

### **Quo Vadis, Managed Care?**

I debated with myself at length whether it was wise to open the emotion-packed topic of Managed Care once again. The conclusion I reached was that revisiting Managed Care's ills and benefits of the past is an exercise in futility. Since Managed Care does affect almost all of our professional lives to a significant degree, and since Managed Care will be with us in one form or another, I decided to polish my crystal ball and look at the future of that phenomenon that has evoked so much controversy and argument among purchasers, providers and consumers of healthcare alike.

Subtle but significant changes have already occurred and are continuing to occur. Recognizing that specialist usage did not materially increase when patients were allowed self-referral, PCP referral requirements were dropped by some of the larger health plans. More and more we see Managed Care firms dropping pre-authorization requirements on a variety of tests, and many plans have allowed patients to see out-of-network physicians by charging a higher co-payment. Electronic verification of patient eligibility is on the rise. All together, these changes have a positive impact on the workload of physicians' office staff and on the attitudes of patients toward their health plans.

But major changes loom large on the horizon for health plans. Interestingly, the changes are neither patient- nor physician-driven. Troubled by the never-ending increases in healthcare costs (overall healthcare spending in the US is estimated by the Centers for Medicare and Medicaid Services to increase from \$1.4 trillion in 2001 to \$3.1 trillion in 2012) for their employees, major employers in all parts of the United States are forming coalitions to force health plans to change their *modi operandi*.

Several additional factors are at work: Because of the constant advances in information technology, healthcare providers are generating huge amounts of useful data. Healthcare consumers are rapidly becoming well informed. The issue of quality is rising to the forefront to such an extent that a business case is being made for quality. Large employer-purchasers of healthcare are demanding that health plans provide them with performance data in order to judge and rank the plans.

Once again, but this time with much greater support from the major purchasers of healthcare and some of the avant-garde providers of healthcare, the concepts of best practices and standards of care are talked about in the healthcare field. The Pacific Business Group on Health, a coalition of large businesses caused several of its health plans to encourage affiliated hospitals – to be sure through financial incentives – to establish computerized prescriber order entry (CPOE) systems because of the ever-present patient safety issues associated with drug orders and the associated medication errors.

Some healthcare systems have forced their associated health plans to come up with sets of quality measures applicable to all the plans. In the East and the Midwest, a coalition of large employers is offering bonus payments to physicians who meet their plans'

performance standards. The initial thrust was to establish an algorithm for the care of diabetics. Other performance standards have been developed, and more are being created.

The National Committee for Quality Assurance (NCQA), a private, not-for-profit organization has sponsored HEDIS®, (Health Plan Employer Data and Information Set) a set of standardized performance measures intended to provide information to purchasers and consumers of healthcare and allow them to compare the performance of managed care plans.

The emphasis of HEDIS has been on key illnesses and healthcare issues. Recently, 11 new measures were published by HEDIS. Three of these are patient service related, and eight deal with clinical issues.

The clinical measures deal with such issues as outpatient management of heart failure, appropriate treatment of children with URIs, appropriate treatment of children with pharyngitis, colorectal cancer screening, management of urinary incontinence in older adults and others, while the patient service measures deal with claims timeliness, call answer timeliness and similar issues. Detailed information about HEDIS® is available from the HEDIS and NCQA web sites.

It is clear that large employers and employer coalitions are exerting significant pressure on managed care organizations throughout the nation to switch from cost-cutting by benefit limitation to cost reduction through quality improvement. Opponents of managed care protest that these measures will increase costs rather than lower them and legitimize cookbook medicine. Early data indicate that best practice care brings significant downstream benefits with respect to outcomes and cost. Rewarding consistent high quality of care as evidenced by appropriate outcomes may make good sense.

At this time, the consumers of care are not yet sophisticated enough to make health plan decisions on the basis of the quality of the plans' providers, but the Internet is making rapid progress in raising the level of knowledge and understanding of matters medical among the general population. The real impetus for measuring the quality of healthcare provided by plans will, for some time yet, come from employers who bear the brunt of the expense of the health insurance costs for their employees. For these employers, most of whom compete in a global economy, cost reduction is essential to remaining competitive.

Accreditation of health plans by organizations such as NCQA and others is well under way and will soon be the primary basis for selection of plans by large employers and employer coalitions. NCQA is working with several of the major disease-specific organizations such as the American Diabetes Association and the American Heart Association to develop additional quality measures.

As yet in their infancy, consumer directed healthcare (CDH) plans have been implemented by some large employers as an alternative choice for their employees. While there are several variants of CDH plans, the most common model allows

employees – with the help of data furnished by the plan – to select a panel of physicians as “their panel”, select hospitals and outpatient treatment facilities of their choice, and decide, based on co-payment and deductibles choices, what their monthly insurance premiums should be. Among the major insurers, Aetna Inc. has invested heavily in technology and e-tools in its quest to become the industry leader. Aetna currently plans to establish a provider evaluation feature based on patient feedback by the end of this year. The feature (entitled “Evaluate Your Health Care Provider”) will ask a variety of questions. Among them will be questions dealing with office waiting times, ease of making appointments, availability of the physician after hours and on weekends. A visit to [vivi.us.com](http://vivi.us.com) gives the opportunity to view a four-minute demonstration on how a consumer would make plan decisions. The Vivius plan introduces the element of provider competition for patients based on, among several other criteria, fee levels.

After evaluating several CDH plans, DuPont Co. of Wilmington, Delaware selected Aetna's CDH plan and offered it as an alternative to several other plans to its employees under the name of “Consumer Choice”. At its first offering this year, approximately 9 percent of DuPont's employees chose to join the plan.

Whether or not these new concepts will succeed is still anyone's guess. What is clear, however, is that buyers, providers and consumers of healthcare are desperately seeking less costly alternatives to the currently available models of managed care.

The winds of change are blowing briskly in the managed care field, and for once, if quality of care becomes the issue of the day, the anticipated changes may be beneficial. Only time will tell, but I believe that cautious optimism is not inappropriate.

**Suresh C. Anand, M.D.**  
**President**