

Managed Care

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Why managed care?

- ▶ To deal with moral hazard – patient and provider choosing too much care because of an artificially low price
- ▶ Also deals with supplier-induced demand – provider chooses too much care to increase revenue
- ▶ Change the incentives of patients and doctors through a variety of interventions, some of which work and others don't

Definitions

- ▶ HMO: Health Maintenance Organization, insurance plan, doctors and hospital are same organization or closely affiliated; doctors on salary or paid per head
- ▶ FFS: Fee-for-Service, opposite of managed care.
- ▶ IPA: independent practice association, doctors group w/ mix of patients, some FFS, HMO, etc.
- ▶ PPO: Preferred Provider Organization, type of managed care, FFS with negotiated prices
- ▶ POS: Point of Service plan, like HMO but doctors spread out, paid per head

Interventions – Patient Side

- ▶ **copayments**-reduces patients *moral hazard*
- ▶ **second opinion program**-must get second opinion before surgery, no cost to patient, second dr knows they won't do procedure, increases patient's information before making choice (not worked well because doctors can collude and have incentive to do so in repeated games)
- ▶ **gatekeeper model**-must see primary care doctor before seeing specialist, reduces costs by avoiding specialty care

Interventions – Provider Side

- ▶ doctor payment strategies
 - ▶ **salary or capitation** vs. fee-for-service — no incentive to provide unnecessary care, instead incentive to provide less care (reduces *moral hazard*, *supplier induced demand*)
 - ▶ **holdbacks** — plan holds back a part of payments until the end of the year, if costs are high, doctors don't get hold back; if costs are low, doctors get to share the holdback, incentive to keep costs low for doctors
- ▶ hospital payment strategies — **pay by case** (event= admission to discharge of patient) – “prospective payment system” pays average amount for a particular diagnostic, not fee for service (reduces possibility of *price discrimination*)

Interventions – Provider Side

- ▶ **provider selection** — want to choose lower cost providers to be in plans, not a lot of evidence that plans are selective though
- ▶ **negotiated prices** — PPO negotiates lower doctor prices in return for higher patient volume, as more patients and doctors join, can negotiate even lower prices
- ▶ **prior authorization** — doctor required to get authorization from plan before expensive procedures, long lengths of stay, etc; hassle reduces these procedures (reduces *moral hazard*, *supplier induced demand*)
- ▶ **denial of payment** – plan denies payment after procedure and doctor, hospital and patient have to ‘eat’ cost, increases caution before certain risky procedures are performed (reduces *moral hazard*, *supplier induced demand*)

Effects of Managed Care

- ▶ quality of care may get sacrificed
- ▶ health has positive externalities, so reduced care may be bad for society
- ▶ dumping (refusing to treat sick patients)
- ▶ creaming (attracting healthy patients)
- ▶ skimping (providing less than optimal services)
- ▶ adverse selection – sicker patients choose FFS care and healthier patients choose HMOs because HMO plans are more restrictive, cheap

Effects of Managed Care

- ▶ costs may be lower – Rand Health insurance study
 - ▶ those randomly assigned to HMOs had cheaper care than those assigned to full coverage insurance
 - ▶ no health differences (battery of 20 physiological measures of health status that encompass every major organ system)

However, may be a one-time cost reduction, but growth rate is same as before

- ▶ could reduce technological advancement by reining in the usage of high-cost high-tech procedures, but not a lot of evidence
- ▶ lower physician's salaries—primary care physicians earn more, specialists earn less with greater managed care penetration