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Learning Without Bounds

ERM 512-13, Getzen – Economics and Financing (Sec. 5.4, 5.5)

Key Points

- Types of Managed Care Plans
- Ways to Reduce Costs
- Features of Managed Care
- Utilization Review

Managed Care Plans

- Why Managed Care?
- Primary reason – rise in health care costs (and cost of employee health benefits)
  - Something had to be done to fight these increases
    - Government cost-containment efforts actually made things worse
    - HMO contracts exploded with growth
- US **spent far more** on healthcare than other countries, but results weren't much better
- Needed **organizational structure** to add elements of planning, coordination and control to health care system to improve efficiency and limit total expenditures

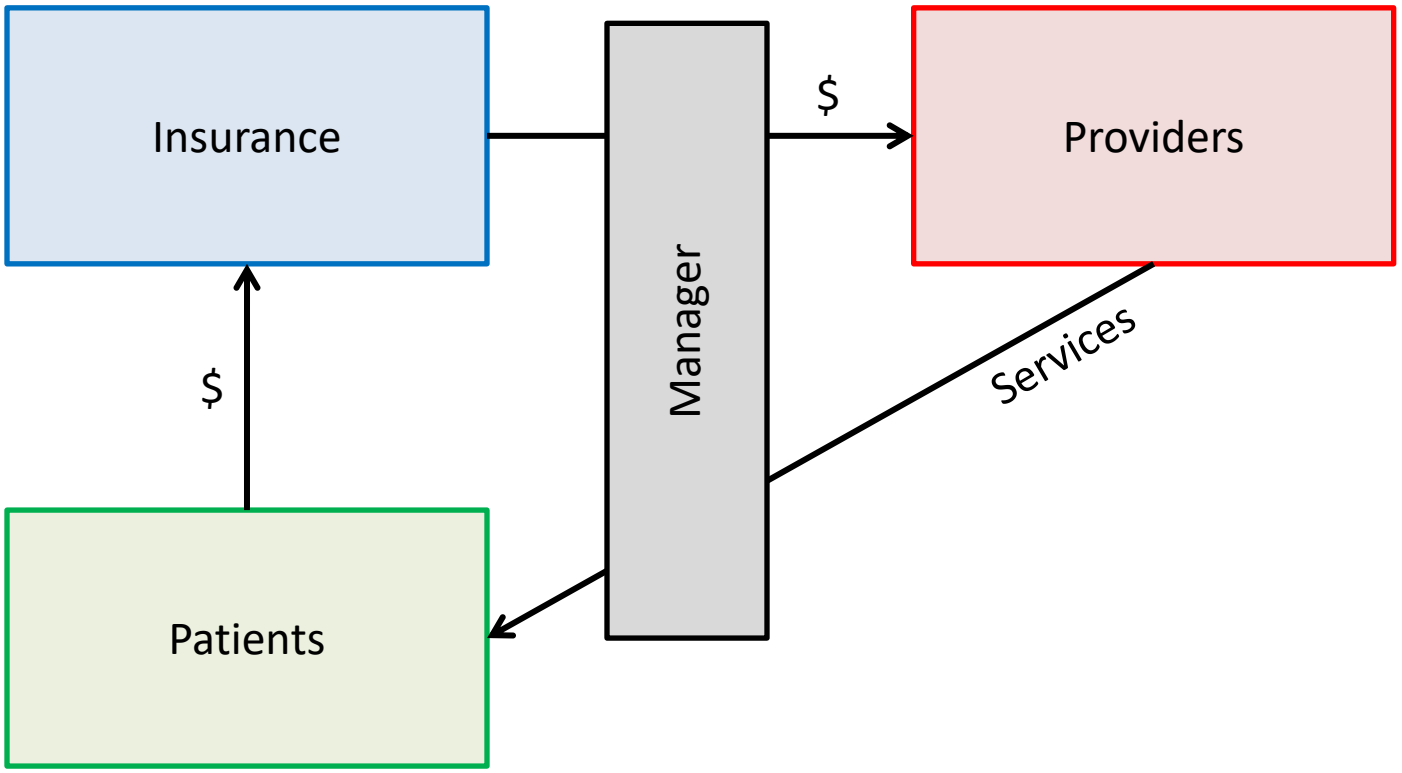
Managed Care Plans

- Management: The Distinctive Feature of Managed Care
- Fundamental Difference in FFS and Managed Care
  - **Manager** intervenes between the doctor and patient

- Identify care that is potentially varying from accepted clinical practice
  - Way to Identify Opportunities for Managed Care
    - Statistical profile of each **physician's practice**
    - Assessment of **laboratory testing**
    - Review of **individual cases**
    - **Combination** of above techniques

Managed Care Plans

- Management: The Distinctive Feature of Managed Care



Managed Care Plans

- Management: The Distinctive Feature of Managed Care
- Managed Care Organization (MCO) takes financial responsibility for medical care
  - Incentive to provide care efficiently
  - Compete on both quality and cost

- Preferred Provider Organization (PPO) or Point-of-Service plans (POS)
  - MCO negotiates network
  - Patients receiving care in network pay only a small copayment
    - Can get out of network care, but have to pay more or get a referral from doctor

- HMO
  - Referrals are necessary for most specialty care
  - Insurance only pays for care within the network

VS

Managed Care Plans

- Contractual Reforms to Reduce Costs
  - $\boldsymbol{Total\ Premiums = \sum(Price\ x\ Quantity) + Overhead\ (load)}$
    - Managed care adds management, so Overhead costs increase

- 1. Cutting Prices - prices are easiest to cut
  - Reasons MCOs are Able to Cut Prices Paid to Doctors/Hospitals
    - Excess supply
    - MCO becomes big buyer and exercises market power
    - Threat of taking away patients
    - Other buyers hadn't haggled in the past, so there was excess in the system

- 2. Cutting Quantity - cutting quantity of medical services is difficult

- 3. Substitute Cheaper Forms of Care
    - Generic drugs
    - Nurse practitioner instead of doctor
    - Medicine instead of surgery

3 WAYS

Managed Care Plans

- Contractual Reforms to Reduce Costs

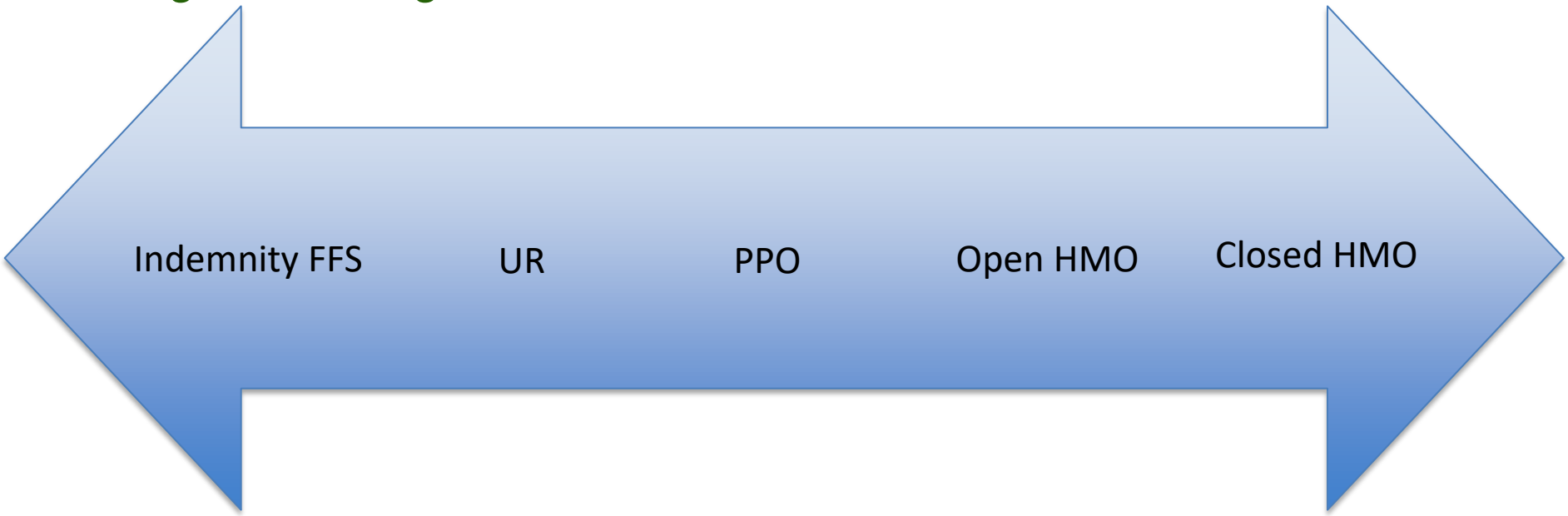
- 4. Reforming the Organization to Reduce Cost
  - Changing the organizational structure
    - Single unified organization could integrate paying bills and having hospital and physicians to provide care (i.e. closed-panel group practice (CPGP))
      - Kaiser, Group Health Cooperative, etc – started in the 1940s
      - Physicians work on salary, hospitals are owned by the organization and drugs are purchased by the organization
      - Single entity combines all the complex functions of providing and paying for medical care

Managed Care Plans

- Medical Loss Ratios
- Most HMOs – 15-20% of premiums for administration, marketing and profit. Remainder used to pay the medical expenses (remainder amount is the "medical loss ratio")
  - Largest expense is physician services

- HMOs – tight hospital controls and younger/healthier group leads to low inpatient hospital services
  - Admin expenses and profit margins have been cut over time, so larger percentage of total dollars are going to treatment (i.e. loss ratios are rising)
  - In early years, loss ratios would vary as much as +/- 25% per year. In later years, +/- 10% is more common

Range of Managed Care Plans



Range of Managed Care Plans

- Provider Networks
- Pure Indemnity
  - Contract is between patient and insurance company
  - Insurer gets bill and then sends check to patient

- Preferred Provider Organization (PPO)
  - Limits patient's choice of physicians and hospitals
    - Pays larger percentage for care from approved providers within the network
  - Patients can go out of network but have to pay a larger portion of the bill

- Health Maintenance Organization (HMO)
  - Usually offers a single, limited network
  - HMO-POS (Point of Service)
    - Allows patients to use HMO but can also opt-out at the "point of service" to see another provider by paying extra

Range of Managed Care Plans

- Gatekeeping
- Two restrictions marking transition from partially managed PPO and POS plans to HMOs
  - 1. Mandatory authorization for hospitalization
    - Physician calls health plan
  - 2. Primary physicians who act as gatekeepers
    - Specialist referrals, etc approved by the PCP/gatekeeper

Range of Managed Care Plans

- Capitation
- PCPs paid a capitation rate – fixed amount per member per month

- Capitation sometimes used for hospitalization, lab services or specialty care
  - "Carve-outs" or "subcapitation"

- Paying for the number of people enrolled changes incentives from doing more (when paid Fee For Service) to doing less
  - Profits are greater when fewer services are used

Range of Managed Care Plans

- Managing Pharmacy Costs: Carve-Outs and Triple-Tier Benefits
- Most companies contract with Pharmacy Benefit Manager (PBM)
  - PBM processes claims and pays the pharmacy

- Drugs have become a carve-out because PBM can do the job better, at a lower cost

- How do PBMs manage care to save costs?
  - 1. Obtain rebates and price discounts
    - Use market leverage with both manufacturers and retailers
  - 2. Substitution (using generics)

- Drug tiers – gives incentive for patients to actively participate in reducing use of expensive drugs

Category	Patient Copay	Type
Tier 1	$2	Generic, Sole source
Tier 2	$10	Approved formulary
Tier 3	$30	Off-patent brand, Lifestyle

Range of Managed Care Plans

- Withholds
- HMOs must use FFS for some types of care

- Withholds – incorporate part of cost-control incentive of capitation into FFS payment

- Example of HMO Specialty Withhold
  - Each specialist gets 80% of agreed amount when patient is treated
  - Remaining 20% goes into withhold pool
  - HMO projects a total spend for specialty referral services for the year
  - If total of referral bills for all specialists is below the projected amount, the withhold pool is distributed in accordance with the amounts billed
    - (Specialist may receive 100% of bill, but may have to wait until end of year for the final 20%)
  - If total billings are more than 20% above target, HMO keeps the pool to pay for the extra
  - If total billings greater than 100% but less than 120% of target, specialists and HMO split the pool

Range of Managed Care Plans

- Utilization Review
- Utilization review and management interventions to **control cost** and **utilization**

  - Second Opinion
  - Pre-Certification
  - Pre-Admission Testing
  - Concurrent Review
  - Database Profiling
  - Intensive Care Management
  - Generic Substitution
  - Discharge Planning
  - Retrospective Review
  - Audits

  - List: C C D GRIDS A A (Control Costs, Draw GRIDS And Analyze)

Breakdown

- Costs were rising – managed care controls it
- Creates oversight and middle man in the process
- Network types and choice vary
- Cut price, cut quantity, generics, change organization