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MANAGED HEALTH CARE
AND ITS EFFECTS ON HEALTH CARE ACCESS
IN BOX ELDER COUNTY UTAH

by

Douglas Sean Linfood

Thesis submitted in partial fulfillment
of the requirements for the degree

of

UNIVERSITY HONORS
WITH DEPARTMENT HONORS

in

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UTAH STATE UNIVERSITY
Logan, UT

1997

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By Douglas Sean Linford
May 20, 1997
Undergraduate Honors Thesis
Advisor: Dr. Roberta Herzberg

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PROBLEM

Since 1994 the issue of how access is impacted by managed care in rural Utah has been the focus of State advisory groups, the Utah Health Policy Commission, and the legislature. The Health Systems Improvement Act (1995) formalized the concern with a request that the Utah Department of Health study this impact (Sinclair et. Al., #2, pg. 1). In focus meetings around the state, the perception that managed care can negatively impact access in rural communities is generally accepted without significant controversy. Such comments often assume that rural residents will be forced to travel further or will receive fewer services that insurers have excluded from their managed care plans.

I intend to study the problem of health care access in Box Elder County. I chose Box Elder County as the site of my study due to its proximity to Utah State University. Some information on Box Elder County has already been gathered by Utah's Department of Health (Sinclair et. al., #1). In particular, I will consider whether health care has been compromised by these changes in the market, whether such restrictions present a mere inconvenience or some consequences in between. I plan to determine if a problem does truly exist in this area. I also want to look at if it is a reasonable problem or rather an inconvenience to some people, the underlying question being when is it a problem when the choice of providers is restricted to a given individual.

BACKGROUND

The state of Utah has 59.5% of its population enrolled in some form of managed care with 78% of all commercial insurance enrollees involved. This makes it an important influence in the state. Preferred Provider Organizations (PPOs) accounted for 47.3% of managed care in Utah in 1995. Health Maintenance Organizations (HMOs) make up the remaining 52.7% (see Fig 1 and 2) (Sinclair et. al. ; #4; Appendix C). Over the past ten years this has grown metrically. In 1985 there were only 201,297 people enrolled in HMOs or PPOs. This number grew to 1,122,505 in 1995. This represents an annual average growth of 26.3% over the past 10 years (Sinclair et. al. ; #4; Appendix C). Box Elder County had 25.6% of its hospital patients enrolled in managed health care in 1995 showing that it is indeed a factor in Box Elder County as well (Utah Department of Health Data Analysis).

Several factors make the health care market more troubling than other markets. The first reason is that in the United States health insurance is tied to employment.¹ Since costs are separated from demand, they are driven up at a faster pace. Lastly, employers looking to limit runaway costs looked to managed care to provide coverage to their employees.

Managed Health Care involves several related forms of health care insurance. The most popular types are PPOs and HMOs. Both of these insurance methods attempt to lower costs by contracting exclusively with certain health care providers. They also try and reduce unnecessary medical services and correct the imbalance between specialty and primary care (Bodenheimer 1996;1025). Managed care can be split into a continuum with PPOs the most closely related to

¹ In many ways this is one of the idiosyncracies of American Society. The history behind why employers purchase health insurance is very complex and beyond the scope of this paper.

the old fee-for-service indemnity plans. Open panel HMOs (IPA type) are next followed by closed panel HMOs (group and staff model type.) As you move along the spectrum, you add new and greater elements of control and accountability. The plans also become more complex and require more overhead to run. At the same time you have greater potential control of cost and quality (Kongstvedt, pg 13).

Preferred Provider Organizations are the closest to the old insurance systems. PPOs have a preestablished list of providers that have agreed to provide health care services for enrollees at a discounted fee-for-service rate. This rate usually is 15-20% less than competitors cost (Kongstvedt, pg. 7). The PPOs, in turn, promise to direct more business toward the providers. Most PPOs charge extra out-of-pocket costs to their enrollees if they leave the pre-approved list of providers for health care (Bodenheimer 1994;972).

Most other types of managed care are known as Health Maintenance Organizations . There are two main types of HMOs. The first type, and the most common, uses the Independent Practice Association (IPA) model. This is a three-tiered system of health care where the insurance company contracts with a large group of health care providers organized together in an IPA. The IPA in turn directs some of the money to Primary Care Physicians (PCPs) and puts the rest into some form of hospital risk pool to pay for care other than that provided by the PCP. This is known as capitation. The PCP gets a certain amount of money per person per month. They are then required to provide care for all of the people that are signed up under them. If the hospital risk pool has surplus money in it at the end of the year then it is directed back to either the hospital, the PCPs, or both depending on how the contract was drawn up originally.

The other form of HMO is the group or staff model. This is a two-tiered system in which

the HMO contracts directly with the PCPs and thus foregoes the IPA organization. Physicians under this type of HMO are either directly capitated by the HMO or given a salary as employees of the HMO. This eliminates the secondary organizational structure utilized by IPAs, but also redirects the influence of management back to the insurance companies.

Managed care has its roots in 1923 in a prepaid health clinic started by Michael Sharded, M.D., in Elk City, Oklahoma. He set up a system where people would buy shares that would allow them medical care with only a minimal co-payment per visit. In 1942 Kaiser-Permanente started a Medical Care Program which became an important managed care prototype. By 1954 competitors to Kaiser-Permanente emerged with the first IPA type HMO. These two HMO prototypes were well established as the beginning of our modern HMOs. During the 1970s, Preferred Provider Organizations (PPOs) were added to the menu of managed care options. At first managed care was isolated to small pockets in California and the Midwest. The HMO Act of 1973 gave federal support to managed care through health care programs financed by grants, contracts, and loans. This helped to open up the market nationwide (Kongstvedt, pg. 5).

The traditional methods of paying for health care are fee-for-service indemnity plans. Under these systems employers pay the insurance company a set monthly fee. The insurance company is then billed every time one of their enrollees requires a medical procedure. The way this system is set up allows those on the insurance plan to go to any provider of health care that they choose. Differences of opinion as to whom the employer wants to provide health care and who the employee wants to provide health care are not brought up under this system because they are nonexistent because the plans cover all available providers.

Fee-for-service does cause many problems in the health care market. As discussed

before, the separation of cost from demand caused runaway costs under this system. The providers had no incentive to keep costs down because the consumers were not tied to health care costs. Consumers did not pay for the cost of their health care because their employers had already purchased health care plans for them. This caused many employers to look for alternative ways to pay for health care in order to save money. Managed Care came up as a solution to these problems.

Managed health care changes the incentives involved in health care. Now doctors do not make more by doing more. This saves the insurance companies money by reducing unnecessary hospital admissions, lowering length of hospital stays, and shifting some services to ambulatory settings (Kongstvedt, pg. 6). This in turn allows them to offer health insurance at reduced prices. Their main goal is to provide low-cost and high quality care accessible to patients.

In order to maintain quality care, managed care products carefully screen all of the health care providers in an area before it is determined who they will allow on their panel. They do background checks to determine if they are properly licenced, if they are Board Certified in their particular specialty, and to make sure they have not had overly-abundant malpractice claims brought against them (Kongstvedt, pg. 39). This is one of the reasons that many rural health care providers are not included in managed care packages. This also leads to problems if the economic viability of these doctors is put at risk due to lack of inclusion by these plans.

Access problems that were not seen under fee-for service indemnity plans start to surface with managed care. Under economic pressure, employers choose to limit the circle of providers available to their employees by purchasing managed care plans. This causes problems if the providers chosen by the managed care plan do not overlap with the providers that the employee

wants.

Differences between urban and rural providers also emerge under managed care plans. Urban areas have a sufficient patient base to remain viable under the new restrictions placed upon them by managed care. If a certain managed care plan decides not to list a hospital on its plan there is a sufficient patient base to retain economic viability by contracting with other insurers or with fee-for-service plans. Rural areas do not have this convenience. If a rural provider, such as a hospital, is not included on the list of possible providers for a managed care product there may not be a big enough patient base to make up for the loss of business this causes. If this in turn causes rural providers to close, bigger access problems arise. Managed care plans usually allow their participants to receive emergency medical care with any provider, even rural providers that are not listed on their plan. If these providers go out of business due to lack of funds from elective procedures then they are not available when true emergency situations arise. It is because of this that the main access problems due to managed care are found in rural and not urban areas. The economic viability of rural providers turns out to be the underlying problem causing loss of jobs along with loss of emergency medical facilities.

PLAN OF ANALYSIS

In order to determine if there is indeed a problem with access to health care one would need several sources of information. The most important piece of data would be a statistical analysis of the number of people in Box Elder County that were forced to travel to outside sources for health care due only to the fact that their managed care company demanded it. It would also be useful to conduct a survey of these patients to determine if this relocation truly

caused a problem to them or if it is only an inconvenience.

It would also be important to talk with health care providers about the issue and whether it created a problem or not. Most of this data was unavailable due to lack of studies done on this area. I thus determined to base my analysis on the study that the state had performed on the impact of managed care in rural Utah (Sinclair et. al., Reports #1-#4). I will then back up this data with more anecdotal sources. I will perform several interviews over the phone and in person with health care providers in Box Elder County.

ARGUMENT

Upon talking with several people involved with health care in Utah I uncovered a lot of evidence that geographic access to health care is not a problem in Box Elder County. Most of those with whom I talked voiced concerns that there could be problems in the future but that they did not see a significant problem at the present time.

The Bureau of Primary Care and Rural Health Systems (BPCRHS) of the Utah Department of Health did a research project on the impact of managed care on rural Utah. As part of that study six of the major employers in Box Elder County were interviewed. This survey found that most of the employers in Box Elder County felt that there were only a few or none of their employees that had to travel more than 30 minutes to get primary care. There was only one major employer who thought that many of its employees had to travel more than 30 minutes from their home or place of work to receive health care (Sinclair et. al. ; report #1;xiv). The same employers felt that there was little to no problem in accessing primary medical care. According to the employers managed care offers lower costs while only slightly limiting

accessability of health care.

The insurance companies in Utah also feel that there is no access problem in Brigham City. One of the major insurance agents in Brigham City, Jimmy Jones, said that there is no problem with health care access at all because all of the physicians in town are participants in all of the health care plans available in the city. He did admit that those who were insured by IHC might not be able to receive care in the Brigham City Hospital. This was countered by his statement that most of the employers in Box Elder County offer their employees more than one choice when it comes to health care. He knew that two of the major employers, Thiokol and Morton International, offered various plans. If a certain employee chooses to subscribe to an insurance in which he is limited then it is his fault that he has access problems. The only problem that could cause limited access in the future is if a particular doctor chooses to quit a health care plan. Jimmy Jones did not think that this would happen in Brigham City in the near future.

Scott Deru, former president of the Health Underwriters Association, came to the same conclusions as Jimmy Jones. He said that all of the providers in Box Elder County generally contracted with all of the managed care products offered in Utah. Scott Deru said that if there was access limited in certain specialties it is because those specialties do not exist in Box Elder County even for those not on managed care plans. The example he used was that of a gastrointerologist. He did know of the case of one lady that commuted to Ogden from Logan to work. Her employer's health care coverage stipulated that she travel at least to Brigham City to receive care.

Most insurance companies in Utah feel that access will increase as more health care

providers contract with insurance companies on managed care products (Sinclair et. al. ; report #3;10). As enrollment in rural areas increases, the cooperation of providers should increase. This is difficult for the insurance companies due to the lack of competition in rural communities. Since some providers are the only ones available in a certain area, they do not accept the discounted rates of service offered by the insurance companies' PPOs (Sinclair et. al. ; report #3;7). One of the solutions to this problem would be to increase the number of primary care physicians in rural areas. Another solution would be to better educate the consumers as to how managed care works. Many consumers in local areas like the benefits of the cheaper managed care products, but do not like the restrictions that come with them. They still like to go to their local pharmacy rather than travel to the one under contract by their managed care company (Sinclair et. al. ; report #3;12).

One of the major providers of health care in the state is Medicaid. Bonnie Anderson, bureau secretary with Utah's Medicaid program, said that Box Elder county is not yet capitated under a managed care plan. Currently all of the Wasatch front is capitated. This has not brought about any new problems with the Medicaid community in the Salt Lake City area. Any complaints that the state has received are the same as those received under the old indemnity plans. Bonnie Anderson did say that with any change there is always a certain percentage that are at first scared of the change, but as they become accustomed to it there is less of a problem. The state does allow a few exemptions to their mandatory managed care in the Wasatch front on a case-to-case basis. This provides for any extenuating circumstances that could cause access problems. As of this time, the state has no plans of pushing managed care products on the Medicaid communities in Box Elder County. In order for the state to change, an HMO would

have to expand their range of service to the specified rural area and then propose this plan to the state. The state of Utah would then make sure that there were sufficient providers offered by the plan before they would accept it. This would prevent possible access problems in the future in the event that Medicaid in Box Elder County did switch to managed care products.

Nursing Homes in Box Elder county have not seen any change in health care access due to the increase of managed care. Frank Shaw, administrator of Pioneer Care Center in Brigham City, said the reason for this is that managed care has not yet penetrated the market of long term care. Managed care tends to prefer home health alternatives or assisted living to long term facilities. Also, two-thirds of the residents of his nursing home are covered by Medicaid. Since Medicaid is not covered by managed care in Box Elder County, they have not been affected. Frank Shaw felt that if Medicaid were to go to a managed care product then many residents would be forced to live in the street. Those patients that are on Medicare have personal physicians who visit the facility making access of little issue to them.

The hospitals in Box Elder County have seen a small access problem do to managed care. Robert Jex, administrator of the hospital in Tremonton, said that he has seen more Brigham City residents having procedures performed at his hospital since the advent of managed care. This is because the hospital in Brigham City is affiliated with Columbia and the one in Tremonton is affiliated with IHC health care. Those patients on some IHC health plans that live in Brigham City have to travel to other cities in order to have procedures performed at an IHC hospital. Tad Morley, administrator of the Brigham City hospital confirmed this statement noting that some residents of Brigham City could not receive care at the Brigham City Hospital due to their affiliation with IHC. This caused them to go to hospitals affiliated with IHC like the one in

Tremonton. The patients are given the option of staying in Brigham City for care, but they would have to pay a larger out-of-pocket expense for leaving the "system." Tad Morley said that they have seen more of a shift from inpatient surgeries and procedures to outpatient. It has also caused a change in terms of length of stay. Managed care has limited the number of days that a patient can stay in the hospital. Overall Tad Morley ranked the access problem relatively low in comparison with the rest of Utah but much greater than other states like Idaho.

The state of Utah has tried to eliminate the problems associated with health care access. As of July 1, 1997, a law goes into affect stating that an insured individual can opt to go to a health care provider other than the ones under contract by his managed care company if the provider approved by the insurance is not within 30 miles (Utah Code Annotated; 31-8-103). This law will eliminate some of the access problems in Box Elder County due to lack of providers under contract with a particular insurer. Those companies that are self-insured and fall under the Employee Retirement Income Security Act of 1974 (ERISA), however, will not be affected by this state regulation (Kongstvedt, pg. 408). This means that any employee of a company with more than 50 employees that is self insured under ERISA might still have access problems in the future.

According to Val Bateman, with the Utah Medical Association, there are some access problems in rural Utah due to the limited number of physicians. Managed care has not had much of an impact on rural areas because it has not yet penetrated much of rural Utah. The medical community is not really concerned with this problem after House Bill 146 goes into effect allowing any provider to receive reimbursement for health care if they live outside of 30 miles from an approved provider. I saw this apathy toward the subject of access to health care when I

attempted to talk with physicians in Box Elder County. One physician I called declined to talk with me about the subject. Another physician was never available to talk with me after calling him more than five times. This shows that this problem does not interest them enough to want to talk about it, at least not with an undergraduate college student.

There is some data that suggests access problems. Residents of Box Elder County are known to go to Burley, Pocatello, Logan, Ogden, and Salt Lake City for health care, all of which are cities outside of Box Elder County (Sinclair et. al. ; report #2;10). In general, the residents of Box Elder County have to travel long distances. Many of them live in one place and work in another. If they have to receive health care in yet a different place then this decreases the availability of health care for them. One example of this problem is with Medicare programs for the elderly in Brigham City. Some elderly in Brigham City have chosen managed care plans. While lowering costs for some eye care needs, it also requires travel to Ogden to receive these services (Sinclair et. al. ; report #1;6). This could create problems of accessibility with some elderly residents of Box Elder County if they choose to accept managed care plans over the other plans that are available to them. Another concern is that insurance companies sell insurance in areas where they do not have contracts with providers. This could definitely cause access problems to those insured (Sinclair et. al. ; report #2;8). If certain patients are uninsurable due to a specific disease, more problems could arise.

The economic viability of the providers in Box Elder County is not a problem at the present time. Both hospitals in the county are backed by large national companies, Brigham City Hospital by Colombia Health Care, and Bear River Valley Hospital by Intermountain Health Care. This provides them with a big enough capital base to disallow any worry about economic

problems. The medical clinics in the area have, up until now, been able to contract with most of the managed care products guaranteeing them economic viability as well.

CONCLUSIONS

The question as to whether access is a problem or not can have several explanations. One possibility is that residents of Box Elder County regularly travel to outlying areas for routine tasks of less importance than medical care, such as grocery shopping. If this was the case then one would wonder if a problem truly does exist. Also, the managed care companies may have more knowledge to the quality of care by local providers. If the quality of care was significantly different then greater travel time might be worth the increase in quality.

With all of the state regulations there is only a slight problem with health care access in Box Elder County. The reason for this is that most health care providers accept payment from all of the managed care companies in the area. Also, most employers offer their employees a choice as to what health care plan they want. All of the providers are willing to provide health care to patients who are willing to pay the difference between what their insurance companies will pay and what the provider charges. Most insurance plans offer point-of-service options for those insured to leave the system if they agree to make up the difference by paying extra.

The only real problem with health care access has been with those who are uninsured or those who commute long distances for work. In some instances employees of Box Elder County who reside in other counties had to come back to Box Elder County for health care. Their decision to commute to work thus limited their access to health care. Based on this study there is

no real problem with managed care limiting health care accessibility in Box Elder County. This does not indicate that there is not a problem in other rural counties in Utah or that a problem will not arise in Box Elder County in the future. Many of those interviewed suggested that future problems might arise, but for now anyway, health care in Box Elder County has not been compromised by these changes in the market. It has caused inconveniences to a small minority, but these are of little consequence.

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Utah Department of Health Data Analysis, Hospital Discharge Data, Internet web site,
http://hlunix.hl.state.ut.us/hda/st1/st1_95/

Appendix

Sample of Questions Asked in Interviews:

Has access to health care been hurt due to the influx of managed health care in Box Elder County?

How big of a problem would you say access to health care is in Box Elder County?

Have you seen a decrease of usage of you facility (Hospital, Nursing Home etc.) since managed care has penetrated Box Elder County?

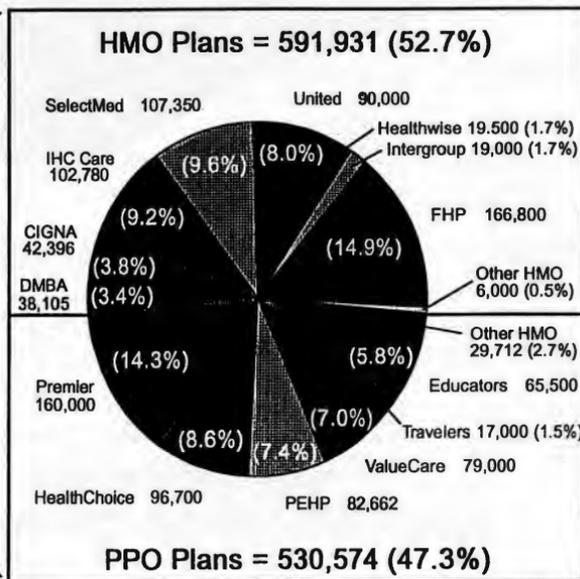
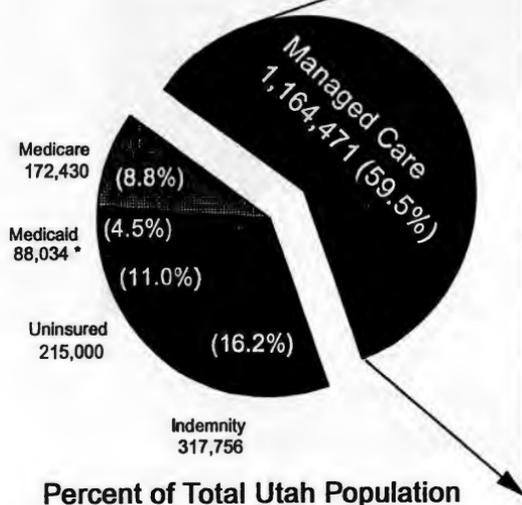
Do Box Elder County residents travel to other counties for health care because their managed care plan does not cover providers in Box Elder County?

(To Bonnie Anderson) Do you think that Box Elder Counties Medicare will be capitated in the near future?

HMO and PPO Enrollments in Utah

August 1995

1995 Total Utah Population
Estimate = 1,957,691

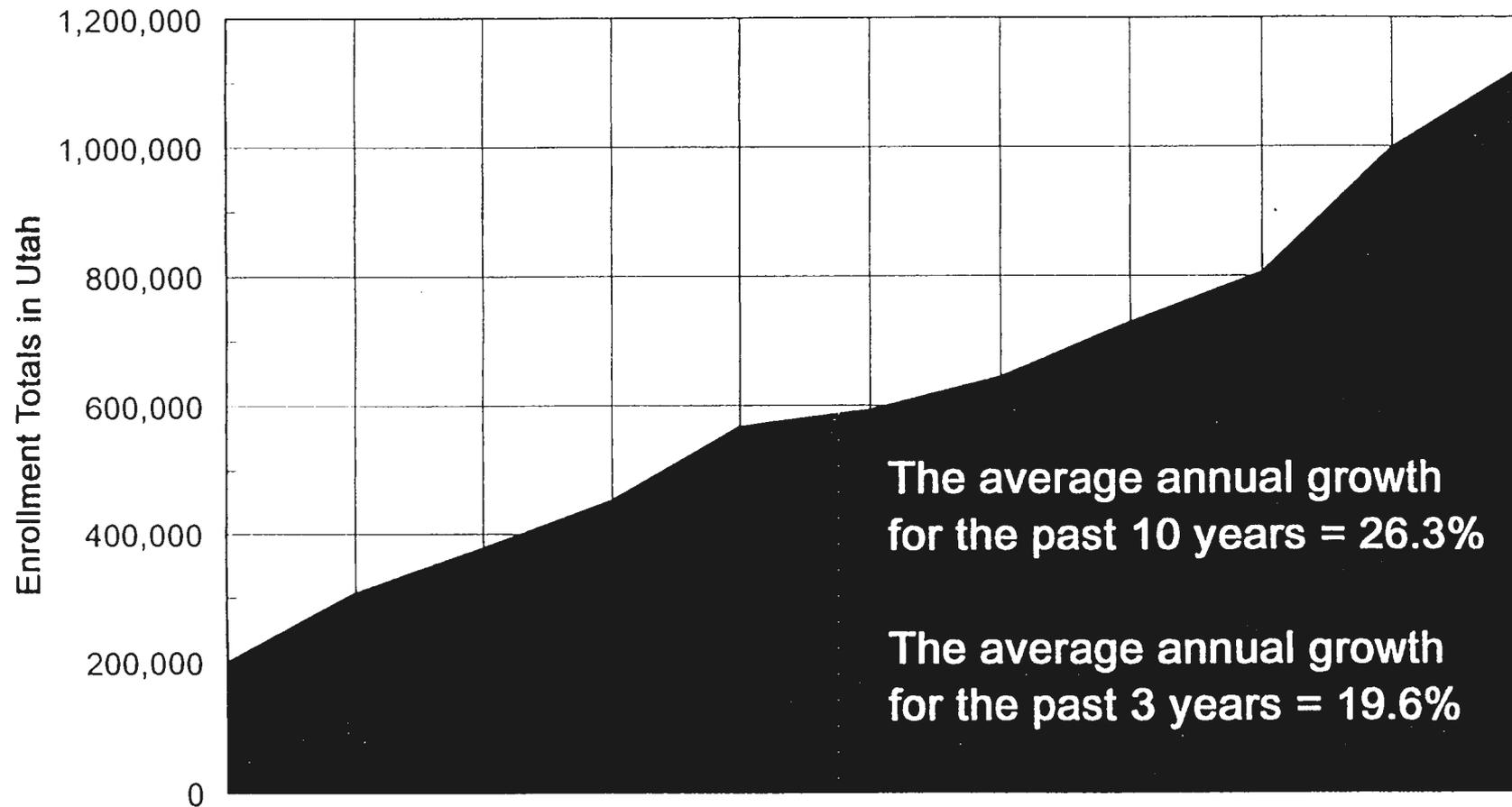


APPENDIX C

* 41,966 Medicaid eligibles are enrolled in an HMO

Managed Health Care Growth in Utah

HMO and PPO Plans, July 1985 - August 1995



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Enrollment	201,297	308,900	378,741	454,904	567,800	594,474	646,033	729,400	806,837	999,980	1,122,505

Source: "Managed Health Care Systems in Utah" Utah Association of HealthCare Providers, August 1995.