warehousing/business intelligence/reporting</td>
<td>16%</td>
</tr>
<tr>
<td>8</td>
<td>Medical management/utilization</td>
<td>16%</td>
</tr>
<tr>
<td>9</td>
<td>Infrastructure/networking</td>
<td>14%</td>
</tr>
<tr>
<td>10</td>
<td>Operational efficiency</td>
<td>12%</td>
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</tbody>
</table>

### Consumers Have Little Financial Impact

- Consumers absorb increased co-pay and premium
- Limited self-service
- Pilot testing patient-guided self-care
- Administrative self-service
- 10% of consumers under-defined contribution
- 40% enrolled in patient-guided self-care
- Clinical communities become economic buyers

### Health Care Costs

#### Growth Rates in Nominal Values

<table>
<thead>
<tr>
<th>Year</th>
<th>Growth Rate</th>
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<tr>
<td>1995</td>
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<tr>
<td>2000</td>
<td>5</td>
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<td>2001</td>
<td>10</td>
</tr>
<tr>
<td>2002</td>
<td>15</td>
</tr>
<tr>
<td>2003</td>
<td>20</td>
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</table>

- Hourly Earnings
- Premiums
- Median Income
- Disposable Income
Serving an Aging Population

- In the United States, one in five people will be 65 or older by 2030. The older population is expected to double over the next 30 years, reaching 70 million by 2030.
- By 2010, the nation will spend an estimated $2.63 trillion on healthcare as the population ages and utilization grows.
- In an Allstate Financial/Harris Interactive poll, rising healthcare costs was the No. 1 fear cited by baby boomers, yet less than one-third of those interviewed said that if given the chance, they would have taken better care of their health.

Managed Care and Satisfaction

- 44 million Americans have no insurance at all and 80 million have very poor or insufficient coverage.
- High price of prescription drugs are compelling Americans to buy medicine from Canada (recent trend)
- Patients in most cases are not happy with the quality of care, specially when HMOs are denying certain coverage, compelling them for early discharge and consequently increasing the burden to family and society
- How do other developed nations evaluate their healthcare? (next slides: A British survey)

Brits Expectations of National Health Insurance

1. More and better paid staff - more doctors, more nurses, more therapists and scientists.
2. Reduced waiting times - reductions in waiting overall, for appointments and on trolleys and in casualty.
3. New ways of working - including 'bringing back matron'.
4. Care centered on patients - action on cancelled operations, more convenient services.
Brits Expectations of National Health Insurance

6. Better facilities - more cleanliness, better food, getting the basics right.
7. Better conditions for NHS staff - reward and recognition for the work NHS staff do.
8. Better local services - improvements in local hospitals and surgeries.
9. Ending the postcode lottery - high quality treatment assured wherever people live.
10. More prevention - better help and information on healthy living.

Brit GPs Quality

• Rewards for family doctors will be based on the quality of care they provide for patients, rather than simply the numbers of patients they treat. GP practices will earn more income for delivering better care in key target areas including coronary care and mental health.
• A 33% rise in resources for general practice over the next three years from April 2003. Individual GPs could see earnings rise "substantially", depending on the level of work that they undertake, including offering services currently provided in hospitals such as minor surgery.

• New measures to allow GPs to manage a heavy workload more easily. GPs can opt out of providing out-of-hours services, although they will suffer a financial penalty if they do so. The local primary care trust will take on out-of-hours services arrangements, where GPs opt out.
Is Managed Care the Answer

- Managed care reduced growth in costs
  - What about other problems

- Risk selection gave the appearance of savings

- What happens after all low hanging fruit has been picked?

- What about the “uninsurable”? 