THE BRAVE NEW WORLD OF MANAGED CARE

Milan Korcok

In Brief • En bref

Canadian hospitals that think they can charge higher-than-normal rates to foreign visitors are learning a lesson as US-style managed care moves north of the border. Dr. Robert MacMillan, president and medical director of Florida-based Insurance Claims Management Systems and past president of the Ontario Medical Association, says that south of the border US-style managed care has already hauled in the reins on wild expectations about high payments, and it is expected to do the same for Canadian hospitals that charge private insurers "as much as the traffic will bear." He says it is no longer uncommon for a large Toronto hospital to charge a foreign patient $3000 a day for care that can now be purchased in a US hospital for one-third that price.

Les hôpitaux canadiens qui pensent pouvoir imposer aux visiteurs étrangers des tarifs supérieurs à la normale s'ouvrent les yeux à mesure que les soins gérés à l'américaine s'implantent au Nord de la frontière. Le Dr Robert MacMillan, président et directeur médical d'Insurance Claims Management Systems, de la Floride, et ancien président de l'Association médicale de l'Ontario, affirme que les soins gérés à l'américaine outre-frontière ont déjà freiné les folles attentes au sujet des paiements élevés et que la même chose devrait arriver aux hôpitaux canadiens qui exigent «le maximum possible» des assureurs privés. Il affirme qu'il n'est pas rare pour un gros hôpital de Toronto de facturer à un patient étranger 3 000 $ par jour pour des soins qui coûtent actuellement trois fois moins cher dans un hôpital américain.

The bill for $2400 per day for 4 days of inpatient treatment of a young British traveller's tonsillitis landed with a thud on the desk of the insurance claims manager.

The numbers on the bill were not the ones he expected from a small hospital in Western Canada. And 4 days of care? For tonsillitis?

A few years ago, this is the kind of claim an insurer might have expected to receive from a hospital in high-priced Hawaii or Manhattan. But Dr. Robert MacMillan, president and medical director of Florida-based Insurance Claims Management Systems (ICMS), says US-style managed care has hauled in the reins on those wild expectations south of the border, and it is expected to do the same for Canadian hospitals that charge private insurers "as much as the traffic will bear."

MacMillan, former executive director of the Ontario Health Insurance Plan and past president of the Ontario Medical Association, thinks it's "unconscionable" that Canadian hospitals should charge private insurers, many of them covering foreign visitors, three, four or five times their usual per-diem rate, but that's exactly what many of them do.

Interviewed in his office in Fort Lauderdale, Florida, where he heads up claims-management-utilization review services for international travel health-insurance companies, MacMillan commented: "It's no longer unheard of for a large Toronto hospital to charge a foreign patient $3000 a day for care that can now be purchased in a US hospital for one-third that price."

It appears many hospital administrators have heard the horror stories about American hospitals charging well-insured Canadian patients exorbitant rates and feel it is payback time. But as managed care becomes dominant in the United States and weaves its way into the fibre of Canada's private health care sector, some of those horror stories should dissipate. If managed care can bring some of the same cost constraints to Canada's health care system that it has introduced in the US, it will become a force to be reckoned with — for not only hospitals that treat private patients but also all other players in health care.

In fact, Canadian insurers covering clients travelling abroad have already taken to managed care like ducks to water, using it for claims control, case management, hospital precertification and, perhaps most important, for access to hospital networks that offer wholesale rates to

Milan Korcok is a freelance writer living in Lauderdale-By-The-Sea, Florida.

clients who can refer them substantial numbers of patients.

And the move seems to be paying off in insurers' bottom lines. Last summer, many Canadian companies were able to reduce their prices after 3 years of astronomical increases. Some cut them as much as 20%, giving credit to reduced claims costs and better management of their clients through the American health care system.

Although out-of-country health insurance accounts for only a small segment of the private health care sector, it has taught Canadians a lot about the way managed care works: it has provided a laboratory in which the basic lessons of the system can be studied.

One of these lessons, says MacMillan, is that there is a difference between "wholesale" and "retail"; providers willing to discuss wholesale arrangements will get the patients referred by insurers, and those who insist on retail prices won't.

American hospitals that customarily charge an all-inclusive rate of $2000 a day (which covers everything except physicians' services) are routinely signing contracts for $650 to $750 a day, says MacMillan — "just so long as we send patients their way."

This is an important message for Canadian hospitals that want to get their fair share — or more — of the growing market created by foreign travellers and patients not insured under Canada's public health care system: foreign students, travellers and workers, aliens awaiting immigrant status and Canadians returning home after prolonged periods abroad. All these people need some health-insurance protection.

The small hospital in Western Canada that was mentioned earlier learned that besides the questionable need to admit a patient with tonsillitis for 4 days of hospital care, a per-diem rate of $2400 would not likely earn them any more referrals from this large insurer of foreign travellers, especially when the established interprovincial rate for this hospital was closer to $400 per day. The hospital settled for less when these facts were pointed out. (Interprovincial per diems are the average rates charged by individual hospitals for treating residents of other provinces.)

"Insurers understand that there should be a margin of profit for hospitals treating privately insured patients," says MacMillan, "but the doubling or tripling of their rates . . . is not acceptable and will no longer be tolerated."

MacMillan has some clout because ICMS's largest Canadian client is Toronto-based John Ingle Travel, a pioneer in the travel-health-insurance business and one of the largest such insurers in Canada. "Those unwilling to negotiate a fair price will simply be left out of the circuit," he adds, "and instead of having $1000 extra dollars a day, they will have no extra dollars a day."

To hospitals strapped by the restrictions imposed by global budgets, the lure of private dollars can be tempting. However, getting them will require some give and take. That's true for not only hospitals, but also other players in the health care system — doctors, dentists, clinics and pharmaceutical manufacturers and distributors.

Canadian physicians are fortunate — MacMillan says insurers don't consider their fees a problem. A knee arthroscopy that is charged at a rate of $5402 in New York City has a rate of $311 in Ontario. A hysterectomy charged at $768 in Detroit is charged at $137 in Ontario.

Unfortunately for Canadian physicians, there seems little chance that the caps and controls imposed by governments will ease in the foreseeable future. That may be one reason, says MacMillan, that each time he returns to Canada and visits colleagues, he sees physicians who are more surly and less contented. "Their morale is dropping steadily," he observes.

Provincial restrictions on physicians' fees means they do not face the huge variations common in the US, where "usual and customary" rates are often tabulated according to ZIP-code area, and where fees in Miami, San Francisco or New York City may be more than double those in Pittsburgh or Cleveland.

"A bypass operation in Hawaii may cost four times what it costs in Detroit," says MacMillan, who in his cost-management role has had several foreign patients evacuated from Hawaii and brought back to Canada by air ambulance for just that reason. One patient who could not be evacuated because of clinical instability ran up a tab of more than $300 000.

The problem Canadian physicians will face with managed care is not wholesale discounting of fees, because these are already considered a bargain, but changes in the way they manage patients and clinical resources.

For example, the inpatient admission of a healthy young patient because of tonsillitis just wouldn't happen in any managed-care system in the US, where MacMillan says the standards of care "are much tighter."

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In a Canadian hospital, the principle guiding the work that gets done is the global amount of money available. In the managed-care environment in the US, competition drives the engine: without quality service, market share will suffer. And without profit, incentive washes away.

Many American physicians still grate under the restraints applied by case managers and utilization reviewers, but few deny the need to coexist with them. MacMillan is one of those reviewers, and he must make tough decisions that balance quality of care with cost of care.

When is enough enough? "We'll cover you for obstetrical care but you can't stay in hospital more than 2 days because we won't pay for it," he explains. "Or we will approve the cholecystectomy you need but you'll have to be out of the hospital the day after tomorrow."

Decisions like these used to be made by physicians, who determined what was acceptable, largely on the basis of the way they had always done things.

"But that doesn't hold up any more — not in a managed-care environment," explains MacMillan. Today, the mantras of US health care are accountability, attention to cost and quality.

"Yes, it's rationing," he says. "But unless we acknowledge rationing, we couldn't afford to pay for health care in the United States."

How does he apply these principles when he manages the care of Canadians or other nationals? "Every single patient seeking hospitalization requires notification from the insurance company. I or my medical or nursing staff immediately contact the hospital to determine the need for admission, the proposed investigation and the treatment plan. We then authorize or certify what the insurer will pay for if we agree that the plan fits within the standards of quality care.

"Necessary things are paid for. Unnecessary things are not."

This is not yet the way things are generally done in Canada, but as managed care spreads that will probably change. MacMillan has already begun visiting Canadian hospital administrators to set up "preferred provider" networks to serve the growing number of people coming into the private-insurance marketplace as a result of provincial cutbacks, everyone from foreign students to returning Canadians, most of whom must wait 3 months before regaining medicare eligibility.

In the past, before hospitals started charging "as much as the traffic will bear" for their privately insured patients, the per-diem rates charged were not conspicuous enough to catch much attention, and the insurers simply paid.

But when the rates began to soar to multiples of what was normally charged to residents of other provinces, a flag went up. "Now," says MacMillan, "we are spending less for some very high-quality hospitals in the United States [through preferred-provider agreements] than we are being charged by Canadian hospitals to take care of our clients."

In addition, he adds, because Canadian hospital personnel are not used to the intrusive nature of utilization reviewers, they create some barriers to US-style case management.

"Let's say a foreign client is admitted to an Ontario hospital with small-bowel obstruction. If I called the Emergency Department to get information I would be told 'that's confidential.'

"I respect the tough confidentiality rules in Canada compared with the US," says MacMillan, "but at the same time there has to be a solution to that because if I don't know what's going on, I can't authorize payment."

Considering everything Canadians have heard about American hospitals denying services to uninsured patients, says MacMillan, many of them would probably be shocked to realize that "it is not uncommon for Canadian hospital personnel to march right to the bedside and demand some kind of assurance of payment — cash or cheque up front — before treatment is started.

"We don't want to put that kind of stress on the patient," he adds. "But at the same time, we're trying to work with hospitals in an effort to understand their needs and have them understand ours.

"One of our needs is that we may want to send our patient, who is from Buffalo and is scheduled for major surgery the next day, back to Buffalo for treatment, just as we require Canadians in Florida to get their bypass back home."

Ironically, it may now cost less to take care of that patient in Buffalo than in a place like Peterborough, Ont. And that is indeed some turnabout. ■