MANAGED CARE TRANSPARENCY AND TRUST

Illustration: Dr Kevin Loy

PROFILE

TEXT BY

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Managed care has been a feature of our healthcare business landscape for many years and a number of third party administrators (TPAs) have come and gone. Doctors, especially GPs in the private sector, have been dealing with such business practices for a long time and are familiar with the role managed care plays in corporate contract medicine; the business model and increased patient load it provides for the GP; and also the many frustrations related to the restrictions and administration burden imposed from such schemes.

The SMA thought this was a matter of sufficient concern to dedicate our 37th annual national convention to the topic of managed care. That event, chaired by Dr Tan See Leng, was held a decade ago in 2006. At that convention, I spoke on the economic considerations of joining a managed care scheme. I stated that the main problem with managed care, which was also the constant source of complaints from fellow GPs, was the low remuneration for GP consultations. Complex claim procedures and increased administrative workload were also part and parcel of joining a managed care scheme. Margins for drugs and procedures were low and late payments for services rendered were a common experience, exposing the practitioner to financial risk (https://goo.gl/vz2Q63).

We conducted surveys on managed care in 2003, 2006 and 2015, with the latest survey results published in our May 2016 edition of *SMA News* (https://goo.gl/k6E28F). Unfortunately, the situation does not seem to have changed much and in some cases, it seems to have gotten worse. Dissatisfaction with managed care remains high. The main cause of dissatisfaction was with the payment of fees, with an overwhelming 92% of respondents agreeing that the fees have not increased over the last

ten years. Late payment of fees to the medical practitioner remains a problem, as were restriction on choice of medication and on referral to specialists.

IS MANAGED CARE HERE TO STAY?

Corporate sponsored healthcare is an important and integral part of employee benefits; most companies in Singapore will provide some form of medical benefit coverage. The HR departments in charge of such benefits used to source for company panel doctors and negotiated with them directly for some form of agreed fee based on services provided. TPAs were later formed to fill the need of the companies to offer a more comprehensive medical coverage to their staff. TPAs offer a ready list of medical providers and are able to remove the administrative burden of managing the data collection and payment for each transaction.

Company costs are kept in check ("managed") by such TPAs who oversee the scheme. In theory, TPAs are supposed to select their doctor partners through some criteria that ensure a specified standard of quality of care for their clients. Patients who are under such schemes enjoy convenient access to healthcare services at an affordable price. This means that patients are able to seek medical attention easily, obtain early medical intervention, when needed, and avoid expensive treatment at a tertiary centre if the condition was allowed to worsen.

Despite these advantages of having managed care schemes, there are, in reality, many problems as well. I shall highlight two issues – the first being the way administrative fees are charged and the second, the issue of lack of transparency.

THE PROBLEM WITH COMMISSIONS

TPAs charge an administrative fee to the doctors who join their scheme. In many instances, this administrative fee is computed as a *percentage* of the total fees charged by the doctor. This type of fee computation is akin to the paying of sales commissions to property or insurance agents in their respective sectors. Sales commissions are used in these sectors because they are strong motivators that align the incentives of sales staff. If no sale is made, the staff does not get the reward. For TPAs however, there are no "sales targets" to achieve but they get the "commission" regardless of the effort. There is no extra administration incurred between a simple and complex procedure that a doctor performs on the patient under the scheme. Moreover, the TPA does not share any financial risk and is unlikely to get sued by the patient if the outcome is bad.

This problem of charging a percentage of the doctor's fees becomes more complex and nuanced when it involves specialists. In recent years, the private specialist sector saw financial pressures from all directions with stiff competition as more specialists leave the public sector, higher property and rental overheads, and a reducing pool of both local and foreign patients due to external economic factors. This has resulted in more specialists who are willing to accept a percentage cut of their total bill to sign on to managed care schemes with TPAs.

TPAs offer specialists a large referral pool of patients from their panel GPs, who in turn are obligated to refer to specialists under the same scheme. You can see that the percentage fee computation quickly becomes a lucrative figure in the specialist market, especially for complicated and expensive procedures. However, this is not ideal for patients because the referring GP is restricted in his choice of referral. Instead of being referred to a specialist with the patients' best interest in mind, patients are referred to specialists who are willing to share their fees with the TPA. The system sets up a conflict of interest and we have to ask frankly if our patients' best interest is served.

THE PROBLEM OF TRANSPARENCY

TPAs render the transactions between the doctor and his patient opaque, thereby obscuring the trust that is needed in the relationship. In the traditional fee-for-service model, the patient pays the doctors' fees after services rendered. With itemised billing, the patient knows how much of the bill was charged as the professional fee, procedural fee and medication costs, if any. With managed care, the patient does not know how much the doctor is being paid. The patient's employer or insurance company who pays for the scheme is also unaware of how much goes to the doctor and how much is retained as administrative fees by the TPA. The expectations of the patient, who was promised a certain suite of medical benefits, cannot be matched by the reality of the managed care scheme, and this can lead to erosion in the doctor-patient relationship.

TPAs charge both the clients (patients/employers) and the providers (doctors), which raises the question of whose interest they represent. Doctors who are sponsored by pharmaceutical companies for talks must declare their interest and researchers who publish sponsored research have to declare their vested interest as well. No such rules apply to TPAs currently,

who are free to serve their own interests when they benefit from both clients and providers.

Patients who are referred to specialists on a preferred panel would expect their primary care physicians to use their professional judgement to recommend a colleague best suited for their contextual problem. However, patients are not aware that the selection of the panel specialists is based on the willingness of the specialist to allow the TPA to retain a fee for the treatment. The more such referrals are made, the more TPAs benefit. This example goes against the trust that patients place in their doctors.

WAYS TO ADDRESS THE SITUATION

The SMA Advisory on Managed Care Contracts was issued in 2009 (https://goo.gl/J0ELPp) and remains as pertinent in today's environment as ever. We stated the lack of transparency in managed care schemes and highlighted examples to our members. Doctors are obliged to act in the patient's best interest, regardless of the terms of the contract, and remain professionally responsible for the patient's well-being.

As an association, we will continue to highlight examples of unfair contracts and questionable terms that put our members at a disadvantage. Our frequent surveys of attitude towards managed care companies help to shed light on their performance. I urge these companies to take a serious look at the results and strive to improve their services, correct any shortfall in their reimbursement processes and engage their partner providers to resolve issues instead of allowing frustration to build up.

Patients of managed care schemes should be given a breakdown of the charges incurred after each encounter to improve transparency. TPAs need to be clear on whose interests they represent when they derive their income from the client and the provider. TPAs should re-examine the practice of charging fees calculated as a percentage of the doctor's fees, especially when it involves large bills such as hospital procedures, and should perhaps adopt a transparent and fixed administrative fee structure to reduce conflict of interest. Finally, doctors should refrain from joining managed care schemes that they think will eventually compromise the quality of care that they wish to provide. ◆

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