"Managed Care: Taming the Wild Beast of Skyrocketing US Healthcare Costs"

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Introduction

The high cost of healthcare in the United States is a significant and complex issue that affects millions of Americans. According to the Commonwealth Fund report "How High is America's Health Care Cost Burden 2015," healthcare costs in the US have been increasing faster than the inflation rate for decades. The report found that the main drivers of healthcare costs were high healthcare service prices, high administrative costs, and a high prevalence of chronic diseases. As such, it is essential to understand the reasons behind high healthcare costs and explore potential solutions to mitigate this issue.

This briefing paper will examine high healthcare costs in the US, specifically focusing on managed care. First, it will provide an overview of high healthcare costs in the US and the importance of the topic. Then, define managed care and the different types of managed care organizations. Next, the paper will evaluate the benefits and drawbacks of MCOs, including the managed care "backlash" in terms of costs and quality. The paper will also identify areas that can help reduce costs and national healthcare expenditures. Finally, the paper will provide personal insights on the subject.

Why are healthcare costs so high?

The US allocates a greater amount of money per individual for healthcare than any other nation. The high cost of healthcare in the US can be attributed to various factors, including:

- High prices for healthcare services: According to the Health Affairs article "It is Still the Prices, Stupid," healthcare service prices are significantly higher in the US compared to other countries. The article cites research showing that US healthcare service prices are nearly double those in other developed countries.
- High administrative costs: The Commonwealth Fund report "How High is America's Health Care Cost Burden 2015" found that the administrative costs of healthcare in the US are much higher than in other countries. The report estimates that the US spends about $1,000 per capita on the healthcare administration, more than double that of other developed countries.
- Chronic illnesses such as heart disease, diabetes, and obesity are widespread in the United States, and the expenses associated with managing them are substantial. According to the article "The Top 10 Reasons for Soaring Healthcare Costs," the prevalence of chronic diseases is a significant driver of healthcare costs in the US.

These factors have mainly led to the high healthcare costs in the US. Addressing these issues is crucial to reducing healthcare costs, and improving access to healthcare for all Americans.

What is managed care?

Managed care is an approach to healthcare delivery that seeks to control costs while maintaining the quality of care. Managed care organizations (MCOs) are healthcare providers that have contracts with insurers or employers to provide healthcare services to their beneficiaries. Managed care organizations (MCOs) are tasked with the responsibility of regulating healthcare services utilization and reducing costs, while ensuring that the quality of care is maintained.

The key features of managed care include provider networks, utilization management, and capitation. Provider networks are groups of healthcare providers that contract with MCOs to provide healthcare services to their beneficiaries. Utilization management refers to reviewing and approving healthcare services to ensure they are medically necessary and appropriate. Capitation is a payment method where MCOs receive a fixed amount of money per member per month, regardless of the number of services provided.

Managed care is different from the traditional fee-for-service model in which healthcare providers are reimbursed for each service they provide. In the fee-for-service model, healthcare providers have little

incentive to control costs, as they are reimbursed for each service. In contrast, managed care aims to encourage healthcare providers to manage expenses and simultaneously provide high-quality care by offering incentives.

Types of managed care

Managed care encompasses various organizational structures that have distinctive attributes and qualities. The primary forms of managed care include:

- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Point of Service (POS) plans
- Exclusive Provider Organizations (EPOs)

HMOs are the oldest and most common type of managed care organization. HMOs typically have a closed provider network, meaning that beneficiaries must receive care from providers within the network to receive coverage. HMOs usually mandate that their members choose a primary care physician who will be accountable for managing their healthcare.

PPOs are another common type of managed care organization. PPOs typically have an open provider network, meaning beneficiaries have more flexibility in choosing their healthcare providers. However, beneficiaries typically pay more out of the pocket for care from providers outside the network.

POS plans are a hybrid between HMOs and PPOs. POS plans typically require beneficiaries to select a primary care physician and receive care from providers within the network. However, beneficiaries may receive care from providers outside the network if their primary care physician refers them.

EPOs are similar to HMOs, typically having a closed provider network. However, EPOs may provide some coverage for care received from providers outside of the network, particularly in the case of emergency care.

Understanding the different types of managed care organizations is essential for understanding the potential benefits and drawbacks of managed care as an approach to controlling healthcare costs.

Evaluating the benefits and drawbacks of managed care

Managed care has been widely implemented in the US healthcare system to address rising healthcare costs. While managed care has been touted as a solution to control healthcare spending, there are also criticisms and drawbacks associated with this healthcare delivery model.

One potential benefit of managed care is cost savings. Managed care organizations (MCOs) negotiate with providers to offer services at discounted rates, which can result in cost savings for patients and insurers. Another potential benefit is an improved quality of care, as MCOs are responsible for managing the utilization of healthcare services and ensuring that patients receive appropriate and timely care. In addition, MCOs often emphasize disease prevention and management, which can help patients avoid costly hospitalizations and other medical interventions.

However, there are also criticisms and drawbacks associated with managed care. One primary concern is the restrictions on patient choice and access to care. Patients may be required to choose a primary care physician within the MCO's provider network and may need referrals to see specialists or receive specific medical procedures. This system can limit patients' ability to receive care from providers outside of the network or to choose the most appropriate provider for their needs.

There are also concerns about the quality of care and patient outcomes under managed care. Critics argue that MCOs may prioritize cost savings over the quality of care, leading to lower-cost treatments or less time spent with patients. MCOs can result in worse health outcomes for patients. In addition, there are ethical considerations related to managed care, such as the potential for conflicts of interest between MCOs and providers and the pressure to limit their use of healthcare services to meet cost savings targets.

Overall, while managed care can offer cost savings and improve the quality of care, it is crucial to consider the potential drawbacks and criticisms associated with this healthcare delivery model. In the next section, we will explore ways to improve managed care to address these concerns.

Solutions to contain healthcare costs.

The high cost of healthcare in the US has led to a range of proposed solutions aimed at containing costs. **Payment reform**, in particular, has been proposed to address the fee-for-service payment system incentivizing expensive tests and procedures. The CMS has taken steps towards payment reform by introducing initiatives like the Medicare Access and CHIP Reauthorization Act (MACRA), which provides incentives to healthcare providers for delivering value-based care instead of the older model of volume-based care.Evidence suggests that these initiatives have successfully controlled costs while maintaining or improving the quality of care. For instance, a study published in CMS found that introducing the Hospital Value-Based Purchasing program reduced 30-day mortality rates for acute myocardial infarction, heart failure, and pneumonia.

An alternative solution to address the challenges in healthcare is to adopt a **value-based care approach**, which prioritizes delivering high-quality, well-coordinated care that meets the individual needs and preferences of patients. To encourage healthcare providers to deliver more efficient and effective care, models like accountable care organizations (ACOs) and bundled payment programs have been established as part of the value-based care system. Evidence suggests that these models can potentially improve care quality while reducing costs. For example, a study published in Commonwealth Fund found that the Pioneer ACO program reduced Medicare spending by $385 million in its first two years of implementation.

Prescription drug pricing reform is another potential solution to contain healthcare costs. Prescription drug prices in the US are among the highest in the world, and there has been a growing concern over the impact of high drug prices on healthcare costs. There are several suggested solutions to address the issue of high drug prices, including enhancing competition among drug manufacturers, improving transparency in drug pricing, and permitting Medicare to negotiate drug prices. According to research published in the Journal of the American Medical Association (JAMA), if Medicare were permitted to negotiate drug prices, it could lead to significant cost savings for the program and its beneficiaries.

Prevention and wellness programs are also proposed solutions to contain healthcare costs. Such programs aim to promote healthy behaviors and prevent the onset of chronic diseases that significantly drive healthcare costs. Evidence suggests that prevention and wellness programs can lead to significant cost savings. For instance, a study published in Health Affairs found that a workplace wellness program reduced healthcare costs by $2.73 for every dollar spent on the program.

Addressing social determinants of health is another proposed solution to contain healthcare costs. Health outcomes and healthcare costs can be heavily influenced by social determinants of health, including factors like poverty, education, and housing. Proposed solutions include addressing income inequality, improving education, and promoting affordable housing. Evidence suggests that addressing social determinants of health can lead to significant cost savings. For example, a study published in Health Affairs found that providing housing and support services to homeless individuals reduced healthcare costs by 53%.

Personal insights and the conclusion

The problem of exorbitant healthcare costs in the United States is a multifaceted and intricate issue that demands a comprehensive and sustainable resolution. As a society, we are facing a major challenge when it comes to healthcare costs in the United States. It is a problem that affects us all and requires our collective attention and action. We cannot afford to ignore the rising costs of healthcare, as it not only impacts our financial wellbeing but also our access to quality care.

I have seen first-hand how healthcare costs have impacted the lives of individuals and families, including myself. It is a frustrating and overwhelming experience to navigate the healthcare system and face high medical bills, which can often lead to difficult choices about our health and wellbeing.

Managed care has been one approach to address rising healthcare costs, but it has its own set of challenges and criticisms. While it can result in cost savings and improved quality of care, we must also consider the potential impact on patient choice, access to care, and ethical concerns.

There are various potential solutions that have been proposed, such as payment reform, value-based care, prescription drug pricing reform, prevention, and wellness programs, and addressing social determinants of health. These solutions need to be carefully evaluated and implemented to ensure that they benefit all individuals and address the root causes of high healthcare costs. We must work together as a society to address the issue of high healthcare costs in the United States. By taking a personal interest in this issue and advocating for evidence-based solutions, we can create a more sustainable and equitable healthcare system that benefits us all. I close by saying that I do support managed care considering some of the solutions like a price reform take place.

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