Dummies' Guide to MANAGED CARE

Have you heard of managed care? If you are a GP or specialist in private practice, I'm sure you have. However, if you are an institutional slave (like me) or an institutional master, perhaps you haven't. Managed care has been a problem for our colleagues in the private sector over the past two decades and it's only getting worse. But despite efforts by various organisational bodies, those in authority seem reluctant to take a stand on it.

WHAT IS MANAGED CARE?

Recently, *TODAY* published an article[1] that highlighted some concerns with managed care practices. A guide to managed care had also been written in 2011 by then-editor of *The College Mirror*, Dr Wong Tien Hua.[2] Invited by the Editor to write, I hope to break down managed care into something even simpler to understand, especially for those who still cannot see or refuse to accept that managed care is a problem. (Do I really have to come out and state who you are?)

In my innocent schooling days long ago, I thought that medicine was all about a straightforward doctor-patient relationship. But then, in the grown-up's world, there are many other players involved: hospital administrators, the Ministry of Health (MOH), patients' employers, insurers and this business of "managed care".

Very broadly speaking, managed care or managed healthcare refers to various methods intended to reduce healthcare costs while improving quality of care.[3] There are many different providers with different business models in the market. One common model asks patients to pay a small sum as copayment (eg, $5 or 10% of the bill) at panel clinics. In others, the medical plan covers the entire visit and patients do not need to copay. The doctors who are on the panel pay 10%-15% of their charges as administrative fees to the provider. Pay attention here, because this is going to be important later.

PROFILE

TEXT BY

SK WARRIOR

"SK Warrior" is the alter ego in each of us who has to regularly face challenges in our work, and gracefully overcome obstacles of all forms, with a smile. May the SK warrior live on in you forever and continue to do SK work for the betterment of your patients.

"Ours not to reason why, ours but to do and die."

HOW DOES MANAGED CARE WORK?

Scenario 1: doctor + patient

A patient has symptoms of upper respiratory tract infection (URTI) and sees his GP, who charges $25 for consultation and three medications (generic paracetamol, antihistamine and a cough suppressant). For branded medications, the patient will need to pay more from his own pocket. The patient pays up the $25, which goes to the doctor to cover his consultation, practice and medication costs.

Scenario 2: doctor + patient + company

Now the situation gets a bit trickier. A company wants to provide health benefits to its staff and sets aside a certain budget to cover the medical costs. The HR department thinks that it is possible to better manage the health benefit budget by approaching doctors directly to negotiate for an agreed fee for "simple" vs "complex" patient encounters. It comes up with a list of "panel doctors" and issues a directive that their staff can only see these panel doctors for treatment in order to be reimbursed. In some cases, the company also states that it would only accept medical leave from its panel. The company's HR department administers the panel clinic by appointing doctors to the panel and deals with the panel doctors directly, incurring significant administrative time and cost.

In such direct company panel schemes, the company's panel doctors benefit from a steady pool of patients – say 500 employees of this company. If all have simple acute problems, $25-$40 can cover consultation and medications. The company can minimise their employees making large claims, negotiate with doctors to control cost and enlist doctors in managing sickness absence. Seems like a good and fair deal.

Scenario 3: doctor + patient + company + TPA

Now, this is even more complicated. TPAs are third party administrators (third parties are seldom welcome in ANY relationship), who may or may not sell insurance and may be run by a business entity. But what do they actually do? They help companies reduce the administrative costs in claims and reimbursements. So, companies pay them a sum to handle the process, which presumably works

out to be less than if they handled it themselves. Not only do TPAs take payment from the companies to handle the medical benefits scheme, they also charge the doctors a 10%-15% administrative fee (aha! Were you paying attention?). Additionally, TPAs have their list of preferred doctors.

Preferred doctors? This refers to doctors who agree to pay the TPAs 15% of their fees. For simple acute conditions, 15% of $40 is $6. That sounds okay for administering the benefits plan, entering the data of each visit, tracking the expenditure and signing a cheque/bank transfer to the doctor at the end of the month as payment for seeing the patients.

Scenario 4: (non-panel) doctor + patient + company + TPA

But what if, just what if, a patient's cough turns out to not be a URTI? Let's call the patient Mr Lim, whose cough was persistent. The responsible GP orders a chest X-ray ($35) that showed a lung mass. The GP then refers Mr Lim to a lung specialist. A CT scan ($600) was done, followed by curative surgery: thoracoscopic lobectomy ($5,000) and in addition, all the other costs of blood tests, histopathology, medications, and intensive care unit and general ward stay of five days. Mr Lim pays for them and submits the claims to his company/insurance, confident that it will be covered for (or up to 90%). TPA receives the claim and finds out that the surgeon is not on its preferred list, which the patient should have checked before making an appointment. The TPA will decline Mr Lim's claim.

IS THE ARRANGEMENT REASONABLE?

The problem we see here is that the basis of having a specialist on the TPA's panel is regardless of skill or experience, but solely on the specialist's acceptance of a 15% payment to the TPA. For a $5,000 procedure, 15% is $750. Is it reasonable to pay $750 for an administrator to do data entry and fill in forms? An offhand example is the booking fees for SISTIC: $1 for each ticket that costs $20 or less, $3 for tickets priced at $20.01-$40 and $4 for those above $40. Please, I find even the $1 SISTIC booking fee ridiculous when the whole process is online and I do my own collection of tickets. Why is the booking fee dependent on the ticket price anyway? Is more ink or more bytes used when the ticket price is higher? Thank goodness for YouTube.

SO IT'S ALL ABOUT THE MONEY?

Yes and no. Yes, because our colleagues in private practice run a business – they need to make enough to cover rental, staff remuneration, medications, maintenance, electrical and water bills, insurances, licenses… and their own salaries, of course. The first few years are tough. It's tempting to sign up with various TPAs that promise to send patients their way for a cut of the fees. But don't forget… there are **many** TPAs out there, with **many** panel specialists. What makes you think you're special? Also, did you know that some TPAs are late on payment and not just by a few days, but by a few months!

No, because by limiting the access to care, a patient may not get referred to the best appropriate specialist to manage his condition. Imagine if Mr Lim was not referred to a thoracic surgeon directly, but to an internist or a general surgeon, because there was no option on the panel. There might be unnecessary time spent in doing a workup before definitive treatment, as well as incurring more costs. Also, patients should always have a choice in deciding which doctor they want to see.

IS MANAGED CARE ALWAYS BAD?

Dr Wong Chiang Yin, in his president's column[4] in 2008, has laid down the pros and cons of managed care, as well as given invaluable tips on how a doctor should approach it. In its ideal form, when first conceptualised, managed care should serve to lower costs for all involved. However, human greed and profiteering have now created a monster with many heads.

WHAT NEEDS TO BE DONE?

In my humble opinion, doctors need to know what they are getting into as far as managed care is concerned. Sure, SMA can advise doctors on how best to protect themselves from being eaten alive by this monster, but the individual doctor too must play a part. The word is that SMA has been actively engaging the powers that be to look into reining in this monster. Let's hope we have a Hercules among us! ◆

References

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