

## policy points

**Managed Care Metamorphosis** Despite its contributions to health care, slow payments and lack of choice have driven some physicians and patients from managed care plans. The plans are being forced to adapt to market needs.

BY JEFF ATKINSON



Managed care, which exerts control over how health care is delivered along with providing a mechanism for paying for that health care,

continues to be on the rise, although complaints about managed care increase as well. Managed care encompasses multiple types of delivery systems including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and the comparatively recent Point of Service (POS). POS is an option similar to PPOs. Both allow patients to see physicians in-network or out-of-network, although the patient pays more for going out-of-network.

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### Positive Aspects of Managed Care

The Kaiser Family Foundation surveyed physicians' attitudes about managed care, including the positive aspects. Physicians cited improvements through managed care in the following areas:

**Increased use of practice guidelines and disease management protocols: --- 63%**

**More preventive care: ----- 42%**

The full survey is on line at: [www.kff.org/content/2002/20020426c/PhysicianSurveypartIII.pdf](http://www.kff.org/content/2002/20020426c/PhysicianSurveypartIII.pdf)

Source: Kaiser Family Foundation

**In 1988, managed care constituted only 27 percent of the employer-based health plan market. Now managed care is 93 percent of the employer-based market, and only 7 percent is fee-for-service, according to a survey by the Kaiser Family Foundation.**

health-plan market. Now managed care is 93 percent of the employer-based market, and only 7 percent is fee-for-service, according to a survey by the [Kaiser Family Foundation](#), a health policy research organization with headquarters in Menlo Park, California. (See "[Changes in the Health-Care Market.](#)")

### Seeking more choice

Dissatisfaction with some aspects of managed care has led to changes in the marketplace. Between 1996 and 2001, the percentage of persons with employer-based health plans opting for PPOs, which offer more choice for patients than traditional HMOs, increased from 28 percent to 48 percent, while the percentage of persons selecting traditional HMOs declined from 31 percent to 23 percent.

The proportion of persons enrolled in staff HMOs, in which physicians are employed by the HMO, declined from about 13 percent in the 1980s to 0.4 percent in 2000. Today, most HMOs are made up of independent practices, groups, networks, or a mixture of those, according to the Kaiser Foundation study.

**Medicare + Choice declines**

The federal government believes it can save money through managed care. Hence, it has been trying to encourage Medicare beneficiaries to forego the traditional fee-for-service Medicare program and enroll in Medicare + Choice in which beneficiaries enroll in a private health-care plan. Most of these are run by managed care companies.

Under Medicare + Choice, the government makes a fixed payment to the health plan each month per beneficiary, with adjustments to payments based on the age, sex, and geographic area of the beneficiary. Enrollees in Medicare + Choice often receive extra benefits, such as coverage of prescription drugs or lower Part B Medicare premiums. Medicare + Choice is more widely used in urban areas than in rural areas.

The program was established by the [Balanced Budget Act of 1997](#). It hit its high water mark in 2000 when it covered 16 percent of the Medicare population. Since then, enrollment has dropped to 11 percent of the Medicare population—from 6.3 million beneficiaries to 4.6 million beneficiaries. The decline in the program has been due to both the dissatisfaction of health plans with the level of payments and dissatisfaction of patients with the level of benefits. The number of health plans offering Medicare + Choice has dropped by more than one-half from 346 in 1998 to 148 in 2003. The

[American Association of Health Plans](#) projects that nearly 400,000 seniors are at risk of losing their Medicare + Choice Plan before January 2004 if Congress does not take action to stabilize the program, particularly by providing more funding.

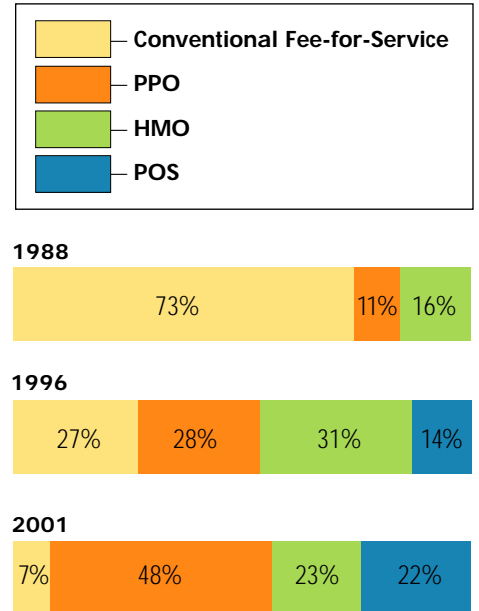
So far, Medicare + Choice does not appear to have been economically efficient even for the government. According to a [Government Accounting Office](#) study of payments made in 1998, Medicare paid 13.2 percent more to health plans than would have been paid had the beneficiaries remained in the traditional fee-for-service Medicare program. Enrollees in Medicare + Choice generally are healthier than those in the traditional program. The government hopes to make the program more efficient by phasing in a payment structure that will take into account the enrollee's health status.

**Lack of prompt payments**

The American Medical Association conducted a survey of the most important issues facing physicians regarding managed care. At the top of the list, according to the survey of state medical associations (data gathered in 2000), were problems with prompt payments (82 percent listed that as a problem), followed by administrative hassles, down-coding, and lack of bargaining power. (See [“Most Frequent Complaints Against Managed Care.”](#))

Another survey by the Kaiser Family Foundation (published in 2002) found that approximately three-quarters of physicians believe that managed care has had a negative impact on the way they practice medicine. Forty-one percent of physicians responded that the impact was “mostly negative” and 35 percent responded the impact was “somewhat negative.” Complaints cited in this

**Changes in the Health-Care Market**  
(Employer-Based Health Plans)



Source: Kaiser Family Foundation

survey included increased paperwork, decreased time with patients, decreased ability of patients to see specialists, increased overhead, and loss of autonomy.

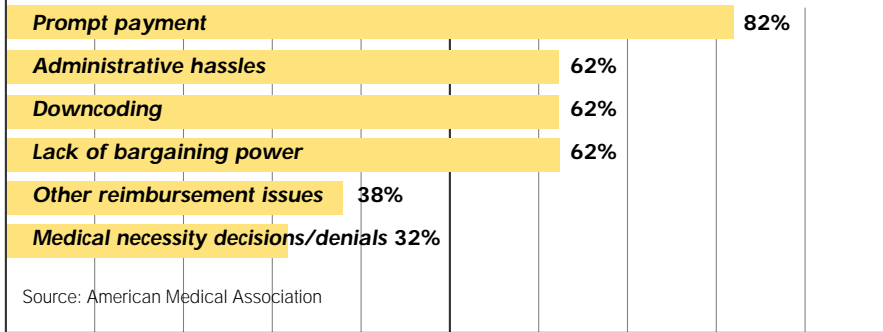
Managed care, however, does not obtain universal negative ratings. According to the Kaiser survey, physicians credit managed care with increased use of practice guidelines and disease management protocols, as well as increasing the likelihood that patients will receive preventative services, such as immunizations, health screenings, and physical exams. (See [“Positive Aspects of Managed Care.”](#)) The Kaiser survey also reported that the number of physicians who would recommend medicine as a profession to young persons increased slightly in the twenty-year period between 1981 and 2001 (from 50 percent to 53 percent), although the overall morale of physicians has gone down over the last five years.

**Preventing payment abuses**

The AMA is seeking to help physicians

**Frequent Complaints Against Managed Care**

The American Medical Association asked state medical associations to list and rank by importance the top five private sector issues facing their membership. Here are the results:



with problems related to reimbursements from managed care companies and insurance companies. The association has developed sets of materials, including a 15-step checklist to “protect your practice from abusive payment tactics.” Key items on the checklist include:

- ✓ Know the coverage terms of the patient’s insurance policy.
- ✓ Obtain all provider manuals, fee schedules, medical policy manuals, and other documents referred to in the contract.
- ✓ Understand and comply with all documentation requirements.
- ✓ Evaluate EOB [Explanation of Benefits] for accuracy to detect processing errors.
- ✓ File complaints with state insurance commissioner, state and county medical societies, and the AMA to report trends in improper handling of claims.

The checklist and other materials are available on line at: [www.ama-assn.org/ama/pub/category/7706.html](http://www.ama-assn.org/ama/pub/category/7706.html)

**Increased state regulation**

The ability of states to regulate managed care plans is increasing. Within the last 15 months, the U.S. Supreme Court has ruled in two cases involving the legality

of states imposing requirements on health-benefit plans for workers under the federal [Employee Retirement Income Security Act \(ERISA\)](#).

In *Rush Prudential HMO, Inc. v. Moran* (2002), the Supreme Court upheld an Illinois regulation applied to an employer-sponsored health plan that gives patients a right to independent review of denials of benefits. In this case, Rush Prudential HMO refused to authorize a particular type of surgery to treat a woman’s pain and numbness in her shoulder. Rush also refused the patient’s request to follow the state law which allowed the patient to seek review of the decision by a physician not affiliated with the HMO. The Supreme Court held she had a right to such a review. The Illinois law was considered to be a permissible regulation of insurance rather than an impermissible regulation of employee health plans that would have been preempted by federal law.

In *Kentucky Association of Health Plans, Inc. v. Miller* (2003), the Court held that the state’s “Any Willing Provider” law could be applied to an employer-sponsored health plan. Under the “Any Willing Provider” law, the health plan is required to accept as a member of its provider panel any provider “who is willing to meet the terms and conditions for

participation established by the...insurer.” This law also was considered to be permissible regulation of insurance. As a result of the state law, the insurance company could not limit the size of the panel as a way to refer a higher volume of patients to its providers in exchange for discounted rates from the providers.

In the wake of these Supreme Court decisions, states can be expected to impose more regulations on managed care companies to meet the concerns of health-care providers and patients. Subjects of regulation may include access to emergency care, rights to second opinions, provision of specific health services, and marketing, as well as external review and any willing provider laws.

**Striking the balance**

Managed care emerged as an approach to control health-care costs while also trying to promote quality of care. The substantial changes in the market for managed care over the last 15 years and level of complaints from patients and physicians affirm that it is very difficult to strike the appropriate balance between multiple, competing, legitimate interests. The interests include quality of care, patient choice, control of costs, and avoidance of undue burden on physicians and other health-care providers.

Given the complexity of the issue and the limits of humans to solve problems, the issue of how to optimally deliver health care may never be entirely resolved. We can hope that by gathering reliable data and applying thoughtful approaches, the system will improve. ■

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