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Healthcare Economics 504

Cost Efficiency of Managed Care Organizations

By

Sample Paper # 2  
Synthesis

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The United States is the home to some of the best medical research and technology the world has to offer. Not a day goes by without hearing or reading about a new life saving surgical technique or a new revolutionary pharmaceutical. It is this technology that people with health insurance have come to demand every time they become ill. Under fee-for-service (indemnity) health plans, physicians provide these services for their patients and not only benefit from it, but also contribute to the inefficiency of the healthcare system.

In today's society new medical technology is extremely expensive. So who pays for these costly treatments and new drugs? The majority of Americans receive their medical insurance through their employers (Journal of Public Health Policy, 1998). In effect, the employers of these sick individuals are paying for these expensive medical services. It is these same employers that are unable to keep up with the astronomical prices of health care today.

From 1960 to 1996 the cost of medical care per capita, in the U.S., has risen from \$141 (approximately 5% of GDP) to \$3621 (approximately 14% of GDP) (Journal of Public Health Policy, 1998). During this same time period the CPI for all items rose from 30 to 157 indicating an increase of 430% and CPI for medical care showed an increase of 923% (Journal of Public Health Policy, 1998). These figures are staggering and show not only over-utilization of healthcare by patients, but the lack of support to control costs by physicians and the rest of the medical community.

Why should physicians support effort to control these costs when it has been this type of over-providing that has padded their bank accounts for years? Most physicians in the U.S. are by paid on a fee-for-service basis (Journal of Public Health Policy, 1998).

over →

Be careful. Just because utilization ↑  
Does not necessarily mean it is over utilization.  
You need something more to substantiate.

Under this payment option the physicians are receiving payment for every procedure that they order and for every exam that they perform. This system offers no incentives for cost controls, but actually rewards inefficiency and over-utilization.

In the wake of the last 40 years the healthcare crisis has now moved into a stage of radical renovation. Managed care is the new politically correct term. Focusing on cost-containment and efficiency of resources, managed care plans are theoretically the answer to the healthcare issue. However, how do these plans actually reduce medical care costs? In addition, what about the quality of health these plans produce? These answers will be examined in this paper which synthesizes literature all ready completed on this topic.

*Papers read better (& are more understandable) if broken into sections*  
**Section II - Managed Care**

What is managed care? Managed care is a complex organization that integrates capitated (prepaid) health insurance with a wide array of healthcare services for a population of enrolled participants (Williams and Torreens, 1995). This is a very brief and simple explanation for an extremely long and complex chain of services. Also within the above definition are various <sup>types</sup> branches of managed ~~of~~ organizations, such as the HMO, PPO, and POS, which will briefly be described.

The HMO (health maintenance organization) is the most restrictive type of managed care plan requiring their enrollees to get all of their medical care from the physicians and services contracted by the organization (Williams and Torreens, 1995). This is the second most common type of managed care plan, with approximately 30% of the total health insurance market (Ku and Hoag, 1998).

The next type of health plan is the PPO (preferred provider organization), which constitutes approximately 35% of the market (Ku and Hoag, 1998). Under the PPO the

enrolled members are offered more flexibility. With this type of plan member can seek medical care outside of the network but must pay a higher percentage of the total cost (Williams and Torreens, 1995).

A third type of managed care plan is the POS (point of service) plan. This health plan contains 20% of healthcare market (Ku and Hoag, 1998). It is sometimes seen as a hybrid managed care plan because it not only allows its enrollees to choose the services and the physicians that they want, but acts both as an HMO and a PPO (Williams and Torreens, 1995). This plan is one of the fastest growing because it allows its members the flexibility that they are seeking.

How?

Managed care is not a new form of healthcare management, but is the result of a “payers revolt” against the alarming escalation of medical costs in the U.S. under the fee-for-services system (Buchanon, 1998). The payers mentioned above are the private sector employers, the state, and the local government, which cannot keep paying the inflated prices of healthcare. Even though corporate America initiated the move to managed care, the government followed close behind.

III The move to managed care

This move to managed care can be explained through simple economic analysis.

Medical care costs in the 1980's were pushing close to 15% of GDP and the premiums could not be afforded any longer. The natural tendency when the price of an elastic item is too high, is to buy less, or find a comparable substitute. We will assume that medical care is price elastic. The corporate world or the government was in no situation to cut back on the medical coverage for their constituents but to find relief from the prices that fee-for-service was yielding. The substitute selected to control the cost inflation of medical care was the managed care system.

why?

Within managed care, there is financial incentive to directly impact the supply of medical care. It helps control these costs affecting the “supply side” of economics where according to the Law of Supply, as the quantity supplied increases and the price increases and vice versa, ceteris paribus (Phelps, 1997). Since managed care plans are prepaid premiums, incentives exist to supply little or no medical care at all. However, this is not ethical or legal in the U.S. These organizations are only responsible for providing, not the most expensive care, the most efficient care possible. By effectively controlling the inputs (the supply) into medical care, managed care organizations are able to reduce the cost of medical care per patient, keeping the prepaid amount of insurance in surplus (Sing, 1998). It is this surplus of money that drives these predominately for-profit institutions to further reduce their expenses in order to maximize their profits (Sing, 1998).

why?

over →

Although no two managed care organizations are exactly the same, each of these plans mentioned use many of the same cost-containment techniques. Some common methods used by most MCO's are the use of the primary care physician, the pre-authorization of certain services, and the “deskilling” of labor (Buchanon, 1998). All of these techniques are helping the managed care organizations win the battles in the medical cost war.

The most important part of the control process starts with the primary care physician. The primary care physician acts as the patient's agent and controls most aspects of the patients care. This type of physician is unique in that all potential medical care must be generated through him. In such instances where this is not feasible, the “pre-authorization” of services must be obtained before any reimbursement will be

Are you saying that because of ethical/legal obligations, no managed care org. will underprovide care?

That seems unlikely. What will induce ~~some~~ such org.s to not underprovide?

considered. So, in a managed care organization a physician is not only responsible for the patients care, but also responsible for the expense associated with the care. A typical primary care physician's practice is to provide the most effective treatment at the least societal cost (Sing, 1998). Within the managed care organization the society consists of the entire patient population and it is a part of the PCP's role to maximize their utility. In effect the PCP acts as the medical rationer, determining what is the most cost-efficient way to treat his patient. A reduction in quality of services are feasible, if for example, plain x-rays would be cheaper than an MRI, as long as it doesn't compromise the patients health. Decisions such as this one are made every day contributing to reduction of healthcare expenditures.

If you use acronyms you must make clear what they mean. For ex., Primary care physician (PCP).

What gives the PCP an incentive to be cost-efficient?

As just illustrated the primary care physician plays an integral role within the managed care environment. In some institutions these physicians are even compensated for their part in reducing medical care costs (Sing, 1998). But in a system that focuses on price controls, the physician's jobs are not even secure. Managed care organizations promote the use of the non-physician provider. These are healthcare professionals, nurse practitioners and physician assistants, that serve the role as the primary care physician. These cost efficient professionals provide many of the services of that of a physician, but with a considerable reduction in cost.

Quality?

A simple way to look at this type of care is to examine the prices of related goods. If the price of one good is increasing, the demand for the substitute will increase. This process overall is efficient, but in reality, these organizations are substituting an inferior good (non-physician provider) for the physicians. Even though this seems to be an



unethical decision, the “deskilling” of labor is used in most managed care systems to contain medical costs.

Why? If they really are substitutes ⇒ what's the problem? Focus on quality issues - this is part of the overall concern w/ managed care.

Focusing on the supply of inputs into medical care has definitely slowed the inflation of medical costs. In addition, managed care facilities have also focused its attention on integration of medical services as well. The managed care systems have taken full advantage of the benefits that vertical and horizontal integration has to offer. Vertical integration is focused, by the MCO's, on all the services that go in to the production of healthcare for their patients (Phelps, 1997). These efficient systems not only reduce duplication of services but also provide most aspects of the patient's medical care, eliminating many of their ancillary costs. In horizontal integration, managed care organizations buy many of the smaller health insurance groups and use their massive economies of scale to negotiate reduction of prices for physician, long term, and other medical services (Phelps, 1997). Both types of integration not only focus on reducing prices in the present, but as they continue to expand, they will only increase their effectiveness in the future.

Since the onset of managed care, these institutions have come under heavy fire concerning the quality of health they provide (Buchanon, 1998). The healthcare industry in the U.S. is unique in that every one of its citizens can provide a definition for health. The irony behind this is that there is no one standard insured members can go by, to see if the quality of health they are receiving measures up. Within America there is no adequate level or decent minimum that health can be measured against (Buchanon, 1998). The fact is, health is a hard measurement to achieve. For this reason, many studies of the quality of health focus on inputs instead of outputs (Olsen, 1993).

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Under managed care we have all ready established that the way they control costs is to “deskill” the quality of their labor. It also has been established that managed care’s focus is to contain costs. So it is a safe assumption to make that the quality if inputs into managed care are not equal to that with which people are accustomed under indemnity plans. However, many people believe that these cost containment techniques lead to inadequate health (Buchanon, 1998). This faulty thinking contributed to the increase in medical costs. People wanted the best medical care that money could buy and since the individuals with health insurance were not paying this full amount, they did not care what the full price was. Under the fee-for-service plans people were lead to believe that it was their right to receive this expensive technology.

With the increasing number of employers switching to managed care organizations it gave the people a lesson in economics. In the real world exists scarcity. That means there are not enough resources available to satisfy individuals limitless wants. Scarcity is prevalent throughout all aspects of society, including the healthcare industry. It is just not conceivable or justified to provide the highest quality of care that is technologically feasible in every situation. It wasn’t this way under fee-for service plans and the health system as a whole benefited from this inefficiency, but society suffered from the inflation of medical care. In today’s society managed care organizations have no obligation to give this expensive technology, but actually have incentives to suppress this quality in order to maintain their focus.

Therefor managed care providers focus on other ways to improve the health of their patients instead of expensive experimental treatments. These organizations spend large sums of money each year on preventative care (Buchanon, 1998). Stopping a bad

habit or creating better eating habits lead too increasingly healthier patients but also prevents these same patients from developing chronic illnesses caused by these habits. In the eyes of managed care organizations, they can spend small sums of money for prevention or large sums of money for treatments.

TV Conclusion

Overall managed care has done an effective job at controlling the cost of medical care. In the future managed care will continue to provide cost efficient medical coverage. With the continued and expanded use of the integrated delivery systems the quality will only get better, but the cost of care will decrease as the excess fat is trimmed from the these stream-lined delivery systems.

Evidence?

However, with the outcry from many people concerning the ethical behavior of managed care systems, changes are sure to develop. Current periodicals are full of horror stories that depict vivid images of managed care that strike deep-seated emotions of the American people. For example, the article in the U.S. News and World Report concerning a young woman, named, Jacqueline Lee. Mrs. Lee was brought into the emergency room unconscious, battered, and bloody. Her HMO denied her claim due to lack of pre-authorization (Shapiro, 1998). Stories such as this one are sure to force legislative changes in the future. Many states have all ready been working on a "Patient's Bill of Rights" that will prove to be a health standard and impose at least decent minimums that managed care organizations can be expected to maintain in the future (Buchanon, 1998).

Given the expectations ingrained in health-insured individuals beliefs under the fee-for-service system, managed care is not measuring up. In addition, people do not know how to react when their medical care is being rationed. These individuals are

saying that it is unethical to ration medical care, but the fact exists that rationing medical care is what is slowing healthcare inflation. As mentioned before, it is not only ethical for managed care organizations to function this way, but cost-efficient as well.

Managed care is doing the job of controlling healthcare costs, while at least maintaining the same level of health (Olsen, 1993). However, to provide for a viable future these organizations must change societies thinking from the inefficient days of over-utilization, to the new era of cost containment.

## Decent Job

- You tended to overstate your case & could have provided more evidence.
- A little work on the analysis & although you laid the basics down.

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