



HEALTH CARE IN THE NEW MILLENNIUM

Managed care is here to stay, while outcome evaluation and cost containment become more important. What does it all mean to your practice?

By Christine A. Hinz

Practicing medicine in today's health-care environment may make you feel like a hamster on a wheel. Round and round you go, only to end up economically where you started—or maybe even slipping back a few steps.

Presumably you're not as sanguine about life as that cheeky rodent, especially if managed care has usurped your payment power and undermined your practice prerogatives. In fact, with insurers holding down most costs and challenging many treatment choices, it's no surprise that physicians feel trapped by the economic cage they believe was never of their making.

But as medicine enters the new millennium, will doctors still be spinning their wheels over the same perceived draconian tactics of the past? Or will a new decade spawn different issues concerning managed care, Medicare, and commercial health insurance? If so,

● **"There are some people who believe that managed care will fail and we'll go back to the old way of practicing medicine. But the market forces driving it will not go away."** — John M. Boltri, a Macon, Georgia family physician and an associate professor at Mercy University School of Medicine.



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what steps can you take now to get more control of your professional options for later?

As you can imagine, there are no simple answers. No one knows for certain what a health-care revolution that's already generated capitation, pre-certification, and patient-care protocols will yield next. Yet one fact seems clear: Managed care is here to stay, even though critics believe it lacks a future vision—and never lived up to its potential in the past.

"There are some people who believe that managed care will fail and we'll go back to the old way of practicing medicine," says John M. Boltri, an associate professor at Mercer University School of Medicine, and a Macon, Georgia, family physician. "But the market forces driving it will not go away. Instead, they'll demand continuous improvement in quality as well as a decrease or at least stabilization of costs."

What does that mean for your practice?

Given the inevitability, steel yourself for many of the same issues that plagued you in the past concerning managed care, Medicare, and commercial health insurance: Patients were always high on the provider priority list, but they'll exhibit increased spunk and demands. Outcomes were always im-

portant, but they will be imperative. Private and public insurers played Big Brother for more than a decade, but the gaze will intensify. Practice incomes have been progressively squeezed, but nothing like what's to come.

Challenges in the future? Most assuredly. Obstacles? Not necessarily. Instead, by increasing your awareness of the potential problems, you can plan for the many pitfalls. In the end, you might even find yourself taking control of the situation—rather than spinning aimlessly like that hamster on his wheel.

ISSUE 1:

Prepare for the 'New Consumer'

While employers finance the health decisions in the next millennium, patients will do the picking and choosing. For if anyone has gained clout—along with new responsibilities—in the health-care turmoil of the past decade, it's consumers.

Employers asked them to shoulder a share of the health-care cost burden with out-of-pocket co-pays, deductibles, premium sharing, and three-tiered formularies. Now they're demanding additional control, choice, and

The Structures of Change

WHILE ANYTHING can happen, expect managed-care plans to consolidate and evolve.

The most popular structures will be those that offer the most choice, such as preferred provider organizations.

A newly released Robert Wood Johnson Foundation-Institute for the Future report, *Health & Health Care 2010: The Forecast, The Challenge*, predicts that by 2005, HMOs will capture the majority of the commercial market and more than 25 percent of the Medicare market. By 2010, 60 percent of Medicaid recipients also will be in some form of HMO.

It will be increasingly difficult to identify these products, say the report's authors, since they'll all offer similar—or even the same—providers and pay them through a mixture of discounted fee for service and capitation.

The health-insurance market will evolve into a mix of different health-plan models, many of which will spend the next several years in a constant flurry of reorganization and mergers. As a result, in 2007 close to 50 percent of the population will be in health plans for which cost containment is a key issue.

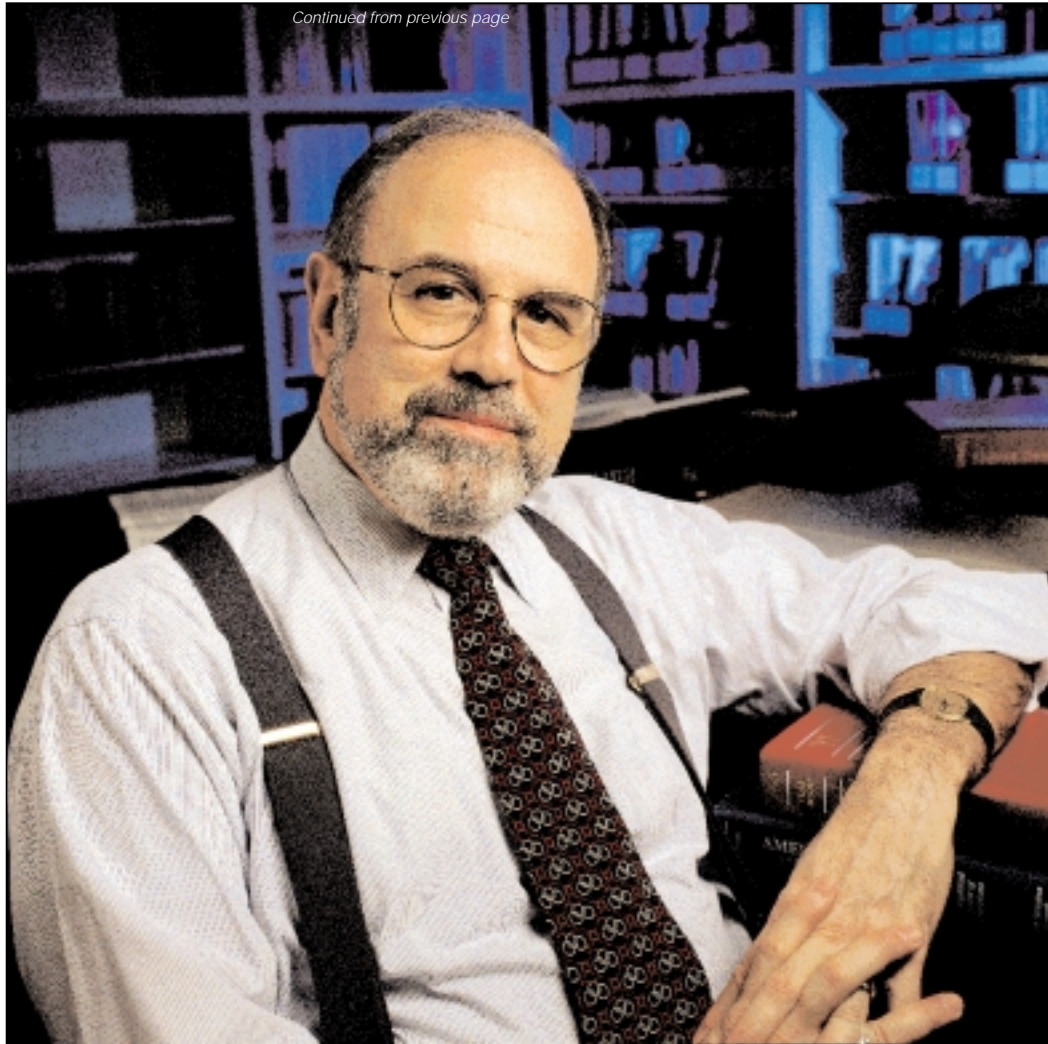
"In the last 10 years we saw a tremendous consolidation take place in both

health-care financing and delivery," says Jeffrey Goldsmith, the president of Health Futures, Inc. of Charlottesville, Virginia. "Many physicians believed that they were headed for a closed panel world, where unless they made huge economic concessions or joined some larger enterprise they weren't going to get paid or permitted access to their existing patients.

"What we've gotten instead is a lot of open panel plans where patients have demanded and secured a great deal more freedom to design their own health-plan networks and continue relationships that work for them." ■

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customer satisfaction.

Expect to see more of the same as managed care proliferates, providing this “new consumer” with a bevy of different options. What will it take to win them over to your practice?

First, continue to offer high-quality, low-cost medical care in an environment that promotes ancillary services such as extended hours, satellite clinics, and even affiliations with alternative practitioners.

Second, show them that you’re on-line, as well as on time.

Patients will not only be well-informed—studies suggest by 2005, 55 percent of Americans will have at least one year of college—but also Internet savvy. In fact, according to one Harvard University School of

Public Health and Harris Interactive survey, some 70 million people already have accessed information via the net; 91 percent of them have found what they wanted.

That means increasing numbers of consumers will add e-mail attachments and computer printouts to their symptom lists when seeing you. What’s the implication? Expect to spend more practice time straightening out the cyberlink confusion.

No one expects you to relinquish that power, especially to a consumer who

finds the information but can’t correctly interpret it. But with a little Web savvy, you’ll know which sources to reference that are reliable and which are just “voodoo science.”

While the Internet and computer technology can force economies of scale by disposing of routine patient work (e.g. renewing prescriptions and delivering lab results), many doctors have yet to embrace it, except, of course, for their own personal purposes.

“Physicians have been remarkably resistant to thinking about how to do busi-

ness better, faster, and smarter using it,” says Wendy Everett, ScD, the director of the Robert Wood Johnson Foundation Institute for the Future, a Menlo Park, California technology and health-care research firm, and the author of its report, *Health and Health Care 2010: The Forecast, The Challenge*. “Employers and health plans are not going to go back to the good old days of paying doctor charges so they need to start paying attention to ways in which they can provide high quality care at a lower cost. The Internet offers that.”

● **“I’m not one who thinks that all decision-making should be removed from doctors, but you cannot have the authority without the accountability since we’re all working on fixed budgets.”** —Allan Korn, MD, the medical director of

the Chicago-based Blue Cross and Blue Shield Association

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Also, with such unparalleled access to data, look for insurers to give patients relevant info on cost-conscious doctors. Princeton University economist Uwe Reinhardt, PhD predicts that instead of managing care, insurers will eventually just be “information brokers.” They’ll laser in on outcomes and price, and the possibility for comparison shopping will be endless. “Doctors will have to be sensitive to the fees they charge,” Reinhardt says. “They’ll have to worry about their image among patients.”

ISSUE 2:

Outcomes Will Count

Measuring outcomes will be as important as moderating costs. As health plans focus increasingly on quality of care, not just economy of services, doctors will have to show that they can produce positive outcomes against specific protocols and manage chronic illnesses effectively.

“HMOs and insurance companies are going to do a better job of analyzing practice patterns, not just with a cost mentality but also an efficiency and efficacy mentality,” says Jeffrey C. Miller, the senior executive associate dean at Northwestern University School of Medicine.

“Organizations that succeed will be those groups that can say, ‘We practice evidence-based, patient-friendly medicine and here’s proof of it in terms of our patient satisfaction surveys—and our results.’”

Indeed, with “value purchasing” an emerging focus, health insurers will turn to groups that distinguish themselves for effective, efficient care. Using meta-analyses and other powerful technological tools, they’ll attempt to ensure that outcomes are consistent not just within networks but throughout the country.

What does that mean to you? You’ll be subjected to increased scrutiny and documentation of your work. Statistics

from a recent Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans reflect just how serious business is about costs. The 1999 figures show that 58 percent of PPO plans provide one or more disease management programs for conditions such as heart disease, diabetes, asthma, back pain, and depression, a significant jump from the previous 47 percent.

In any case, look for plans to focus on evidence-based medicine, gauging outcomes by measuring a patient’s quality of life, social or economic functioning, and ability to return to work. As such tools are refined, you may be “graded” on your compliance and paid based on your performance. Whether or not that comes to pass, expect to see more gold standards of care for individual illnesses.

But while the emphasis will be on performance, you’ll also regain the decision-making authority, says Allan Korn, MD, the medical director of the Chicago-based Blue Cross and Blue Shield Association. Yet, you’ll also have to accept more responsibility for the costs, particularly in light of your outcomes.

“I’m not one who thinks that all decision-making should be removed from doctors,” he says. “But you cannot have the authority without the accountability since we’re all working on fixed budgets. We need to understand that our expectations have probably been a bit more than they should have been in the past. So what’s necessary now is that we modify those expectations.”

ISSUE 3:

Big Brother Will Be Watching

Insurance companies will continue to peer over your shoulder as you work to keep health costs under control. Even as companies shift decision-making back to providers, expect them to monitor how you manage patients, particularly those

who are chronically ill.

“You’re going to see physicians have more sway than they’ve had in the past,” says Northwestern University’s Miller. “They’ve really been subjected to arbitrary dictates, constantly shifting rules—the ‘hassle factor.’ But there’s been enough of a backlash that insurers are realizing, ‘This is not a good problem.’”

Look for plans to ease or eliminate pre-certification hassles by instituting approaches such as ‘exception monitoring.’ They track aberrant practice patterns while greenlighting procedures that fall within routine limits.

“The case-by-case or decision-by-decision regulation of physicians has been a horrible waste of time for the plans, forget about the doctors,” says Jeffrey Goldsmith, the president of Health Futures, Inc., a Charlottesville, Virginia, trend analysis and forecasting firm. “This has been a huge administrative and political burden. I see a lot of that disappearing.”

Companies such as Aetna US Healthcare are already relying on doctor notifications in lieu of pre-certification. In an effort to streamline and speed up processing, they’re encouraging doctors to use the Internet for daily business dealings. For instance, at Aetna, where billings, referrals, and pre-certifications are routinely transmitted over the ‘net, officials reward doctors willing to submit charges on-line by turning around payments in seven days, not the typical three weeks.

Federal administrative directives mandated under the Health Insurance Portability and Accountability Act (HIPAA), will soon force all health providers to use a common transaction form when communicating electronically with Medicare or other insurers.

“They’ll have the information as fast as it takes the electricity to get from one spot to

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another," says Edward Millunchick, MD, Aetna's network medical director. "It will crank up their efficiency enormously."

But while electronic formats and on-line connections should help streamline insurance requests, they could easily be offset by additional regulations sure to come down the pike. For instance, the Department of Health and Human Services (HHS) is poised to release a massive new tome of regs in the Health Insurance Portability Act related to items such as electronic medical record privacy.

But while the environment may be ripe for such controls, don't expect them to be tied to a large-scale health-care system overhaul—such as the one proposed in 1992 by the Clinton Administration—in the immediate future.

You're more likely to see incremental legislative reform. Further, before Congress passes any additional laws, such as those ensuring 48-hour hospital stays for deliveries, look for states to adopt their own patient protection legislation. Some 30 have done so already.

Also, a recent Institute of Medicine report on medical errors is sure to feed any regulatory trend since it suggests that 44,000 patients a year suffer serious medical errors in the nation's hospitals. It could prompt even more constituent pressure on Congress and the federal government to clamp down on providers.

"There will certainly be increased pressure to be accountable for the outcomes of their care," says Samuel Shomaker, MD, the senior associate dean for academic affairs at the University of Utah School of Medicine. "I don't necessarily think that that is bad. But I do worry about what it will take for physicians to document the quality they're providing, especially if it becomes another burden added onto the burdens they're already facing.

"If it can be done in a way that's not terribly time-consuming and intrusive, then I

think that's a positive thing because I think it's important for physicians to be accountable for the care that they render."

ISSUE 4:

Cost containment continues

The phrase "cost-effective" will be just as important an issue in the next decade as it was in the last. Emerging technology may take the profession to new heights, but it's against a backdrop of decreasing dollars.

In the past 10 years, managed care has gone from an aberration to the mainstream health-insurance structure in this country. It not only stabilized dramatic growth rates after 30 years, but also spotlighted quality and patient services.

While containing costs will be the future's underlying theme, accomplishing it may be a tall order, given an aging population with growing health needs as well as emerging technology and expensive new drugs.

Physicians will have to show some business moxie to get the most from their managed-care contracts, particularly at a time when compensation in general is leveling off or dipping lower. In fact, while some reimbursements may rise, or be adjusted for certain specialties, don't expect wholesale rate increases anytime soon.

As pharmaceutical and technological expenses take a heftier portion of the health-care dollar—and big payers such as the federal government seem adverse to rewarding providers at top rates—be prepared more than ever for payment squeezes.

Also, while health-care observers thought capitation would sweep the country in the past decade, expect it to be far less of a force in the next one. It may have regional appeal, but this cost control mechanism, which was the heart and soul of traditional HMOs, has leveled

off, in part because many practitioners took on but couldn't manage the risk.

"I think a lot of the negative things that you've heard about capitation are a result of physicians getting into areas that they really didn't have any expertise in," says Susanne H. Lanza, the director of managed-care policy for the Health Insurance Association of America. "They wanted to take risks by capitating but they didn't understand the complexities. Hopefully, going forward, people with financial skills will do the administrating and doctors will be involved in delivering the medicine."

Whether or not you're in a capitated plan, you'll still have to worry about cost containment, especially if your patients are graying. By 2010 most medical practices will experience a dramatic influx of Medicare recipients as Baby Boomers age and older people simply live longer. That gives Medicare an increasingly important role in determining your earning potential.

At an increasing rate, these patients will trade traditional fee-for-service programs for HMOs, PPOs, and other organized plans. But the shift could be bad news for both consumers and physicians. A recent American Association of Health Plans study predicted that some 711,000 beneficiaries will be affected next year when their plans pull out of the Medicare Choice program, citing inadequate payments relative to costs.

Those types of defections not only leave recipients in the lurch, but reveal some of the problems intrinsic in this program for both patients and physicians.

Unfortunately, with a federal budget surplus ensuring immediate solvency of the trust fund—and little appetite by Congress to tamper with a popular program of a powerful demographic group—there's no gigantic overhaul in sight.

Instead, look for incremental changes directed primarily at providers, say the

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authors of *Health and Health Care 2010*. (The exception may be a drug benefit.) The real heavy lifting—changing Medicare to affordably cover the vast numbers of Baby Boomers retiring after 2010—won't be dealt with until later in the decade.

"With the budget surplus that we're now experiencing, it seems like the pressure has really been taken off of Medicare," adds the University of Utah's Shomaker. "Unless there's some urgent need it's very hard to summon the will to deal with an issue prospectively. So while there's still talk about structural changes to prolong the life of the Medicare trust fund, there really isn't much momentum."

Nor is there any great craving for universal coverage. There are any number of reasons, say observers, why this country is unlikely to embrace such a plan despite the fact that 44 million Americans remain insurance "bare." (An estimated one-half by choice.)

First, there's not a yearning for rationing and the tough decision-making necessary to provide coverage for everyone. Also, unlike Canada and Britain, there seems to be no overriding belief in this country that health care is a basic right for everyone.

Further, since the Health Security Act failed in 1994, Congress and the public have shown little interest in pursuing another "big" government program; in this case a federally-run or assisted health-care system.

Of course, that picture could change if costs soar so rapidly that employers can't cover them. One could imagine, suggests Reinhardt, a coalition emerging as disparate medical, political, religious, and other organizations come up with similar plans that would patch together the present system with subsidies filling any gaps.

"It is conceivable," he believes, "that

at some point the burden of health spending in America will be so high—and the gap with other nations that have managed to constrain their costs so glaring—that Americans will be asking "What are we actually getting for all this extra money?"

But for the present, you'll be delivering care in a "tiered" insurance system that, on one end includes, "empowered consumers," educated and well-fixed, and on the other end, "excluded consumers," uninsured, on Medicaid, or with no access to the health-care marketplace. In between, say the authors of *Health and Health Care 2010*, will be "worried consumers" or those people with access but little or no choice.

How will those divisions affect you? Expect a mix of reimbursement approaches depending on your patient caseload: Capitation and discounted fees to cover lower income patients in HMOs; implicit fee schedules to reimburse for middle income Americans in various PPO or POS plans; and open-ended charges for those "unconstrained classes" with thick pocketbooks open for top-notch care.

"In the 1930s, '40s and '50s physicians had sliding fee schedules," says Reinhardt. "They will have that again."

But, watch for employers to limit their involvement in health care by moving toward defined or fixed contributions, says Reinhardt. That is, while businesses offer employees a wider choice of health plans, they'll do it by providing those employees with fixed dollars to spend in the marketplace, expecting them to pick up any premium slack or excess costs.

What will that mean for physicians? You'll have to pay closer attention to your patients—since they'll be paying closer attention to you. For the first time, employees will be taking a real interest in their doctors' fees, simply because the

payment onus is on them. That shift, say observers, could change the alliances. Instead of physicians and consumers forging a bond against insurers, doctors may be the odd-man-out as their patients scour for the best cost-effective plans.

"It's going to get more competitive and the competition will be on quality measures as patients get more of a choice," says Bruce Bagley, MD, the president of the American Academy of Family Physicians.

"Instead of having a plan that the employer buys, they'll get their own health insurance. They'll also get information from the Web about which doctors or groups offer the best value. That isn't even in the equation right now.

"So I think that physicians will compete on value, or quality divided by price. Part of that value will be effective treatments as well as good communication, using e-mail and Web pages. They'll have to interact with patients in their own language—and understand their own culture." ■

Chris Hinz is a regular contributor to Unique Opportunities.