

Optimizing Growth Opportunities during the Managed Care Revolution

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Despite reports to the contrary, managed care is pervasive and growing. By understanding employers' needs and how those needs are forcing managed care to change, hospital and physician provider organizations can create growth opportunities for themselves. To optimize their organizations' financial performance under managed care contracts, healthcare financial managers of providers should develop an overall managed care strategy for their organizations that includes customer-service initiatives and system planning and development, instead of focusing only on contract negotiation.

Hospital and physician provider organizations have welcomed recent predictions of the demise of managed care, hoping it will spell the end to financial challenges brought about by managed care. In reality, however, managed care is more pervasive than ever. An October 2001 study performed by InterStudy found that HMO enrollment for the past several years has been leveling off, but it is not dropping as dramatically as many in the press have concluded.(a) Providers would be wise to pursue growth opportunities in managed care aggressively rather than expecting the end of managed care.

Because the annual growth rate of managed care enrollment has slowed to 5 to 6 percent from its normal rate of 12 to 18 percent, it now is possible to examine the positive impact of certain HMO practices and the negative impact of actions by some payers. These observations then can be used by providers to develop an institutionwide managed care policy that optimizes their growth opportunities.

All industries go through cycles of change. In *The Innovator's Dilemma, When New Technologies Cause Great Firms to Fail*, Clayton M. Christensen points out that the disruption of the insurance industry by HMOs forced many insurance organizations to develop innovative new managed care products and services to combat the movement of policyholders to HMOs.(b) Christensen contends that this disruption had a positive influence in forcing large insurance organizations to become more efficient to avoid an acquisition or merger or the need to exit the health insurance industry altogether.

Managed care features exist within every insurance carrier, including Medicare. Every self-funded or self-insured employer depends upon its third-party administrator to set restrictions and make payment determinations based on medical fee schedules and definitions of medical necessity, just as managed care insurers have done. Consequently, managed care exists throughout the United States, but has varying levels of influence in various markets.

Managed Care Revolution

The HMO Act of 1973 mandated that employers offer HMO options whenever traditional insurance options were offered. Employers have reported, however, that if a PPO or HMO option

is offered to their employees, the competing traditional healthcare insurance organization may threaten to not renew its contract with the employer, thereby abandoning employees enrolled in the traditional plan. Under such circumstances, an employer must seek either another traditional insurer or a managed care organization that also offers traditional product lines. As a competitive strategy, therefore, managed care organizations are expanding product lines to include traditional insurance options in addition to point-of-service plans (POS), workers' compensation plans, PPOs, and HMOs.

The restrictions inherent in a traditional HMO created savings that could not be realized through indemnity insurance products. Because they could not entice enrollees away from the indemnity insurance option, HMOs developed an indemnity option with HMO-like restrictions that subjected employees to limitations regardless of the insurance option they chose. These restrictions, along with more restrictive contracts with physicians and hospitals, created a situation in which the employer was taking away the enrollee's choice of health plans by offering products from a single carrier. As a result of the restrictions and the perceived lack of choice, many HMOs had to defend themselves in court against care-denial and medical-necessity challenges. The situation has led the Federal government to propose and several states to enact a patients' bill of rights.

In response to legal and political pressures, insurers removed some restrictions and began to offer enrollees a process for appealing care disputes as required of all Federally qualified HMOs by the HMO Act of 1973. Insurers that did not want to pursue Federal qualification lost the early opportunity to adopt an appeals process to meet consumers' needs.

Loosened restrictions and controls have led to rising medical expenses and, therefore, higher premium costs. Not long ago, HMOs and other managed care plans would have attributed premium increases to rising prescription drug costs, but the increase in two- and three-tier drug benefit programs that pass some drug costs along to enrollees has helped to control costs. Managed care plans now attribute higher premiums to the rising costs of inpatient care. But employers responding to higher premiums this time are unwilling to accept cost-management efforts that intrude upon enrollees' choice of physicians.

If HMOs ease some restrictions (e.g., authorization requirements and requirements for physician credentialing), high-cost and perhaps medically unnecessary procedures may adversely affect insurer's premiums. These rising costs are likely to sap the profitability of managed care plans that have become increasingly sensitive to financial losses and setbacks, particularly in the present economy.

Although most providers maintain that they are exiting the risk business and capitation contracts, some large provider systems and medical groups are continuing to manage their medical expenses profitably under capitation. Due to product-line and organizational-model changes over the past five years, the original, "classic" HMO that was intended to be a provider-driven and community-owned structure is evolving into a less-restricted model similar to indemnity insurance. Managed care structures that are owned and operated by insurers are very different from the classic, provider-sponsored health plan and HMO structures, just as insurance-owned, for-profit payer entities that claim to "manage" care but merely limit access are very different from community or regional healthcare delivery systems that believe in quality, access, and affordability.

For example, critics now assert that the delegated-risk managed care model that has been popular on the West Coast for decades tends to destabilize medical networks, drive up costs, and limit access. In the late 1970s, when physician groups took on delegated risk, they received one check for capitation and often were paid in advance of the service. But physician groups suffered when capitation rates plummeted, capitation payments were delayed, and insurers focused on paying nonphysician investors out of their profit margins rather than on funding care.

In New York, however, where there is little delegation of risk to providers in managed care contracts and managed care still is in its classic form, the discussion of delegated risk is replaced by an emphasis on annual fee renegotiations. Such discussions do not consider improvement of care or the value of managed care to a community.

It is interesting that both California and New York have provider-owned staff-model organizations (Kaiser Permanente in California and Health Insurance Plan of New York) in which physicians balance care goals with financial objectives, rather than being contractors in a series of financial transactions. Staff-model organizations offer a traditional HMO product to compete against larger independent practice associations and payer-owned products offering large provider networks. These provider-owned plans require enrollees to pay a significantly higher price, in some cases, to obtain comparable access to physicians.

Many provider organizations currently are questioning why they should expect a PPO that presents no steverage advantages to pay the same capitated fees as are paid by an HMO that guarantees a certain number of patients. Yet in many ways, the payment approach is beside the point. Providers are at risk whether they receive capitation payment or not, because any inefficiencies inevitably will expose a growing healthcare delivery system to increased enterprise risk. Even on a fee-for-service basis, there is a limit to the inefficiencies the managed care consumer or HMO will subsidize.

The provider has a financial risk of not being able to effectively recover payment for services rendered because its billing system cannot monitor payment writeoffs or cannot bill properly using the complicated rate structures negotiated, or its clinical data system does not illuminate denials on medical-necessity grounds that can be challenged. The possibility of underpayment of claims grows as managed care insurers consolidate, often gaining stronger negotiating positions, and as plans lose business due to mergers of large employers and reduce claims payments to make up for premium shortfalls.

The hospital or physician network also endures marketing risk if the managed care plan it selects is not, or ceases to be, the marketplace leader. Contracting with a noncompetitive or declining plan can lead to shrinking patient volume or employer dissatisfaction with the insurers' customer service or pharmacy benefit management.

The Consumer Focus

In some markets, managed care payers are developing consumer-based products, such as Section 125 offerings in which consumers obtain a lower premium price but have very high deductibles,

and defined-contribution products that allow consumers to bypass the employer, set aside funds in a retirement-like, tax-free account to pay for medical expenses, and select providers for their own network based on price and outcomes. Employers purchase catastrophic insurance on behalf of each consumer, but the coverage options are designed to make consumers more sensitive to price and quality in choosing their healthcare delivery.

Last year, employers that wanted to use defined-contribution programs to share costs with employees instead determined that, because of the wildly strong economy, it was more important to maintain existing benefits to retain employees. The current weaker economy and increasing layoffs are likely to encourage the use of defined-contribution plans by employers. As premiums increase and defined-contribution plans give employees greater choices about how to spend their healthcare dollars, many prospective enrollees will find HMOs more attractive than ever.

The Provider Response

To remain competitive in markets where the new, consumer-focused products are being offered, healthcare providers should focus on improving customer service and management of delivery systems so that their prices, convenience, and quality are attractive to consumers. This focus is particularly crucial in such markets because payers and employers no longer can be depended upon to maintain and increase patient volume for providers. If hospitals are not selected by consumers for whatever reason, the impact of this loss of business may not be recognized for months. Consumers typically choose a provider on the basis of their experience with that provider. It therefore is critical for providers to focus on enhancing quality and consumer relations.

Large payers have continued to merge or even leave the health insurance business recently for a variety of reasons, including reluctance to bear the costs of preparing to meet HIPAA requirements and lack of critical mass to sustain profit margins. Payers that exit the market leave thousands of enrollees to enroll in plans offered by other payers or providers. Providers therefore could experience the collapse of their highest-paying payer and subsequent enrollment of the abandoned enrollees to the lowest-paying payer. In areas where large employers are merging and dropping local payers in favor of large, single-payer options, providers are receiving reduced payment for a large volume of patients.

Providers therefore may want to focus on more than fee schedules and prices when negotiating contracts with payers. It may be advantageous to negotiate the terms of the agreement that affect timely payment and the definition of medical Necessity so that claims denials will be minimized. Providers also may want to negotiate a successorship clause in the contract so that they are guaranteed an ongoing relationship with the payer even if the payer should be acquired or if some employers decide to offer employees defined-contribution plans or point-of-service plans rather than traditional health plans.

Opportunities for Growth

The theory of "industry stall" says that smaller enterprises can take market share from larger corporations by offering better customer service, value pricing, and improved use of technology. If growth is the imperative, then effective management of care should be a core competency of the

provider rather than the insurance organization. A lack of real medical management by providers encourages insurers to manage claims - perhaps through the use of delays and denials - rather than manage care.

The provider also should emphasize strategic planning to achieve long-term goals and de-emphasize cost-cutting efforts, which historically have had disastrous short-term and limited positive long-term effects on the organization's viability and growth.

Providers may need to affiliate with a licensed payer to finance care or design and develop their own community health plans to combat the possibility of inadequate payments. Providers steered clear of developing their own health plans in the past because of consumers' dissatisfaction with HMOs. However, results of a Kaiser Family Foundation survey suggest that public opinion is shifting once again in favor of managed care.(c) This shift is likely to continue if the economy worsens and premium costs exceed employees' ability to pay them.

Conclusion

The health insurance industry is in the process of reforming itself, because employers are demanding more value from health insurance products. Healthcare providers that are better prepared to truly manage care as a core competency within their organizations are more likely to succeed with their growth plans. By focusing their efforts on improving delivery, providers can move beyond merely negotiating rates and terms each year to improve processes, create innovations, and contribute services to the community as a local delivery system.

Managed care should be central to the overall corporate strategy of providers that want to focus on growth versus mere cost cutting. As the number of payers is reduced and greater influence is wielded by payers remaining in the market, providers that can manage care effectively in a predictable and measurable fashion may find that it is best to pursue an integration strategy to provide the full spectrum of healthcare services, without entering capitation contracts with payers. By avoiding such discounted payment arrangements with payers and developing an institutionwide approach to managed care, healthcare providers can reap the optimum financial benefit from their efforts to minimize clinical costs.

- a. *HMO Industry Report 11.2*, St. Paul, Minnesota: InterStudy Publications, October 2001.
- b. Christensen, Clayton M., *The Innovator's Dilemma: When Technologies Cause Great Firms to Fail*, Boston, Massachusetts: Harvard Business School Press, 1997, pp. xv, xxv.
- c. Kaiser Family Foundation/Harvard School of Public Health, *National Survey on Consumer Experiences with and Attitudes toward Health Plans: Key Findings*, August 2001.

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