LESSONS FROM AMERICA

# US 'managed care' may come to UK

## Doctors in Britain can learn much from the American experience with managed care, says top US medical accountant Mark O. Dietrich


MANAGED CARE encompasses many different financial incentives and disincentives. Some are designed to influence clinical behaviour and some are simply designed to reduce the cost of providing insurance coverage.

The core feature of managed care, however, is the attempt to shift the insurer's cost of providing care from one group of providers and/or consumers to one or more other groups of providers and/or consumers.

Health insurers make money by spending less than they charge for insurance, of course. In the US, the percentage of the premium expended on providing care to insured patients is referred to as the medical loss ratio.

It is well documented in the US through public filings that large for-profit health insurers have lower medical loss ratios than their not-for-profit competitors, and therefore higher profits. Of course, to attract equity capital, for-profit health insurers have to provide a return to their investors.

The American health insurance market long ago moved away from paying whatever the physician or surgeon charged – fee for service – as well as from paying 'usual and customary fees' based on an average or other measure of actual charges.

Although the term 'usual and customary' survives in usage, it really became a means of cost-shifting insurance companies' costs onto consumers through heightened co-pays and onto providers with increased collection efforts and bad debts.

This was recently exposed in the action by the New York State attorney general Andrew Cuomo and others against Ingenix, a company that supplied purported 'usual and customary fees' to much of the American health insurance industry. The ability of insurers to share many forms of information free of anti-trust (competition) action by the government gives them a substantial advantage over providers.

Insurers in the US generally have a 'network' fee schedule around which they build the amount they are willing to pay a provider for a given service. A provider who is part of the network generally has a contract which requires them to accept the negotiated fee and precludes them from billing any difference to the patient – referred to as 'balance billing'. Some insurers have even succeeded in having state legislatures outlaw balance billing where the provider did not even have such a contract.

The American Medicare programme that provides insurance for all those aged over 65 and certain others has standardised fee schedules or tariffs by state and county for the whole country, and these are readily available on the internet.

Health insurers may build a fee schedule around the Medicare Fee Schedule, such as 90% of Medicare or 120% of Medicare. This could

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conceivably be an important precedent in the UK. if insurers were to obtain NHS rates/tariffs for consultants and base their own rates on that.

Negotiating strength plays a critical role in the numerous health insurance markets throughout the States. Alliances of physicians, surgeons and hospitals in key geographic areas may succeed in negotiating a fee schedule arrangement that is considerably better than their competitors. Due to structural differences in the delivery of healthcare – America has no National Health Service, of course – primary care physicians are often the beneficiaries of these alliances.

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Negotiating strength may also come from shortfalls of specialists or primary care physicians in a given geographic area. An insurer with a relative lack of insured individuals may initially have to pay premium tariffs to providers in order to enter a geographic market area. These tariffs may be reduced when their number of insureds gives them market leverage over providers.

There is a very well-developed set of procedure codes in the US referred to as Current Procedural Terminology (CPT), which was developed and copyrighted by the American Medical Association (AMA).

Due to CPT's use (royalty free) by Medicare, which is the largest single payer of healthcare services, the AMA has an effective statutory monopoly, since most insurers require its use as well. All the data on the services provided to Medicare is available by CPT code with total services performed, total amount charged, amount paid, both nationally and by individual state and county. Insurers therefore have ready access to statistical data on how providers code their services.

## The cost shift

The most basic cost shift an insurer can accomplish by paying less than the amount charged by the provider is forcing the insured or consumer to reach into their pocket to make up the difference.

Depending upon the labour market and the importance of insurance benefits, employers can be victimised by the cost shift through being compelled to buy more expensive policies with higher levels of coverage.

Later stages of cost shifting are more sophisticated. Insurers may have preferred provider networks where the providers who sign on are actually paid a better rate than those who do not sign. This may seem counter-intuitive at first, but sometimes friendly providers get better deals.

Of course, there is no free lunch in the US, and the better rates come with strings. These strings may include heightened levels of reporting, compliance with stated clinical goals or agreeing to a long-term contract, to name but a few.

Another common form of cost shift exists where providers compelled to provide a discount to an insurer like Medicare, or a large private insurer with a strong negotiating position, attempt to recoup that discount from insurers with less negotiating strength or from patients with limited insurance coverage or without insurance.

This is a principal reason why the stated price for a service in many US practices is often more than double what they expect to be paid by insurers.

In the area of hospital charges, a stated fee of ten times what the insurer will actually pay under the contracted rate is not unusual. Only someone unfortunate enough to be without coverage is faced with paying the stated price since the practice is generally contractually obligated to accept whatever the insurance company says their services are worth. The attempt by providers to recoup managed care discounts is one of the basic structural reasons for healthcare cost inflation in the States.

There would appear to be an analogous situation developing in the UK, given that there are different insurance products, some of which cover all services at the consultant's stated price and others of which pay a limited amount, leaving the patient to pay the rest.

As insurers with more market power attempt to limit what consultants can charge a given group of insureds, consultants are likely to pass those forced discounts onto others lacking that market power.

## Other consequences of managed care

Physician and surgeon practices in the US have also responded to managed care's fee restrictions by expanding the nature of their practices.

There are numerous examples of these expansions, but high-tech imaging is one of the better examples. There has been an explosive growth in physician-owned MRI and CT machines. Orthopedic surgeons, gastroenterologists and ophthalmologists in particular have opened their own outpatient ambulatory surgery centres to compete with hospital outpatient surgery departments.

This has caused the cost per procedure in hospitals to go up because the large fixed costs have to be spread over a smaller volume of cases.

Physician and investor-owned ambulatory surgery centres are one of the few areas where the federal government has taken sides against hospitals, recently granting a major expansion of the types of procedures that can be done there rather than at a hospital. The reason? Ambulatory surgery centres are paid around 65% of what a hospital would receive for the same service, saving the Medicare programme a considerable amount of money.

## Benefits of managed care

There are, in fact, some apparent benefits which might seem surprising given the rate of growth of healthcare spending in the US and the 16% share of the economy it represents.

Hospital lengths of stay declined dramatically during the 1990s under the managed care regime, which is believed to have saved a considerable amount of money and caused the expansion of less expensive care venues including Skilled Nursing facilities and Home Health.

On the other hand, Home Health spending grew so rapidly that a legislated stop had to be engineered and it is often targeted for fraud investigations.

Given the dynamic interaction in an economy, it is impossible to develop a multivariate statistical model that could actually quantify the savings of reduced length of stay.

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Much of the analysis is done by simply multiplying the per diem rate by the fewer number of hospital days that were paid for. Similarly, if patients are never admitted to the hospital, the savings are determined by multiplying the reduced number of admissions by the diagnosis-related group (DRG) for those admissions. This is a fee-for-service payment mechanism used for hospitals, which pays a more or less fixed fee based upon the diagnosis assigned to a patient at the time of discharge.

The clinical patterns developed around the import of the primary care physician in directing the patient through the healthcare system – a key feature of true US managed care – have arguably led to better clinical results, although that is better discussed by clinicians than accountants.

The advent of Integrated Delivery Systems including providers along the entire continuum of care – analogous to the vision of the UK's NHS – has made electronic medical records a possibility. And, the US has almost endless volumes of clinical data to be analysed and debated, used and abused!

## Conclusion

In my view, the sequence of developments in a healthcare market leading to 'managed care' seems all but inevitable in the absence of a concerted effort in the early stages to keep the proverbial horse in the barn.

Closing the barn door requires co-operation among those most likely to be harmed by managed care – providers, employers and patients – and preventing disproportionate power from vesting in one element of the private health insurance marketplace.

Involvement of government authorities in maintaining a level playing field in healthcare is critical to precluding a de facto monopoly – or, technically speaking, a monopsony – for insurers. ■

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