

Findings Brief

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Study Shows Physician Gatekeeping May Help Lower Costs, But Questions Remain about Physician and Patient Satisfaction

Gatekeeping — a system in which health plan enrollees choose a primary care physician (PCP) as a de-facto services-utilization manager and consultant to make decisions regarding the need for specialty providers and services — is a term that is widely recognized within the context of managed health care. But how well the public understands both the objectives of gatekeeping and its effects on health care delivery, is not widely known. Thus, the question posed by David Blumenthal, M.D., chief of the Health Policy Research and Development Unit at Massachusetts General Hospital (MGH), and his colleagues was how does gatekeeping effect access to, quality of, and satisfaction with health care. Specifically, he examined the outcomes for employees of a large Massachusetts hospital who chose to join a health maintenance organization (HMO) that required the use of a PCP gatekeeper, rather than remaining in a similar plan without a gatekeeper.

Overall, they found that while gatekeeping did serve to lower costs for the insurance carrier, satisfaction with the gatekeeping plan was lower from the perspective of both doctors and patients. And while HMOs are touted as improving rates of preventive care, the study results show that there was no significant increase in preventive care (measured according to number of Pap tests, mammograms, and other screening devices) for the gatekeeping population. In terms of understanding what makes people who have the option choose either an indemnity or an HMO plan, it was found that overall, higher-income employees were less likely to switch. This implies that for those who can afford an indemnity plan, flexibility and choice are high priorities.

“Gatekeeping is recognized as an important and significant change in the way health plans do business,” Blumenthal explains. “It makes sense from the HMOs’ standpoint because they can delegate management to the doctors, who theoretically have closer relationships with patients and can better understand what patients need.” But what the researchers found was that doctors themselves were less satisfied with the gatekeeper arrangement. While the gatekeeping plan effectively improved enrollees’ continuity of care, its main achievement was to curb the cost of that care.

Project Description

At the heart of Blumenthal’s analysis is a natural experiment that occurred at MGH in 1993. That year, MGH employees were given

the following choice: to continue their enrollment in the Blue Cross and Blue Shield indemnity plan (BCBS) offered by the hospital, or to switch to an HMO plan called MGH Plus (MGHP), which required a primary care gatekeeper. Approximately half of the BCBS enrollees made the switch, creating both a treatment and a control population upon which the effects of gatekeeping could be measured.

Blumenthal and his team of researchers — Daniel Singer, M.D. and Nancyanne Causino, Ed.D., both from MGH, and John A. Rizzo, Ph.D., from the School of Public Health at Yale University — formulated three sets of hypotheses that focused on 1) the effects of gatekeeping on access to, cost of, and quality of care for all MGH employees; 2) the effects of gatekeeping on patient and provider satisfaction; and 3) the economic, demographic, and other factors that influence employees to choose a plan that mandates use of a gatekeeper. These hypotheses were tested using both patient and provider data in the form of self-administered surveys to both populations, as well as through claims data.

To account for health utilization behavior both before and after the HMO plan was introduced (thereby controlling for self-selection bias), data were collected from 1991 to 1995 — the two years before and two years after the switch took place. In addition, because they understood that differences in utilization could be attributed to characteristics other than the health plan, the researchers controlled for several variables, including type of job and salary level. They also noted who had been previously diagnosed with hypertension, diabetes, or asthma, in order to analyze gatekeeping’s effect on enrollees with chronic illness.

Achieving the Balance: Costs vs. Quality of Care

Based on the patient and claims data, the researchers found that during the first year post-MGHP, gatekeeping did, in fact, result in lower costs, mainly due to the reduced use of specialists. At first, the fact that doctors were given no financial incentive for restricting referrals to specialists in the MGHP plan implied that the decline in costs could be attributed mainly to the strength of the gatekeeping mechanism as a case management tool. In year two, however, the gatekeeping plan witnessed an increase in costs that brought them just below those for the indemnity plan. The general explanation for this dichotomy is that the “switching” factor led

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to a decline in specialty referrals, which subsequently sparked the noticeable decline in costs. In practical terms, the act of switching health plans may have caused a decrease in overall health plan utilization, which was reflected in the drop in cost over the first year after the switch occurred. Unfamiliarity with gatekeeping, delays in choosing a PCP, and miscommunication over the process of using specialty services could all contribute to the drop. After re-enrolling for a second year, however, employees may have become more familiar with the processes involved in obtaining care through the HMO and been better equipped to bear the administrative burdens imposed by gatekeeping.

While costs were one issue, the evolution of a new type of relationship between physicians and patients that could be initiated by the gatekeeping mechanism is another important variable in this study. The data implied that the MGHP gatekeeping method served to promote continuous care in a way that the traditional indemnity plan did not. Patients who enrolled in the MGHP had to choose a single physician whose job it now was to advise on what kind of services they needed, and in some cases, to make sure those services were received. The mandate that each enrollee consult with a PCP before getting additional care apparently improved continuity of care, which could be seen as a positive aspect of gatekeeping.

While MGHP enrollees gave their actual care high absolute marks, they were not as positive about their overall experience with the plan as were indemnity members. In fact, MGHP members were less positive on several categories related to quality of care, including information received from their PCPs, the thoroughness of exams, the PCPs' personal interest in and attention to the patient, the amount of time spent with their doctors, and communication with their doctors when not on a scheduled appointment. When it came to use of specialists, enrollees expressed dissatisfaction with the difficulty in obtaining referrals and a high incidence of billing mistakes related to specialist visits.

Physicians' Response

The survey of physicians examined their attitudes regarding the effects of gatekeeping compared to traditional care in three areas: administrative burden, quality of care, and appropriateness of resource use and cost. Again, although gatekeeping's ability to control costs was rated positively by the majority of physicians, quality of care and satisfaction were highlighted as areas in which gatekeeping

did not perform as well as the traditional indemnity plan.

Similar to their patients, doctors responded negatively to questions relating to the effects of gatekeeping on the doctor-patient relationship and time spent with patients. It should be noted, however, that when cost and quality were taken together as a summary rating, 72 percent of PCPs considered gatekeeping to be equal to or better than traditional care. The physician survey controlled for characteristics that could affect ease or difficulty of adjustment to a gatekeeper system. The results of that analysis indicate that the physician characteristic most strongly associated with attitudes was number of years in clinical practice — the fewer years, the more positive the gatekeeper ratings. In addition, being a generalist rather than a specialist and having a smaller number of patients enrolled in an HMO were also associated with better overall attitudes and subsequent ratings.

Implications for Policy and Research

Blumenthal notes that "gatekeeping is always subject to physicians' poor judgement, which could be a threat to quality." When financial incentives are added to the mix, both patient and provider satisfaction may decline as access to and quality of care become lower priorities than saving money. "Gatekeeping must be imposed with sensitivity and flexibility," he states, especially since he sees financial incentives to reduce specialty care becoming more common among plans that use the gatekeeping mechanism.

As far as further work on this subject, Blumenthal is now using the data collected for this study to look at how the need for pediatric care factors into the choice of indemnity vs. HMO and is planning to prepare a paper exploring this question. Other issues that he believes warrant further study include efforts by health plans to eliminate gatekeeping all together. Basing this kind of study on the reverse of what occurred at MGH, he would examine changes in access, quality, and satisfaction among patients who became "trained" in going through a gatekeeper. But until a natural experiment takes place, this type of evaluation will have to wait.

In addition, Blumenthal would eventually like to study what happens when gatekeeping evolves from being a strictly administrative tool to being a process linked to financial incentives. Answers to that question will also have to wait until there are working models available for examination. ■

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