Medical Law and Ethics
Handout 1.7
Managed Care in the United States

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In this handout we are going to discuss the administrative structure of managed care in the United States. Healthcare has been constantly evolving as new developments in technology and clinical research arise. As a result, critical issues such as rising healthcare costs and inability to access quality medical care create barriers for many Americans in the 21st Century.

The healthcare environment integrates several different factors in an individual's life including (but not limited to) culture, ethnicity, gender, family structure, and religious beliefs. Healthcare professionals treat diverse populations and must adapt to the changing healthcare landscape.

It is important for a healthcare professional to respect a patient and his/her family's wishes throughout the treatment process. Although this plays a significant role regarding the relationship between healthcare professionals and patients, ethical dilemmas may come into play when the opinions and beliefs of these healthcare providers conflict with those of their patients' (as well as their family's). In the last part of this handout, we will examine the conscience clause where a healthcare professional's beliefs might make it difficult to perform certain procedures (e.g. abortion).

In the next handout (Handout 1.8), we will finish discussing managed care by looking at the different types of medical practices as well as discuss the roles of allied health professionals who work together with physicians.

Managed Care in the United States

Managed care in the United States experienced a major change with the passage of Medicare and Medicaid in 1965. Due to increasing life expectancies and advancements in medicine, the aging American population has been steadily growing since these programs were passed. In addition, the demand for quality healthcare services has also increased.

Health insurance coverage covers costs resulting from illnesses or injuries. For example, if an individual is hospitalized or has screening tests performed, insurance should cover a portion of the expenses related to these necessary procedures and stays.

In a **fixed-payment plan**, members pay a monthly fee and in return, they get access to medical services and care. Health maintenance organizations (HMOs) operate under this system. We will discuss HMOs in more depth later on in this handout.

Insurance companies fall under a group called **third-party payers**. Third-party payers are parties other than the patient who handle the responsibility for paying the costs of a patient's medical bills.

Managed care becomes more complex due to insurance companies, healthcare providers, and patients seeing things differently. Since patients want comprehensive quality care, healthcare providers have more tests and procedures performed to avoid negligence or malpractice lawsuits. On the other hand, insurance companies want to keep reimbursement costs low and save money. The issue of medical necessity regarding these tests and procedures lead to each party examining "**who decides what is or is not necessary?**"

The structure of managed care is designed to keep the costs of health related services down and ensure that only necessary medical procedures are performed. In managed care, a **gatekeeper,** such as an insurance company or a primary care physician (PCP), approves nonemergency medical services, procedures, and hospital stays as well as manages referrals to specialists.

The **primary care physician (PCP)** is the physician designated by the HMO to handle the enrolled patient's medical care. As stated in the previous paragraph, PCPs manage which procedures and tests the patient needs and refer them to a specialist if specialized services are required. Specialists have advanced education and training in fields such as dermatology, neurology, gynecology, or radiology.

Patients have the choice to select a provider or specialist to handle their medical needs (as long as it fits within the constraints provided by the managed care organization they subscribe to).

Since we touched upon managed care organizations, we can define what they do. A **managed care organization (MCO)** is a medical plan that pays for and manages a patient's medical care.

We noted earlier that the MCO has constraints regarding a patient's care. These constraints include:

- **Physicians-** Under this point, the MCO has a list of providers that a patient can choose from, manages the number and types of treatments the physician can

perform, and conducts prior authorization (reviewing medication to check whether or not the insurance plan will cover it) for prescriptions written by physicians

- **Hospitalizations-** Under this point, the MCO has a list of hospitals that a patient can choose to stay in and determines the length of stay (LOS) in the hospital based on their diagnosis

- **Specialists-** Under this point, the MCO manages the choice of specialists, necessary referral to specialists, and any orders for a second opinion regarding diagnosing and planned treatment

Three types of managed care we will look at are **health maintenance organizations (HMOs), preferred provider organizations (PPOs),** and **exclusive provider organizations (EPOs)**. These forms of managed care were implemented to reduce healthcare related costs and manage patients' use of services and hospital stays.

Health maintenance organizations (HMOs) are types of managed care plans offering a variety of health services for its members for a predetermined fee. The predetermined fee is called the capitation rate. The **capitation rate** is the fixed monthly fee paid by the HMO to healthcare providers to provide medical services to its members. The member will have access to a limited group of physicians and hospitals who will provide these services (regardless of whether they go for services or not).

The capitation rate was implemented to replace the fee-for-service (FFS) model and reduce costs. The fee-for-service model paid physicians for each separate service (services are not bundled). From this you can see that the FFS model was seen as more expensive as the quantity of procedures increases.

As we covered earlier, HMOs utilize a primary care physician (PCP) who handles the enrolled patient's medical care including services and referring them to specialists. The PCP is the gatekeeper who ensures that the enrolled patient only receives necessary services and works with him/her in managing their medical care.

Preferred provider organizations (PPOs) are types of managed care plans where a patient receives care from a physician or hospital under contract with the insurer for an agreed-upon fee in order to receive copayment from the insured member. A **copayment** is an agreed-upon, fixed fee paid by the insured patient for certain medical services or prescription drugs they will receive. Copayments are usually around $10-$20.

For example, a person will pay a lower copayment for a generic drug and a higher copayment for a specialty drug. A copayment for outpatient primary care services will be lower (e.g. $15) while a copayment for inpatient care is higher (e.g. $200).

There may be no copayment required for a few services covered by insurance. For example, the copayment is waived for preventive care services (e.g. cancer screenings, annual physical checkups, or immunizations).

Unlike an HMO, the PPO is fee-for-service and a capitation rate or prepayment is not paid. PPO designated providers are paid based on each medical service they provide. Also, members under the PPO plan are not as limited to the choice of physician or hospital compared to HMO members (and as you will see next, EPO members).

Exclusive provider organizations (EPOs) combine aspects of both HMOs and PPOs. Managed care under EPOs has a selected group of providers, but the providers are paid on a modified fee-for-service (FFS). If a nonemergency service is rendered by a provider who is not part of the EPO group, there is no insurance reimbursement.

Now that we took a look at these forms of managed care, we can begin with examining the federal and state insurance programs in the United States.

Federal and State Insurance Programs

Medicare is a federal insurance program providing healthcare coverage to the following groups:

- Eligible individuals who are U.S. citizens and legal residents aged 65 years or older, worked a certain number of years (usually at least 10 years), and paid Medicare taxes in that job

(The next few do not have to just be 65 years or older)

- Individuals with disabilities
- Individuals with end-stage renal disease (ESRD)
- Individuals with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease

***For more information on Medicare, please see the U.S. Social Security Administration's website.**

Medicare's regulations were established under Title XVIII of the Social Security Act, a part of the Social Security Amendments of 1965.

Medicare expenses grew very quickly which led to problems with reimbursement. The review and organizational process became increasingly complex and this created delays for reimbursing healthcare providers (physicians and hospitals). Since costs were also rising, rationing of medical services under Medicare was put into place. For example, a Medicare recipient may have to pay a certain portion of inpatient hospital expenses as part of their deductible in a given period. Another example is that some services won't be fully reimbursed.

As a result, some Medicare recipients pay for supplemental insurance to cover costs that are not reimbursed by Medicare.

Under current Medicare rules, if a medical service is denied to a Medicare recipient who is part of an HMO, he or she has a right to appeal the denial of treatment.

Diagnostic related groups (DRGs) are designations classifying a Medicare patient by their illness for reimbursement conditions. DRGs were a part of the rationing of Medicare services and implementation started in 1982. The reason behind DRGs was that patients in a category would have similar clinical aspects regarding diagnosis and treatment in a hospital setting. Therefore, these patients under the same category would be expected to utilize the same medical services in a hospital. For example, patients under DRG 202 are classified under Bronchitis with Asthma with Complications or Comorbidities (CC) or Major Complications or Comorbidities (MCC).

Hospitals would be paid a set determined sum for treating a patient under an illness category regardless of how long the patient stays in the hospital. This encourages hospitals to keep costs down, but the downside is that patients may be discharged prematurely. In this case, treatment and discharge may have been rushed before the patients are able to fully recover. Instances of patients being discharged too soon have led to hospital readmissions or conditions worsening (which could have been handled and prevented had there been proper medical supervision if the patient remained under their care for a few more days).

Medicaid is a joint federal-state program providing financial assistance for poor and indigent (without funds) individuals. Medicaid is managed by the individual states and established their own laws to allocate how the funds used for Medicaid are utilized. Similar to Medicare, Medicaid also has experienced rationing. Individuals under Medicaid may not receive access to medical care funding as a result of states not directing enough finances to the Medicaid budget.

Under the law, Medicaid patients must use their excess income before Medicaid will help pay for their medical expenses in long-term care facilities.

Since this can create a financial burden for the patient and his/her spouse, some nursing homes offer a **per diem** (daily rate) option of payment when providing care to the patient. Some states also offer a **prospective payment system**, a system where the amount of payment or reimbursement has a set rate known in advance for these certain procedures such as nursing home care.

To learn more about state financial requirements for Medicaid, please visit www.longtermcare.gov and click Medicaid.

In 2010, the United States healthcare system had another significant development and restructuring when President Barack Obama signed the Affordable Care Act into law.

The goal of the Affordable Care Act was to decrease the number of uninsured or underinsured Americans by improving on the following points:

Under the Affordable Care Act,

- Health insurance coverage will be more affordable and accessible to individuals
- Healthcare related costs will decrease
- The quality of healthcare delivered services will improve

One example that fall under these points is the Affordable Care Act enacting a change extending health coverage for young adults. Under this change, most insurance plans allow children to be a part of their parent's health plan until they turn 26 years old. Before this change health insurance companies removed children at age 19 or later on when a child finished their full time studies.

Ethical Issues in Managed Care

As we had seen from our overview of managed care in the United States, there have been issues with finding a balance: **providing people with equal access to healthcare, economizing (cutting costs) and allocation, and providing quality medical care**.

In Handout 1.1, we discussed several ethics theories. In utilitarianism, the focus is on allocation of resources in which the needs of most people will be satisfied. The negative aspect of this is that not everyone will be able to receive these resources. In Medicare, funds are limited and not all services are fully reimbursable. Another point that we looked at was in regards to organ transplants. Since organs are scarce, the ones benefiting the most will have a higher chance of getting the transplant versus terminally ill and elderly patients who are seen as risky and won't be able to use the organs for a longer period of time.

Another theory was justice-based ethics. The foundation of this theory was a democratic approach where everyone should have an equal chance of accessing and receiving quality medical care regardless of status such as age, gender, ethnicity, or income. However, the American healthcare system is large which makes it difficult to ensure that everyone will get the same level of quality medical care. When it came to giving everyone an equal opportunity to access this quality medical care, the opponents of justice-based ethics raised objections stating that it is unfair for healthy individuals to also subsidize individuals who are more "at risk" health wise. For example, under justice-based ethics both smokers and non-smokers will have equal access to the same quality medical care since insurance rates are all paid equally by the population.

Individuals who have a higher income may receive better care than someone who is poor. As we had discussed in the Medicare section, individuals who have the financial support can purchase supplemental insurance to cover costs not provided by Medicare.

Under Medicare and Medicaid laws (The Stark Law, 42 U.S.C. 1395nn), physicians are prohibited from referring their patients for designated health services in which they (or an immediate family member of the physician) have financial interests, compensation agreements, or ownership (e.g. referring a patient for durable medical equipment or outpatient prescription drugs to companies they invest in).

A major concern in the managed care system deals with insurance fraud. Both healthcare professionals and members of a managed care plan may be guilty of committing insurance fraud. Physicians may bill for services not performed/rendered or billing Medicare or Medicaid for patients they have not treated are a few points that fall under this category. For health plan members, they may conceal pre-existing conditions or lie when filling out enrollment forms (e.g. not disclosing previous coverage).

At the end of this handout, we will keep a few questions in mind as we consider the interplay between medical ethics and the American managed care system.

Conscience Clause

In the United States, several state governments have enacted laws protecting healthcare professionals and institutions who have religious or moral objections with performing or assisting with certain procedures (e.g. abortion, contraception, or sterilization). This legislation is referred to as a **conscience clause**.

Under the conscience clause, if a healthcare professional does not want to participate in a procedure, they can refuse to participate in that procedure and cannot be discriminated against or disciplined by the institution (e.g. hospital or clinic).

For example, if a healthcare provider is Catholic, he or she may not be comfortable with performing or participating in an abortion procedure.

These issues have raised several important points regarding ethical and professional conflicts in the healthcare environment. An issue includes disagreements between the patient and the healthcare provider regarding medical services.

An example would be a gynecologist refusing to provide a prescription for birth control to a patient. The gynecologist will cite religious freedom and how providing contraception violates their beliefs. The patient, on the other hand, will cite that their rights and decisions are not being taken into consideration.

Patient advocates have stated that the healthcare professionals have an ethical and professional responsibility to put the patient's needs first. Advocates for the conscience

clause believe that citizens of the United States should not be discriminated based on their moral and religious values.

Another major issue that also falls under this topic is physician-assisted suicide (PAS). In Oregon, Ballot Measure 16 was passed in 1994 which legalized physician-assisted suicide under the Death with Dignity Act (ORS 127.800 to 127.890, 127.895, and 127.897).

Under the Death with Dignity Act, a terminally ill individual may choose when they will die under certain restrictions placed by this law. The restrictions include (but are not limited to):

- Patient must be a legal adult (18 years of age or older)
- Patient must be capable (can make healthcare decisions and appropriately communicate them as determined by the court or a professional practitioner; professional practitioner would be the physician in charge of the patient's care, a physician assisting with the patient's care, a psychiatrist, or psychologist)
- Patient must have a terminal disease (medically confirmed as incurable or irreversible and through sound medical judgement, lead to death within six months)
- Physician must be a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) in the state of Oregon
- Patient must be counseled by a licensed psychiatrist or licensed psychologist who provide consultation sessions to the patient to determine that there are no other factors impairing their judgment (such as depression or other mental illness)

To read the complete list of requirements and restrictions, please see the Oregon Health Authority website and use the search function to type in "Death With Dignity Act."

Regarding the conscience clause, how can healthcare providers balance their moral or religious values with their duties in the medical field? For example, if an Oregon physician with religious objections to physician-assisted suicide is the primary caretaker of a terminally ill patient and the patient decides to end their life, how can this be handled?

How can patients in regions with limited options to medical services work with healthcare providers who cite religious or moral objections? In an emergency, it becomes critical to deal with this ethical dilemma.

There have been options where these conflicts are handled. A coworker can perform or assist in the procedure in place of the employee after discussions. The employee might look for work in another department or institution or be reassigned to another position.

After considering the issues in the American managed care system throughout this handout, we can see the complex layers within the healthcare system. There is no "**one**" right answer or perfect solution to these issues. There are several ethical questions that come to mind as people navigate through the complex American medical healthcare system:

Do higher income individuals have greater access to quality healthcare?

Although individuals pay for a managed care plan, do they receive the necessary benefits for services such as preventive care (e.g. annual checkups, health education, cancer screenings) or are they lured into a plan that only provides minimal coverage?

Does making a profit and keeping costs down take precedence over a patient's treatment and care? Is the rationed medical care sufficient for these patients?

How can patients under Medicare navigate through the complex healthcare system with some physicians not accepting individuals on Medicare? For those who do not have extra financial resources to fund services not covered under Medicare, what changes can be made to provide an acceptable standard of care?

Is it ethical for a physician to refuse patients who are uninsured or have minimal insurance from their practice to avoid reimbursement issues?

As we can see through these questions, there are three interconnected elements that play a key role in the managed care system:

- **Access**
- **Cost**
- **Quality**

When access increases while keeping costs low, quality is affected since demand increases and healthcare professionals and institutions may not have the resources and funding to conduct procedures (which may be expensive) such as radiology services and blood work.

On the other hand if the healthcare system wants to maintain a high standard quality of care, costs may increase to maintain programs and medical services which then decrease access to those who may not be able to afford it.

Just from these three elements we can see the complexity of healthcare in America and how finding a balance for these three elements ends up affecting the others (where an increase or decrease in one aspect creates adverse effects on the others).

Although it can be difficult to pinpoint an exact solution to these medical care issues, a well-established managed care plan can offer individuals necessary care such as

emphasizing preventive care to avoid illnesses. These preventive services can also help individuals avoid unnecessary testing and procedures which can be costly and not beneficial in the long run.

As healthcare in the United States continues to evolve, Americans are called to adapt as informed consumers when choosing the right care for themselves and their families.