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Managed Care Organizations and Physicians

The idea that access to healthcare, and the right to good health is a basic human right is a very recent phenomenon. The 20th century was a time of unprecedented and repeated social upheaval with regards to the rights of individuals, with World War II marking a significant transition point in the belief in individual agency and rights. In this vein, post-World War II United States developed numerous systems to ensure its constituents had greater access to healthcare in particular.

Many mechanisms have arisen to dispense healthcare, and one such model is the managed care system. Managed care is a healthcare delivery system organized to managed cost, utilization, and quality. Managed care plans provide health benefits and services through contracted arrangements between insurance providers and managed care organizations (MCOs) that deliver medical care.[1]

Managed care attempts to rectify two fundamental social health issues. First, it attempts to instigate cost savings for healthcare purchasers compared to traditional indemnity insurance. Under traditional indemnity models, healthcare resource utilization is uncontrolled, and resources are utilized at the discretion of physicians and patients. Managed care, however, has a defined and inclusive list of covered services and benefits to influence physicians and patients to follow plan policies and procedures to utilize resources in a cost-effective manner. In this way, managed care pays claims submitted by contracted healthcare providers willing to accept discounted reimbursement. By preventing unnecessary consumption of resources by requiring prior authorization for non-critical procedures and pharmaceuticals, costs are controlled.[1]

Second, managed care offers an integrated financing and delivery system that providers preventative care and coordinated chronic care for its members. This comprehensive claims system allows an individuals medical coverage to be tracked, and can be utilized to provide preventative care for subscribers.[2]

Thus, managed care plans typically cover a wide range of health services, such as general checkups, necessary diagnosis and treatment of illnesses, appropriate specialist referrals, and hospital care – as most insurance plans do. It differs in trying to limit excess expenses by focusing on preventative healthcare services, and by contracting with specific hospital networks, physicians, and pharmaceutical companies to help control fees charged.[1,2]

There are a variety of managed care plans, and they vary in mechanism between HMOs, and traditional indemnity plans. HMOs, or health maintenance organizations are managed care systems in the simplest sense. A primary care physician (PCP) is selected who can refer to specialists, provide diagnostic services, or hospitalize patients within a limited network. HMOs most often function through capitation payments – fixed payment arrangements for healthcare service providers (ie physicians) for each enrolled person assigned to them per period of time, regardless of whether care was sought. HMOs also have fee-for-service plans, but these are less common.[2] PPOs, or preferred provider organizations, are less restrictive managed care systems where contracts with a network of *preferred* providers from which to choose – meaning a PCP is not necessary. Receiving care from physicians within the network limits costs to deductibles and copayments, but going out of network entails higher costs and coinsurance. PPOs generally cost more for individuals than HMOs.[1,2]

In contrast, traditional indemnity plans provide group-funded insurance to individuals so that they have the freedom to choose the provider of healthcare services. However, indemnity plans cost more than managed care systems like HMOs and PPOs. Unlike HMOs, PPOs and indemnity plans reimburse healthcare service providers for specific care provided through fee-for service only, rather than through capitation payments.[3]

It should be noted that other managed care systems exist (like POS mechanisms), but for the context of this paper, an evaluation of managed care organizations from a physician's perspective, the more traditional managed care system and networks will be analyzed (HMOs in a capitation payment system – which constitute the bulk of insurance delivery). PPOs and POS care models attempt to blur the line between managed care and traditional indemnity models, and cannot be easily differentiated between the two, and so many of the analyses presented in this paper will also apply to PPOs and POS but not as rigidly as they do to HMOs.[1,3]

Managed care systems provide a sound framework for the delivery of medical care, and have dominated healthcare services in the United States from the 1980s. However, in practical terms of ease-of-service and in health outcomes, managed care organizations have proven difficult to manage, and are inefficient in providing top-of-the-line care. It is important to analyze managed care system impacts on primary care providers through the requirements and limitations of such managed care plans.

Physicians, as the instrumental care providers within the managed care networks are directly affected by managed care systems. From a primary provider standpoint, the excess control over the healthcare treatment of the policy holder entails burdens to ease of treatment and distribution of medical resources.[4]

One of the fundamental aspects of managed care is the distribution of financial risk beyond the risk-sharing member individuals and their insurance plan providers to healthcare providers – physicians, hospitals, pharmacies, and others. Managed care programs also call for greater integration of administrative claims, communication among health care providers, and the introduction of wellness and prevention programs which increase the specificity of benefits of those covered in different pay plans.[1,5]

This is achieved by "utilization reviews" that are required for almost all covered services except primary care. Reviewers who are hired by overseeing agencies may or may not be licensed to practice medicine, and they make use of uniform guidelines to make determinations without being well versed with each of the insured. This results in costly and time-consuming pre-certification for most procedures and diagnostic tests beyond what is provided in a conventional check-up visit. This only increases physician responsibility in overall patient health, and often, patients are not as invested in their own welfare as they should be.[2,5]

Moreover, the distribution of financial risk is achieved through the capitation payment system, whereby providers carry risk that they will exceed a policy holder's payment from an HMO, and without balance billing, this puts them at a loss. Additionally, a critical aspect of managed care plans is reimbursement for positive results. This aspect, in cohort with an emphasis on preventative care can entail bonus payouts for maintaining a majority of patients at some arbitrary benchmark (ie 60% of patients do not smoke) – but this could also result in decreased funds if a provider has a particularly difficult patient population, increasing risk further.[5]

These are the financial and administrative systems that burden healthcare providers of all types . But there are issues in the managed care system that directly affects patient outcomes.

For example, new drugs and biotechnology agents can improve outcomes for many life-threatening illnesses, but the pharmaceutical benefit cost of managed care organization has nearly quadrupled in the last 10 years. In order to meet this ever-increasing cost (that is facilitated by patented formulae and restricted production), MCOs utilize specialty pharmacies to optimize cost and utilization. The development of a formulary system – or preferred drug list – takes advantage of a continually updated list of medications and related products supported by pharmacists, physicians, and other experts in diagnosis and treatment of disease. The purpose of a formulary is to encourage the use of safe, effective, and affordable medications.[6]

The use of drugs listed in the formulary is typically highly incentivized or required. Most drugs constitute generics that are created at a discounted rate from brand-names, and others are received directly from the primary manufacturer at a discounted rate on a contractual basis between different pharmaceutical companies that could vary from year to year. Unfortunately, this can result in a form of drug-promotion by companies, and in unethical systems could result in patients not receiving the best medications. Even without this concern, limiting access to brand-names and newer medications proves difficult for patients with acute conditions who require access to a variety of drugs quickly to determine their efficacy.[6]

Formularies are effective cost saving mechanisms, but rigid adherence in a malleable field is difficult. This proves true for diagnostic and therapeutic procedures as well. As discussed earlier, pre-certification is required for many procedures, and this also increases the administrative and financial burden on physicians who are already receiving less funds than they would in a traditional indemnity plan. Patients may be saving money, but they have harder time gaining access to necessary procedures and pharmaceuticals.[4,5,6]

In assessments of doctors' opinion on the impact of managed care, viewpoints are seen to be predominantly negative. Typically, only general practitioners and primary care physicians have positive views on managed care systems, but this is due to the administrative and financial benefits afforded to them by the managed care system. Specialists are less likely to benefit from approving diagnostic procedures and maintaining patient baseline health. Moreover, most private physician groups only accept HMOs on a fee-for-service basis, and most capitation services are relegated to network hospital systems who have access to an immense patient population. This inequity stems from the numerous administrative hurdles and complexities established by conventional procedures, and the need for immense resources to turn a profit under a capitation system.[7]

There is no doubt that the managed care system is riddled with flaws, but then so are the majority of care delivery systems accessible to the United States. The managed care system must be lauded for its efforts to provide equity to the medical system. Unfortunately, as presented above, equity in drug distribution, diagnostic examination, procedures, and payment simply isn't feasible for a diverse and heterogeneous population. Moreover, introducing inefficiencies in administrative costs and hurdles on providers in pursuit of this equity isn't sustainable, and increases costs upon institutions that are attempting to help constituents. While risk-sharing is a socially sound concept, it should not be sought with such gusto that it alienates integral individuals in the care system.

It should also be recognized that the limited cost distribution to the insured is slowly coming to an end. In the last ten years, MCOs have made significant changes in benefit design, and constituents have seen benefit coverage maximums capped at lower amounts (limiting the total dollar amounts of benefits covered); up-front member deductibles increasing steadily; and even copayment and coinsurance levels rising.[1,7]

On the other hand, there are beneficial aspects of more standardized control systems. An HMO can more easily leverage provider participation, requiring certain levels of competency in education and board certification. Moreover, continuing medical education requirements can be established, and centralized control allows direct access to understanding of data collection on policy holder results and satisfaction. Although regular insurance plans require similar principles, few are able to leverage such authority as the managed care model.[2]

It is quite easy to see why managed care systems are so popular institutionally. A system that is centered upon controlling costs, prioritizing preventative care, and still provides the gamut of medical care with specialists and diagnostic procedures is destined to become a political powerhouse. Decades after the implementation of Medicare and Medicaid by Lyndon B. Johnson, and long after the HMO Act of 1973 was signed by President Nixon, Medicare and Medicaid have long since adopted managed care systems. The introduction of the Patient Protection and Affordable Care Act will certainly see the expansion of such models in oversight of the medical care delivery system. As such, it is important to recognize the impacts of managed care on patients, physicians, hospitals, and the government, to ensure equitable and efficient care can be provided at reasonable cost.[7]

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