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Healthcare And The Evolution Of Managed Care Plans

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HEALTHCARE AND THE EVOLUTION OF MANAGED CARE PLANS

by

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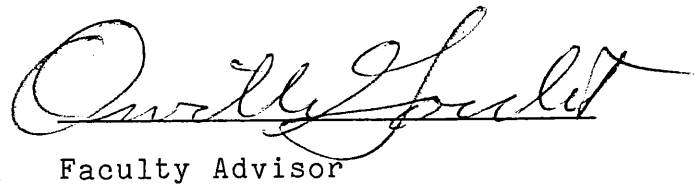
APPROVAL

This independent study submitted by James S. Bogan in partial fulfillment of the requirements for the Degree of Master of Business Administration from the University of North Dakota is hereby approved by the Faculty Advisor under whom the work has been done. This independent study meets the standards for appearance and conforms to the style and format requirements of the Graduate School of the University of North Dakota.



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ABSTRACT

Many consumers and employers are becoming increasingly concerned about the cost, quality, and appropriateness of health care services. This study examines the different managed care systems that integrate financing and delivery of health services. It describes the three most common managed care systems in use today and discusses the issues that medical providers must deal with in contracting with these systems. The study also explores the limitations of the different systems in curtailing the costs of health services or increasing the quality. The research is conducted in current literature.

Details of a specific HMO plan are presented. The level at which this HMO could control the cost and maintain the quality of health services is explained.

The information on the three managed care systems is shown which indicates the acceptance of the different systems by the consumers and the medical providers. The paper concludes with a look at the long-term possibilities of the managed care market.

CHAPTER I

INTRODUCTION

Purpose

The future of the health care delivery system depends on competitive approaches for organizing, pricing, and delivering high-quality health care services. Competition has fostered the development of managed care systems that integrate financing and delivery in ways other than the traditional fee-for-service system.

Managed care plans are an important factor in the development of a health care delivery system which needs to provide high quality and be cost effective. The purpose of this study is to evaluate the managed care systems that are present today and the TeamCare HMO in particular. TeamCare HMO, a North Dakota HMO, highlights the problems that managed care plans have in curtailing the high costs of health care.

Problem

This paper is an attempt to analyze the managed care systems in the health care industry. It will seek to identiy the major systems or models in the managed

care field, to assess their impact, and to make a recommendation for the future.

Justification

Managed care plans in a variety of forms have been offered as a solution to rising health costs for the American public. Such plans are designed to produce more cost-effective care and consequently to provide comprehensive services at lower health insurance premiums. The findings of this paper should be valuable to employers, health care providers, and insurance companies in deciding which system of managed care is most likely to succeed in providing a cost-effective, high quality delivery system. The concerned parties should also find them helpful in assessing which system is suitable for the various conditions of different locales.

Scope

This paper will concentrate on the three most common managed care systems for the under 65 population. This will be further defined in the second chapter. It will emphasize the TeamCare HMO.

Limitations

As in other analysis, the study will be limited to available relevant data for the managed care plans. Further limitations arise due to the evolutionary process that these systems are experiencing at the present time.

Methodology

The study undertaken will be a product of secondary research. Relevant information will be analyzed from health care periodicals, case studies, and other pertinent sources.

The author has been personally involved in the operations of TeamCare HMO. This personal involvement has provided first hand knowledge of the history, development, and operation of TeamCare HMO. This will also be included in the findings.

Summary

A person needs to be aware of managed care systems regardless of where a person is in the health care network. A study of managed care will prove valuable in determining whether success or failure happens in the provider network.

CHAPTER II

MANAGING CARE

Managed care systems are recognized as those alternative delivery and financing systems that integrate financing mechanisms, appropriate utilization management, and high-quality service delivery. Such systems in effect "manage" care by controlling the selection and utilization of services and provide for appropriate benefits coverage.[1] Managed care plans may be health maintenance organizations (HMOs), preferred provider organizations (PPOs), and direct agreements between employers and providers. Exhibit 1 shows the growth in managed care by type of system or model. The percentage figures on how each model fits into the health care market, show an absolutely radical change taking place.[2]

Health economists predict that more than two thirds of the American public will be receiving health care services from managed care plans by the mid-1990s.[3] If

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[1]Kathryn A. Schroer and Donald A. Penn, Hospital Strategies for Contracting with Managed Care Plans, ed. Gary J. Rahn, (Chicago: American Hospital Publishing Inc., 1987), 2.

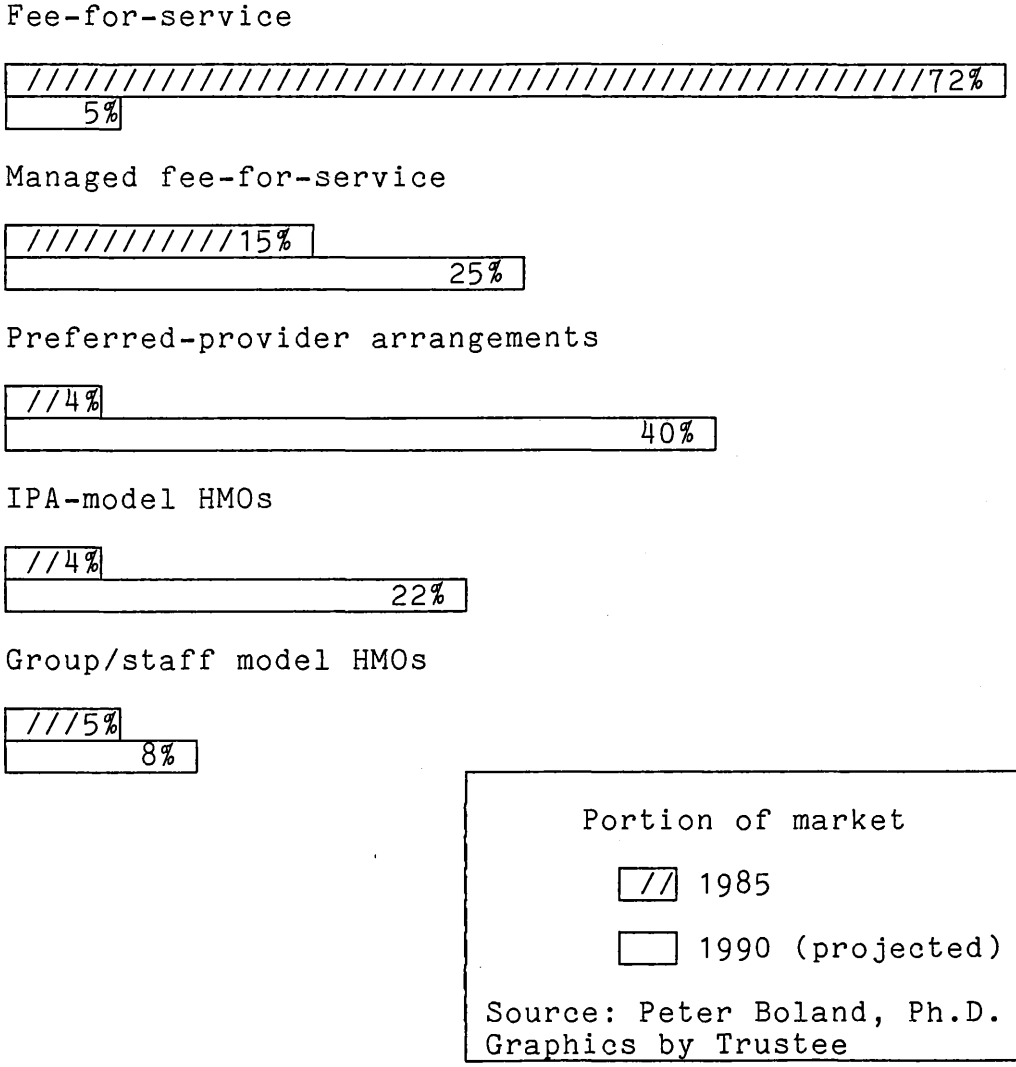
[2]P. Boland, "Reposition now for the Managed Care Market of the 1990s", Trustee 41, (March 1988), 9.

[3]T. Roovers, "Managed Care. Where, When and Why. Part I.", US Healthcare 5, (October 1988), 64.

EXHIBIT 1

MANAGED CARE GROWTH

THE SHIFTING MANAGED-CARE MARKET



these predictions become a reality, a majority of the nation's hospitals will provide a significant percentage of their services through managed care contractual arrangements within the next five years. Health care management must set priorities, gather information, and think in an innovative manner when developing strategies for "Managed Care".

The industry must realize that managed care plans represent a key force in the future of health care delivery. Some trends have emerged with the advent of managed care systems.

Employers recognize the need to establish more business-like buyer and supplier relationships between themselves and health care providers. Meanwhile, the providers are increasingly willing to accept various external control and audit mechanisms to establish their accountability for both the quality and the cost of their services when these mechanisms are responsibly directed by local community employers and other purchaser groups.

Many employers have established positive economic incentives in their health care benefits to reward employees for choosing lower cost options. The health care providers have developed processes and programs to achieve the efficiences required for cost control.

The objective of all these efforts by employers who

are responsible for financing health care benefit programs and by individual consumers is to contain health care expenditures and ensure appropriate utilization and high-quality care.

In a managed care system, policies and procedures are established to control utilization. Common controls include preadmission authorization, concurrent review, second opinions for elective surgery, etc.[4]

Along with the controls, managed care has produced some unique problems which hospitals must face. Saddled with losses from big discounts, many hospitals are taking a closer look at new contracts with managed care systems.[5] The financial discounts to managed care plans are not matched by sufficient increases in patient volume. As hospitals learn to track the results and benefits of contracts, they may drop plans which don't deliver increases in patient volume and revenues. The hospitals need financial systems that are capable of monitoring patients involved in negotiated arrangements on a daily basis and of aggregating utilization data.

Hospitals striving for true competitive strength assess the marketability of their services and products

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[4]Kevin Flores, "Managed Care Contracting: A Systematic Approach", Health Care Strategic Management 5, (December 1987), 10.

[5]Paul J. Kenkel, "Managed-Care Promises Under Scrutiny," Modern Healthcare 18, (March 11, 1988), 60.

as viewed by the consumer. Hospitals must take a look at the financial issues that may influence their decision about contracting: pricing and payer mix, employer analysis of costs, financial profiling, uncompensated care, and financial monitoring.

As hospitals assume more financial risk for the mix of cases and the resources being used in providing treatment, it is becoming more essential that hospitals efficiently track and manage the types of cases in their organizations.[6] Each patient is assured high quality care under the case-mix management process, but individual cases may be managed differently based on payor type. Managing payor types in a different manner may be necessary because of the variations in the managed care contracts.

Most health care providers don't have the financial monitoring systems necessary to analyze full-risk contracts. Data systems have become nearly the only negotiating issue left for health care providers because their respective price structures are all about the same. Many data information staffs are trying to prepare for employers' future data demands.[7] More over,

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[6]Glen I. Kazahaya and Guy M. Masters, "Case-Mix Management Enhances Profitability," Healthcare Financial Management 42, (September 1988), 76.

[7]M. R. Traska, "Managed Care: Whoever has the data wins the game," Hospitals, (April 5, 1988), 55.

the hospitals must consider appropriate data collection systems absolutely necessary because utilization and prices of services by payor must be available before any managed care contracts are signed.

The structure of the organization must be flexible enough to allow a President or the individual with designated responsibility to evaluate and respond quickly to various contract opportunities.

The President should analyze the hospital's mission and goals to ensure that any developed competitive strategies are consistent with its mission and goals. In 1983, as part of a competitive strategy, one church-sponsored hospital developed a hospital-based PPO. The strategy involved revising the hospital's mission and goals to reflect the intent to provide competitive options for employers seeking to contain health care costs.[8] When the hospital is in a competitive position, the mission and goals must reflect a philosophy that can often balance two potentially opposing forces.

Organizations should be aware of a contract's effect on the reputation and image of the facility. Just as the organizations should realistically examine its image and reputation, so should it examine the reputation of groups with whom it chooses to affiliate via

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[8]Schroer, Hospital Strategies For Contracting With Managed Care Plans, 13.

contracts. The image becomes increasingly important in a competitive market.

To compete in today's marketplace, health care organizations need to look at their patient care services as separate and distinct product lines rather than as a broad collection of individual services, as has been the practice. For example, the individual services of breast cancer screening, osteoporosis screening, stress management, and weight reduction classes should be regarded as a comprehensive program aimed at women. A marketing strategy should be specifically designed to promote these services as a product line.

Management should determine which services distinguish the hospital from other competing institutions in the community and then decide to whom the services should be marketed. Because the hospital's products are an integral part of the strategic plan for contracting with managed care plans, the hospital should determine how each product line fits into the short-term and long-term plan for external contracting, associated pricing arrangements, and potential profitability.[9]

Hospitals should not overlook the significance of its medical staff in the strategic planning for contracting with PPOs, HMOs, and employers. Physicians

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[9]Peter Boland, "Learn From The Past: Keep managed care manageable and profitable with hard facts", Modern Healthcare 18, (August 19, 1988), 32.

must play a key role in hospitals' participation in managed care plans. If they feel threatened by the venture, the hospitals' ability to succeed will be low. Physicians need to participate in issues like utilization management and peer review. The hospitals should avoid alienating nonparticipating physicians and allowing a negative political situation to arise among physicians on staff. A managed care plan that improves the quality of medical care and of patient and family life would provide a positive effect on the medical staff.

Similarly the employee benefit aspects of these goals are a major factor in many employers' decision to purchase or sign on for a managed care plan. One approach to the quality improvement would be to have the managed care plan and the employer agree to a set of so-called quality indicators.[10] These quality areas could be integrated with information on health care claims generated. The integration of this medical information in data bases will allow for the comparison of costs with the costs of similar non-managed patients. The evidence of cost-effectiveness will come from the results of such analysis.

Even with this flexible and comprehensive corporate

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[10]M. Henderson, B. Souder, & A. Bergman, "Measuring Efficiencies of Managed Care", Business and Health 12, (October, 1987), 46.

structure, health care organizations are faced with difficult choices about managed care partnerships.[11]

How closely is a health care organization willing to work with an insurer?

How much political capital in medical staff relations is a hospital willing to spend to keep employer and insurer business?

How many characteristics of a service organization is a health care entity able to incorporate in day-to-day customer activities?

Each of these questions implies trade-offs and uncertain scenarios for the future. These questions have to be addressed by health care organizations if they are to remain viable in a managed care market.

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[11]Peter Boland, "Managed Care Dominating Healthcare Delivery System," Modern Healthcare 18, (January 22, 1988), 29.

CHAPTER III

SYSTEMS

The movement toward managed care plans has occurred for several reasons:

1. Substantial variation in medical practices and in costs of care among hospitals and physicians treating similar types of patients both locally and regionally have been identified by insurers, employers, and government agencies.

2. Health care professionals and organizations have had few economic incentives for providing medical care services efficiently and at reasonable prices.

3. Individuals, families, and employees, the consumers of care, are becoming more cost conscious as they assume a greater proportion of the costs of that care.[12]

The market for health care is not naturally competitive. There are tools available to enable employers to use competition to achieve a reasonable degree of efficiency and equity for their employees. The market in this type of system should be viewed as "three-cornered" -- including consumers, health plans, and employers or the purchasers -- and not merely two-sided.[13]

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[12]Schroer, Hospital Strategies For Contracting With Managed Care Plans, 2.

[13]Alain C. Enthoven, "Managed Competition: An Agenda For Action", Health Affairs 7, (Summer 1988), 28.

In this system the employer serves as the broker that structures the coverages, contracts with the beneficiaries and health plans regarding the rules of participation, and pays the premiums to the managed care plan.

The employer may consider a health maintenance organization (HMO), preferred provider organization (PPO), or a direct contract agreement with providers.

CHAPTER IV

DIRECT EMPLOYER CONTRACTING

Direct contracting places hospitals in control of their utilization standards and performance. This technique enables health care providers to design plans that meet the needs of specific employers.

Hospitals have the opportunity to regain control of delivery by showing that they can provide high quality, cost-effective care. Health One Corporation, Minneapolis recently reorganized its marketing staff and it now promotes direct relationships with employers for a variety of services, including contracts to provide all inpatient and outpatient services for local employers.[14]

The purpose of these arrangements is to promote flexible, direct contracting without the inclusion of such middlemen as insurers and preferred provider organizations (PPOs).[15] Employers believe that significant advantages can be achieved through developing and

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[14] Alden Solovy, "Cutting Out The Middleman," Hospitals, (November 20, 1988), 52.

[15] Schroer, Hospital Strategies For Contracting With Managed Care Plans, 69.

controlling their own arrangements and working directly with health care providers. Either a provider of care or the employer can initiate direct contracting.

Direct contracting is an innovative method for combining the resources, goals, and methodologies of health care providers and consumers of health care services to achieve the common objectives of high-quality services, cost-effectiveness, and market control.

Health care providers which seek to do direct contracting should include this goal in their strategic plans. This plan should include a method for evaluation of potential arrangements and forecast outcomes as well as a method to evaluate each contract in terms of administrative requirements, profitability, quality assurance, utilization management, and market potential.[16]

The advantages of this type of managed care plan to the provider are a direct and controlled relationship with a group of service utilizers to which the provider can market health care services, an ability to implement creative direct-marketing approaches, and the exchange of utilization and cost information is easier to manage and more useful.

Employers have direct control over where their employees seek care, how that care is paid for, and how the marketing is being done. They can directly design

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[16]Ibid., 70.

flexible benefit plans that encourage employees to seek services from contract providers.

The size of the employer and the scope of services available from the provider determines whether direct contracting is a viable option.[17] The critical number is dependent upon the community being served. Employers with 1,000 employees in Chicago won't have the clout. An employer in West Virginia with 500 employees may have clout. The provider must be large enough to serve home locales of a businesses' employees.

Key provider considerations in direct employer contracting are:

1. The true advantages or disadvantages of each employer contract should be carefully evaluated and the long-term, as well as the short-term impact of the contract should be considered.

2. Ongoing monitoring of the contract and communication with the employer is crucial to the success of the arrangement.

3. The ability to work directly with employers, and directly with their employees, can provide significant marketing advantages to the health care organization.[18]

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[17] Solovy, Cutting Out The Middlemen, 57.

[18] Schroer, Hospital Strategies For Contracting With Managed Care Plans, 100.

CHAPTER V

HEALTH MAINTENANCE ORGANIZATIONS

Health Maintenance Organizations (HMO) were the first system of managed care some fifteen years ago. HMOs represented at that time a major departure from indemnity health insurance, the dominant method for financing medical care in the United States. The HMOs primary interest was the delivery of affordable, comprehensive medical services; insurance was viewed solely as a mechanism for financing medical care.[19]

Review of the growth of HMOs over the past 15 years has shown a rise from 6 million in 1976 to nearly 30 million at the end of 1987. The enrollment trend is shown in Exhibit 3. As HMO membership grew steadily and changed from an isolated phenomenon in California and a few other states to a nationwide movement, providers aggressively have to seek out contracts with HMOs.

Contracting with health maintenance organizations (HMOs) has become the key element in the survival of hospitals. Most hospitals choose to be involved in many

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[19]Lynn R. Gruber, Maureen Shadle, and Cynthia L. Polich, "From Movement to Industry: The Growth of HMOs," Health Affairs 7, (Summer 1988), 198.

HMO contracts in communities where HMO penetration is at the national average or higher. This growth and spread of HMOs has had a sweeping impact on the structure and functioning of the nation's health care system over the past fifteen years.[20]

In determining the extent to which providers plan to become involved in HMO contracting, the providers must keep in mind that an HMO's primary goal is to control utilization of inpatient hospital services. The goal of hospitals is often to increase or retain utilization of inpatient services. Hospitals need to be able to forecast the HMO's ability to increase patient days when considering a contract. Hospitals must also take into consideration other service utilization by HMO members and the number of primary care physicians on staff who are contracting with the HMO. A shift in their admitting patterns can affect the hospital's overall utilization.

Contracts between hospitals and HMOs can be an agreement to receive full charges or an arrangement in which an HMO contracts on a capitation basis. Hospitals are also frequently compensated by HMOs on a discount or per diem basis similar to arrangements found in a PPO and direct employer contracting. HMOs are using the capitation basis as a means of shifting risk to providers

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[20]Ibid., 197.

and improving the efficiencies of providing care to beneficiaries. Capitation payments are based on a payment per member of the plan per month.

An evaluation by providers of an HMO's market position, financial goals, and potential benefit to the organization is a key element in the process. Key considerations in contracting with an HMO include the following:

1. Gathering maximum information from the HMO before making a decision is important.

2. The provider must try to determine the HMO's long term financial and market viability.

3. The provider should carefully assess the level of risk it can assume.

4. The provider should determine the pros and cons of marketshare exclusivity.[21]

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[21]Schroer, Hospitals Strategies For Contracting With Managed Care Plans, 136.

CHAPTER VI

PREFERRED PROVIDER ORGANIZATIONS

A preferred provider organization (PPO), also known by the derivative preferred provider arrangement, is a fee-for-service alternative to traditional health insurance under which those covered are given financial incentives to choose from a panel of preferred providers with whom the employer or purchaser has contracted. The employer hopes to contain health care outlays by obtaining discounts from preferred providers, choosing providers who have either lower-than-average fees or more economical practice patterns, or applying utilization controls with a panel of providers that have agreed to cooperate, making such controls more effective.[22]

Health care providers may benefit from an increase in market share that results from the incentives to consumers to favor them over providers that are not in the panel. The prospect of obtaining additional volume or retaining volume through discounts should be approached cautiously and conservatively. In active markets, few

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[22]Elizabeth S. Rolph, Paul B. Ginsburg, and Susan D. Hosek, "The Regulation of Preferred Provider Arrangements," Health Affairs 6,(Fall, 1987), 33.

if any of the PPOs will actually control enough volume to justify the discounts they ask for.[23] For this benefit to be fruitful, the hospital must first find out who its present patients are, where they work, and the level of severity of their illnesses. A market analysis would be done by the hospital to accurately complete a comparison with the PPO enrollment base. This information is gathered to determine if there is a match beneficial to both the provider and the PPO.

The other concern in the PPO system is from the employer's perspective. PPOs primarily contract with providers based on discounts or fee schedules. Seldom do they incorporate a gatekeeper or primary care physician concept. This system brings savings to the employer in only one area: unit costs. Savings must be generated in utilization as well. The savings from unit costs and utilization must be an amount greater than the company is spending for the steering mechanism -- that is, how much in benefits the company has to give in order to persuade employees to use the preferred providers and the incremental administrative expenses of running the provider network.[24]

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[23]David H. Hitt, "Walking a Fine Line", Texas Hospitals 44, (August, 1988), 12.

[24]Joyce Gildea, "Managed Care? Not without Gatekeepers and Capitation", Health Cost Management 5, (July-August, 1988), 2.

The ability or willingness of the parties involved in a PPO to take an economic risk will dictate the organizational design of the PPO. Exhibit 2 shows a simple PPO structure in which a separate legal entity is formed by a sponsoring group that has for-profit or not-for-profit status. This entity operates as a broker, contracting with selected providers for medical services and with employers or insurance companies to sell those services.[25] Thirty two insurance companies own and operate PPOs, serving more than 3.38 million Americans. An additional twenty five insurers with 123,000 eligibles offer a PPO product to employers, but rather than owning and operating the PPO, purchase services from an existing, usually provider-sponsored PPO.[26]

This system of managed care has two major differences from the other managed care models. One, the PPOs allow patients the freedom to use providers that have not contracted with the PPO. Two, physicians in PPOs generally do not bear the financial risk for the excessive use of specialty and hospital services. Some direct contracting by employers allows for freedom to use non-contracted providers but not very often.

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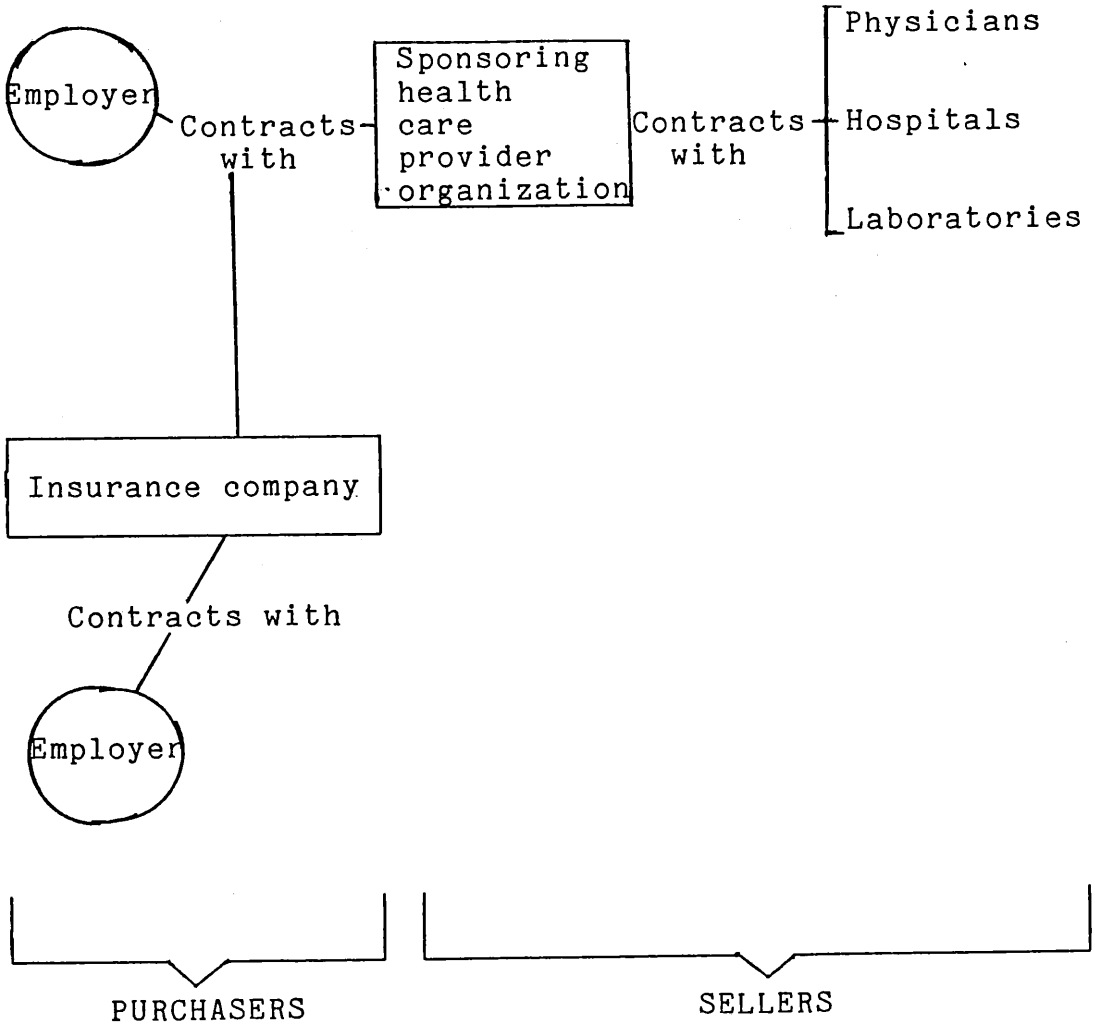
[25]Schroer, Hospital Strategies For Contracting With Managed Care Plans, 107.

[26]Jan Gabel, Cindy Jajich-Toth, Karen Williams, Sarah Loughran, and Kevin Haugh, "The Commercial Health Insurance Industry in Transition," Health Affairs 6, (Fall, 1987), 49.

EXHIBIT 2

PPO MODEL

Simple PPO



CHAPTER VII

TEAMCARE HMO

TeamCare HMO's strength was being the only available option for the people of northwest North Dakota to the traditional fee-for-service type of health delivery. Northwest North Dakota lives with the common perception of rural America that its pastoral environment is difficult to penetrate with new ideas and slow to change.

The provider driven HMO was started in North Dakota to serve the population of the northwest quadrant of the state. Trinity Medical Center, a 250 bed hospital, and Medical Arts Clinic, a multispecialty clinic with 30 physicians formed a legal corporation whose purpose was to provide a prepaid health plan to this rural population.

Medical Arts and Trinity started to discuss the concept of a health maintenance organization in November, 1984. Many meetings were held during the next six months. Medical Arts did a feasibility study on joining a health maintenance organization in Bismarck. This option was discarded after review of the study. Medical Arts wanted to discuss the possibility

of Trinity and Medical Arts starting a new HMO with 50% ownership for each partner.

The objectives of the new HMO were: to promote cost effective, high quality medicine in its service area; to provide an adequate return on investment for its sponsors; and to direct the pattern of referral in its service area so that utilization is maximized for the HMO providers. The hospital was interested in the HMO as a new source of revenue with the present and future downturn in inpatient utilization. Both the hospital and the clinic would be capitated for their services.

The HMO was started in the fall of 1985 under the name of Northwest Healthcare, Incorporated. This corporate name had been set up by Medical Arts back in 1979 but wasn't being used for any purpose at the present. Northwest Healthcare, Inc. would be doing business as TeamCare HMO. In the summer of 1986, Northwest Healthcare, Inc. changed its corporate name to TeamCare HMO, Incorporated.

The HMO has a number of pools set up for capitation purposes. There is an institutional capitation pool which is Trinity's capitation and a physician capitation pool which is Medical Arts' capitation. The HMO has a capitation pool for pharmacy services.

TeamCare HMO signed an agreement with Blue Cross/ Blue Shield of North Dakota for claims administration,

re-insurance, and marketing functions. Two features of this agreement are that TeamCare enrollees will have automatic transferability of coverage in the event they leave the TeamCare service area. Second, TeamCare enrollees will carry an I.D. card displaying the Blue Cross/Blue Shield symbols which are recognized nationwide in the event the enrollee needs out-of-area emergency services.

TeamCare HMO, in its first year, met its budgeted enrollment of 2600 members. In the second year, the budgeted enrollment was set at 5300 members with financial breakeven at 5000 members. TeamCare HMO did not meet its budgeted enrollment of 5300 members but had actual enrolment of 4400. Losses from operations in the second year were $244,862. Projected financial breakeven was changed to 7500 members.

The strength of TeamCare has been mentioned, now let's address the weaknesses. In fact the problems set out here led to the demise of TeamCare HMO in 1989. The problems may be categorized into four general areas. These general areas are the reasons for the lack of availability of HMOs in rural areas.

The four problem areas are: 1) acquiring financing, 2) overcoming the opposition of rural providers, 3) achieving financially viable enrollment levels, and 4) containing costs and rate increases.[27]

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[27]Jon B. Christianson, Maureen Shadle, Mary M. Hunter, Susan Hartwell, and Jeanne McGee, "The New Environment for Rural HMOs," Health Affairs 5, (Spring 1986), 106.

TeamCare required substantial development capital during the startup period. Grant funding for starting HMOs was provided by the federal government from 1974 to 1979. These grants were not available for TeamCare HMO. TeamCare's organization costs of $500,000 were being amortized on a straight line basis over five years. Financing of TeamCare was capital stock of $100,000 each for Trinity and Medical Arts. Trinity loaned TeamCare another $900,000 which was subordinate to all other liabilities of TeamCare. Acquiring enough financing to reach financial breakeven was a problem which caused TeamCare to close.

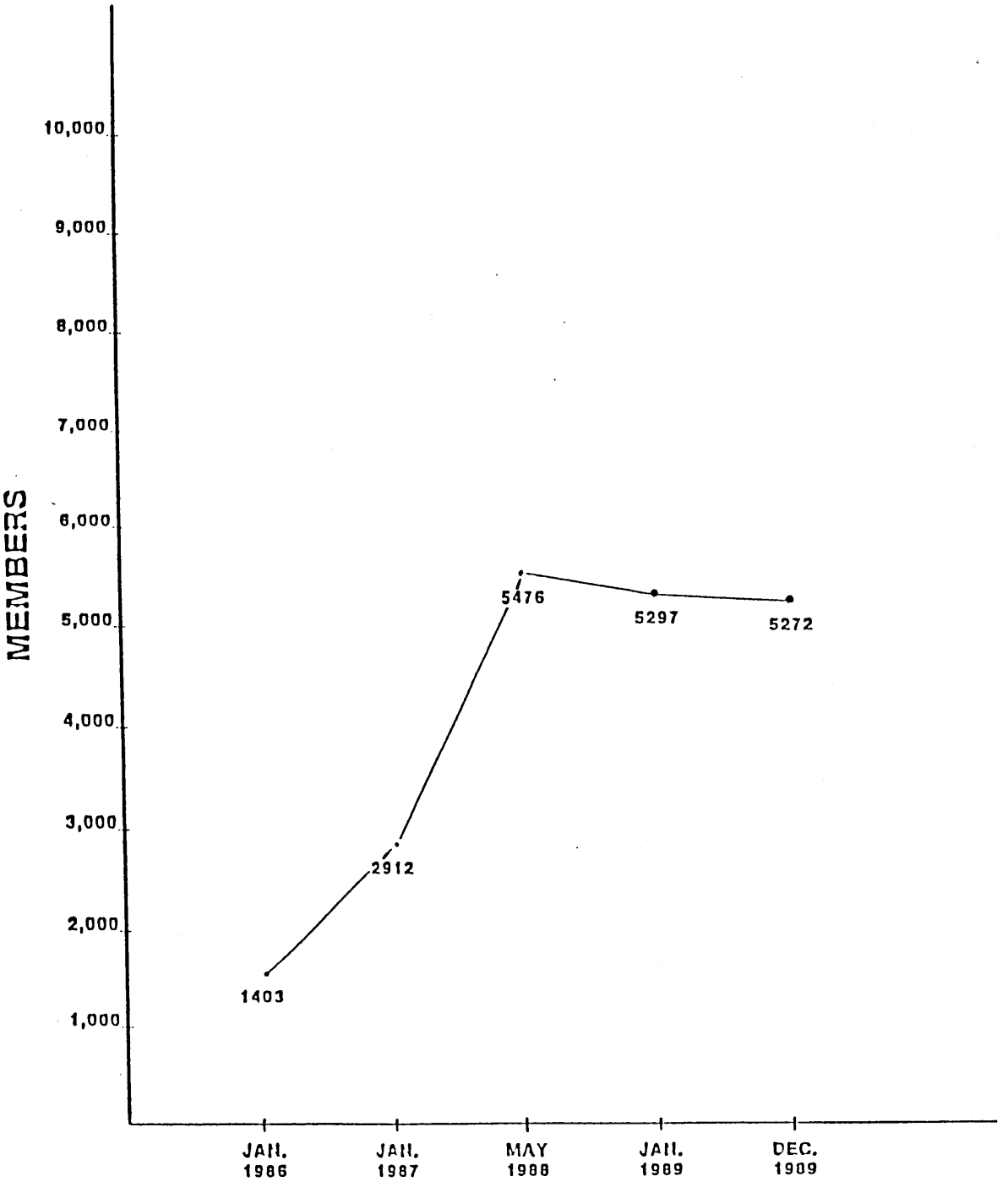
The lack of a broad base of medical providers throughout northwest North Dakota was another serious problem for TeamCare. Medical providers in the Williston, North Dakota area were needed in order to have market penetration in that area. Most of the providers were philosophically opposed to an HMO practice.

The number of specialists in the area was low. Therefore, medical services had to be secured outside the area on a fee-for-service basis. This expense was too high for TeamCare.

TeamCare HMO was not able to appeal to a comparatively broad cross-section of the population for building enrollment. Enrollment did not meet the projections starting in the second year and continued to get worse as exhibit 3 shows.

EXHIBIT 3

TEAMCARE ENROLLMENT



* ACTUAL ENROLLMENT
• PROJECTED ENROLLMENT

Containing the costs and rate increases for TeamCare was good on one side and bad on the other. TeamCare controlled their medical expense costs by capping Trinity and Medical Arts at 85% of premium. By keeping the capitation rates low, extreme discounts off charges were experienced by the providers. The inadequate return to the providers, who were also the owners, led to the downfall of the HMO.

Unlike the situation for TeamCare HMO, many rural providers appear more willing to accept both financial risk sharing and more comprehensive utilization review procedures as conditions of participation in HMOs. The two owners of TeamCare were the only providers willing to accept the risk. With increased competition in the rural market, the availability of HMO services in rural areas will possibly accelerate in the coming years.

CHAPTER VIII

CONCLUSIONS

These competing managed care plans are having a dramatic impact on physicians and hospitals in nearly all parts of the nation. Until recently, providers could regard HMOs and other managed care plans as an optional involvement. Providers who chose to participate could do so; the remainder would practice fee-for-service medicine without feeling pressure to change.

Over the past three years, that situation has evolved in most metro areas toward one in which health-care providers feel compelled either to contract with one or more managed care plans. The impact of managed care on providers manifests itself in three ways:

1) Selective alliances among providers;
2) widespread expectation of conservative practice patterns and demonstrable quality;
3) increasing financial pressure.

Managed care plans are structured to encourage prevention and early detection but few embody a true preventive approach. Little research has been available to document the cost-effectiveness of preventive measures until recently. Managed care plans have been reluctant

to invest money in coverages that might simply add to overall costs. Rather than underwrite such research themselves, managed care plans chose the surest cost-saving route - reductions in hospital utilization.

Forces underlying the growth of managed care will remain strong. Foremost is the purchasers' revolution. After years of double-digit rates of increase in health care costs, employers are changing their buying patterns. Excess capacity, both a surplus of hospitals and physicians, enables purchasers to negotiate with providers, trading discounts and utilization review for the promise of increased patient volume. This factor is enough of a reason for providers to stay in the managed care game. Advances in the data processing field enable purchasers to monitor utilization and shop as prudent buyers for efficient, high-quality providers.

As a system or model, Direct Employer Contracting will continue to grow. Analysis shows that employers will continue to exert considerable influence over the shape and direction of the health care market. High costs forced employers to play a major role in the past and quality will force employers to continue their role in the future as more employees participate in managed care plans.

Despite the massive restructuring of the health care industry, competition in some areas has not been

strong enough to put emphasis on managing "care" as evidenced by the demise of TeamCare HMO. A competitive strategy doesn't exist in many of our rural areas. Thus the original goals of cost containment, enhanced quality, and improved access to care was not fulfilled.

CHAPTER IX

RECOMMENDATIONS

Providers who have not undertaken an analysis of the managed care market should start immediately. Any barriers to effective entry into this market should be addressed and eliminated for the purpose of increased patient volume.

Health care providers should incorporate within their mission and goals the appropriate direction to participate actively in managed care. More specifically, Direct Employer Contracting is the model of managed care that employers and providers should address. Direct contracting is the next step today in the natural evolution of managed care.

Employers will have long-term contracts with shared risk and exclusive hospitals. The providers can assume risk by holding the employer harmless for inappropriate utilization. The providers may offer services for a unit price.

The providers will need to seek patients from smaller businesses as well as the large ones. The providers will need a good solid base of patients directly from employers to insure the viability of their organizations.

Employers have shown increased willingness to steer employees toward cost-effective providers. Direct Employer Contracting returns employees to one risk pool. This system can hold down costs for employers and employees. Employers will want assurances of the quality and cost effectiveness of selected providers.

Managed care plans are experimenting with a multitude of financial and structural organizations and provider payment arrangements. Presently, however, only minimal knowledge exists about the effectiveness of these various arrangements and even less is known about its impact on quality of care.

APPENDICES

DEFINITION OF TERMS

Alternative delivery system (ADS). An alternative to the fee-for-service financing system, such as a health care organization (HCO), health maintenance organization (HMO), independent physician association (IPA), or preferred provider organization (PPO).

Capitation. A method of payment in which a provider receives a fixed fee per person (per capita) for a period of time, and the provider agrees to furnish to persons for whom the capitation payments are received all the care that may be required without further fee.

Carrier. An organization which handles the claims for beneficiaries on behalf of certain kinds of "health insurance."

Direct employer contracting. Direct contractual relationships between health care providers and employers as purchasers of services.

Fee-for-service. A method of paying physicians (and other health care providers) in which each "service", for example; a doctor's office visit or operation, carries a fee.

First-dollar coverage. Insurance which has no co-payment or deductible provision; the insured does not have to pay the first dollar - the insurance pays it.

Gatekeeper. An individual who comes between the patient and secondary (specialist) care. This is one role of a primary care physician.

Health maintenance organization (HMO). A health care providing organization which ordinarily has a closed group of physicians along with either its own hospital or allocated beds in one or more hospitals. Patients join an HMO, which agrees to provide all the medical and hospital care they need, under a contract stipulating the limits of the service, for a fixed, predetermined fee.

Indemnity benefits. Insurance benefits which are provided in cash to the beneficiary rather than in service. Indemnity benefits are usual with commercial insurance.

Independent Physician Association (IPA). A type of health care provider organization composed of physicians in which physicians maintain their own practices but agree to furnish services to patients who have enrolled in a prepayment plan in which the physician services are supplied by the IPA.

Managed care plan. A plan that integrates financing mechanisms, appropriate utilization management, and high quality service delivery.

Preferred provider arrangement (PPA). A form of organization for physician services in which the third party payer establishes a roster of physicians who are believed to be cost effective. All services covered by the plan, when furnished by these physicians, are without charge to the beneficiary.

Preferred provider organization (PPO). An organization that facilitates arrangements between health care providers and group purchasers of health care services to ensure the delivery of cost-effective, high quality health care services.

Service benefits. Insurance benefits which are the health care services themselves, rather than money.

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