Winter
1999

ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

Patient Protection and Managed Care

Managed care has made a significant impact on the delivery and pricing of health care in the United States. Systems of managed care are found both in the private health insurance market and in public insurance programs such as Medicare and Medicaid. Consumers and medical providers have raised a number of questions about the effect of managed care on the quality of health care. These concerns have resulted in a variety of state and federal legislative proposals to regulate or limit the use of managed care in health insurance.

The American Academy of Actuaries formed the Managed Care Reform Work Group to explore the actuarial issues in a number of the managed care bills being considered by Congress and state legislatures. The purpose of this issue brief is to assist policy-makers in their understanding of those actuarial issues as they develop legislation and regulations for managed care plans.

Introduction

Managed care originated as a system to provide health care services on a budgeted, prepaid basis, including preventive services and disease management. However, its concepts and structure provided a vehicle to respond to escalating health care costs. Pressure from employers and public entities to control health care costs resulted in creative efforts to eliminate unnecessary services and to use health care resources efficiently. A second generation of managed care mechanisms put more responsibility on providers through reimbursement arrangements designed to share responsibility for cost containment with those providing the care. However, some systems were perceived as not flexible enough to identify the idiosyncratic nature of health conditions, while others were perceived as being over-zealous in their cost-cutting efforts.

Legislation has been introduced in Congress and a number of state legislatures to regulate the use of managed care strategies in health insurance and self-insured employer health plans. These proposals are based, in part, on concerns that some managed care practices may be detrimental to consumers if health plans sacrifice health care quality in favor of saving money.

Managed care can be a component of any health benefit program, whether offered through an indemnity "fee-for-service" health insurer, health maintenance organization (HMO) or self-insured employer health plan. These systems are also being used in public health insurance programs such as Medicare+Choice health plans and state Medicaid programs. Various elements of managed care have been incorporated into indemnity plans, preferred provider organizations, point-of-service (POS) plans and HMOs.

Members of the Managed Care Reform Work Group: Alfred A. Bingham, Jr., M.A.A.A., F.S.A., Alan D. Ford, M.A.A.A., F.S.A.; James Gutterman, M.A.A.A., F.S.A.; William P. McNamara , M.A.A.A., A.S.A.; Donna C. Novak, M.A.A.A., A.S.A.; Mary P. Ratelle, M.A.A.A., F.S.A.; Geoffrey Sandler, M.A.A.A., F.S.A.; Gordon Trapnell, M.A.A.A., F.S.A.

AMERICAN ACADEMY of ACTUARIES

1100 Seventeenth Street NW Seventh Floor Washington, DC 20036
Tel (202) 223-8196 Fax (202) 872-1948
www.actuary.org

James J. Murphy, Vice President, Health
John H. Trout, Director of Public Policy
Ken Krehbiel, Director of Communications
Tom Wilder, Assistant Director of Health Policy
Alison Kocz, Policy Analyst

Managed care systems may include utilization review protocols, the use of primary care provider "gatekeepers," a requirement for the prior authorization of medical services and various types of medical provider contract incentives.

Managed care has changed the dynamics of health care by directly involving health plans in decisions about the delivery of medical services. Previously, a health insurer or self-insured health benefits program would decide whether to pay for coverage after care had been provided to the enrollee. Under managed care, questions about coverage under a policy and the medical necessity of services must be determined before the procedures are performed.

The following discusses some of the major legislative initiatives being considered to regulate managed care practices. These proposals are frequently described by their proponents as "patient protection" measures.

Mandated Benefits

Benefit mandates are the establishment, by legislation, of medical procedures and conditions that must be covered by a health plan. The mandate proposals may require (a) coverage for a specific disease or condition, (b) the availability of a particular type of medical treatment or procedure or (c) access to a health care provider or service without requiring prior authorization by the health plan. Mandated benefits legislation has included a requirement for minimum hospital stays after certain medical procedures, such as childbirth; payment for emergency room care using a "prudent layperson" standard of review; coverage for prostate cancer screening and mammograms; and provisions to permit enrollees to designate an obstetrician-gynecologist as their primary care physician.

Supporters of mandated benefits legislation argue that health plans must cover the types of medical services typically required by their members. They also believe health plans should not limit their members' access to primary care medical providers or specialists. One consideration with such legislation is whether the law requiring coverage for additional benefits or medical services applies to the entire health plan market (both fully-insured and self-insured) or if the mandates are placed on a specific market segment such as small group, large group or individual health insurance. If mandates are required only for fully-insured health plans, it may push employers to self-insure their health coverage in order to avoid the expectation of higher costs for providing health care to their employees.

In addition, if certain individual health insurance plans are required to offer a specific type of mandated benefit (e.g., coverage for mental health services), people with those conditions will tend to purchase the applicable coverage. This adverse risk selection may result in additional costs for those insurance plans that include those mandated benefits most frequently used by its members.

Mandated benefits may increase costs to members when health plans are required to provide benefits and services not previously covered. The inclusion of mandated benefits in health plans may require employers and enrollees to pay for coverage they might not want, or cause them to drop coverage. To the extent that additional coverage results in higher costs to the health plan, such cost increases generally are passed on to policyholders. However, it must also be recognized that where additional preventive services are mandated (such as cancer screening), the overall cost to a health plan may be reduced by early medical intervention in serious health conditions.

Point-of-Service Plans

Many managed care plans require members to utilize medical providers who belong to a panel of doctors under contract with the health plan. This arrangement allows the health plan to control costs by directly negotiating its fees with the providers who contract to be on the panel. These negotiated fees are generally lower than what those providers would charge patients who are not members of the plan. By using a panel of providers, a health plan may reduce costs. In addition, the managed care plan can coordinate the utilization of services provided to members by those doctors and hospitals.

Point-of-service (POS) products offer enrollees in managed care plans the ability to obtain care from providers who are not members of the health plan's provider group. The members simply choose which providers to use at the time of service. In exchange for a greater choice of providers, the amount paid by the member is usually substantially higher when care is received from non-panel providers.

Point-of-service coverage legislative proposals have included a requirement that all health plans or all HMOs offer POS benefits to their group policyholders or that all employers that provide group coverage must provide a POS option for their employees. The ultimate cost of POS legislation to health plans will vary due to the relationship of several factors such as the differential in benefits offered under

the network and non-network options, the size and composition of the provider panel and the cost of non-network claims.

A POS plan will generally have higher costs than health plans that only offer a closed panel network, although the cost to the plan may be reduced through higher levels of member cost sharing. The utilization of services by members who use non-network providers may be greater because preauthorization for medical care may not be required. The fees charged by non-panel providers are frequently higher, which results in higher health care costs for POS vs. HMO enrollees.

There can be higher administrative expenses to a health plan for handling claims filed by non-panel providers. There may also be additional costs because the health plan is unable to closely monitor utilization data for those doctors and hospitals that are not part of the closed panel established by the plan. Further, adding a POS plan option in certain environments can be difficult, especially under a staff-model HMO plan.

Point-of-service mandates may result in adverse selection that will segment enrollment in health plans and drive up costs, causing health coverage to be less accessible. This phenomenon occurs because individuals who are healthier will tend to select health plans with fewer benefits. Insurance rating practices can account for this adverse selection by establishing premium rates that adequately predict claims payments and other financial obligations assumed by the health plan. If legislation prohibits adequate provision for adverse selection, the effect over time may be to transfer costs among various constituencies, resulting in healthy individuals electing not to be covered. As a result, there will be more uninsured people, and unit costs of those insured would increase.

In addition, the growth of POS products may result in providers choosing not to join closed panel managed care organizations, especially if they can bill their patients higher amounts. As a result of lack of control over non-panel providers, managed care organizations may have less incentive to develop innovative products, improve quality and reduce costs.

Grievance Procedures

Most health plans have an established process for dealing with complaints from members regarding coverage for services. The legislative debate over grievance procedures involves the question of whether enrollees should have the right to submit disputes to an external review process outside of the control of the health plan to assure an objective review. A number of states have recently passed laws that establish an outside review panel to handle health plan grievances.

Some of the issues raised about external reviews include questions about the composition of the review panel, whether the cost of the review should be paid by the health plan or the enrollee, and which types of disputes should be submitted for decision. The significance of external grievance programs will depend on the extent to which they are utilized by health plan members. Any decision to file a request for external review is influenced by how enrollees believe their original complaint was handled by the plan.

The use of external appeals may increase administration and claim costs for health plans. Limiting external review to more serious claims, such as those in excess of a specific dollar amount, could help contain such costs. In addition, requiring even a nominal fee to be paid by the member for participating in the external grievance process may help in limiting the number of marginal appeals.

The added costs associated with the external grievance process may induce health plans to change their operating procedures in order to limit outside reviews, either by relaxing their standards for the payment of claims or providing a more rigorous internal review of enrollee complaints. The cost to a plan for external grievance reviews must be weighed against potential increases in claims and related expenses.

It is too early to determine the impact of external review procedures on the delivery and cost of health care. The very limited experience available to date from those states that have established such procedures indicates that most external appeals submitted by enrollees are decided in favor of the health plan.

Provider Incentives

Managed care adds an element of cost accountability to the delivery of medical services by shifting insurance risk from the health plan to the medical provider. The incentives inherent in traditional fee-for-service health care delivery can result in a propensity to overtreat, and therefore higher costs. Provider incentives under managed care seek to share risks and align financial considerations between a health plan and those medical providers who contract with the plan. Risk sharing is any arrangement in which a targeted financial amount is established for the cost of care and losses or gains are shared by the provider and health plan.

In general, there are three major types of provider incentives in today's managed care marketplace: cap-

itation, fee discounts and profit distribution. Capitation occurs when a medical provider is paid a specific amount for each patient and in return is expected to provide all necessary services for each covered individual. Discount arrangements provide doctors and hospitals a scheduled amount for services that is typically lower than their normal fees. Providers accept a lower fee because they expect an increased number of patients to result from participation in the health plan. Profit distribution means that a financial bonus is paid to the provider following an accounting period if the provider meets specific financial targets. A financial bonus may be paid to the provider when utilization levels fall below expectations. The distribution may be limited to primary care providers or "low utilization" providers, and can be based on all services provided under the plan or limited to those provided by the primary care providers. Funds for distribution can be provided from a withhold on fees for services paid to providers or from general revenues.

Some patient protection proposals attempt to limit the use of provider contract incentives that are viewed as inhibiting patient access to necessary medical care. The legislation is designed to prohibit "negative incentives" such as contract provisions that reward primary care physicians for not referring patients to medical specialists.

Proposals to eliminate or limit incentives available to physicians and hospitals practicing under managed care contracts may increase premiums, depending on how effective those incentives have been in shifting risk from the health plan to the provider. However, certain stop-loss programs that limit a provider's insurance risk can be used to minimize the financial incentives for not providing or recommending the care. This can be particularly useful in the case of serious, treatment-intensive conditions.

Data Collection and Information Disclosure

A number of recent legislative proposals are intended to help consumers make more informed decisions about their selection of health plans. Such legislation typically requires health plans to disclose certain types of information about the plan to enrollees and to those interested in purchasing coverage. This information may include disclosure of benefits, financial obligations of enrollees such as deductibles and co-payment amounts, utilization review requirements, and grievance procedures and claim appeal rights. In addition, a number of proposals require the collection and disclosure of quality indicators for health plans, such as immunization rates, which give benchmarks to employers and employees by which to judge competing health plans.

Some proposed data reporting requirements may be extensive and increase the cost of plan administration. The added cost of developing data collection capability may be passed on to enrollees through either increased premiums or reductions in benefits.

To be effective, data collection must be standardized. This is often hard to achieve when different types of health plans (closed panel HMOs vs. POS products), levels of case management or methods of provider contracting are compared. It is also difficult to compare data among different health plans where the characteristics of plan participants may lead to variations in health outcomes. For example, a health plan with an older population of enrollees may have higher costs than one with younger members even though both plans provide the same benefits.

Ideally, data provided to enrollees and purchasers should be summarized in a manner that is useful and not misleading to the consumer. Information disclosure may be counterproductive if too much data is provided. Consumers need manageable and meaningful information in order to effectively compare health plans.

Conclusion

Managed care has resulted in a dramatic change in how health care is utilized by consumers. The use of managed care systems has resulted in lower costs for providing health coverage. Managed care has also allowed health plans to better monitor and coordinate the utilization of health care by their members.

However, there have been concerns that managed care has shifted control over health care decisions from the patient and providers to the health plan. The current patient protection legislation illustrates consumers' anxieties about their ability to obtain necessary health care without unnecessary interference by their health plan.

In considering patient protection legislation, policy-makers also need to assess the potential cost implications for health plans. Employers are sensitive to any increases in health care costs and may choose to drop health coverage if legislative changes dramatically raise premium costs. The benefits to consumers from patient protection legislation must be weighed against the possibility that access to affordable coverage will be reduced.