Managed Care and the Treatment of Skin Disease, 1995

Continued Growth and Emerging Dominance

Robert S. Stern, MD

Objective: To document changes in the type of financing for office-based visits for the treatment of common skin conditions and to dermatologists.

Design: Data from a national survey of visits to office-based practitioners conducted by the National Center for Health Statistics were used. The stratified sampling technique permits estimation of the total number of office visits with specific characteristics in the United States.

Setting: A national probability sample of visits to office-based practitioners occurring in 1995.

Subjects: In 1995, 36 875 visits were sampled. Of these, 2121 were for common skin problems to any physician and 1886 were visits for any reason to dermatologists.

Main Outcome Measures: The distribution source of payment and presence of managed care arrangements for office visits for common skin problems and to dermatologists.

Intervention: None.

Results: In 1995, preferred provider and health maintenance organizations provided payment for 34% of all ambulatory care and 38% of office visits for common skin complaints.

Conclusions: Managed care is already the dominant mechanism of payment for the treatment of skin disease for many patient groups and in many areas of the country. Preferred provider organizations are much more likely to employ dermatologists to provide care of common skin problems than are health maintenance organizations. If the recent trends continue, by year 2000 most patients seen by dermatologists will be seen under the auspices of managed care systems.

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IN THE United States, the organization and payment for medical services is rapidly changing. From 1985 to 1992, managed care grew rapidly as a source of payment for outpatient care of common skin problems.1 Data now available from the 1995 National Ambulatory Medical Care Survey document that changes in the financial arrangements for visits to office-based practitioners changed even more rapidly from 1992 to 1995 than in prior years.

RESULTS

In 1995 there were 697 million visits to office-based practitioners. As detailed in Table 2, more than 11% were provided under PPO contracts and an additional 22% under the auspices of HMOs, independent practice associations, or other prepaid or managed care plans. Medicare (excluding Medicare HMO and PPO contracts) and commercial insurance provided payment for about the same number of office visits for skin complaints as HMO insurance. The distribution of the type of payment for skin complaints followed a pattern similar to that of noncutaneous complaints (Table 2). The HMO and PPO contracts provided payment for about 38% of office-based care provided for common skin complaints.

Overall, nondermatologists provided care for 56% of visits for common skin complaints. The relative importance of various types of payment for office visits for skin complaints was significantly different for dermatologists and nondermatologists (Table 3). Preferred provider organization contracts were especially important as a source of payment for dermatologist-provided services. Individuals visiting physicians for common skin complaints who had HMO insurance were much less likely to see a dermatologist than other types of physicians (odds ratio, 0.36; P<.01). Less than one fifth of Medicaid-insured patients with common skin complaints visited a dermatologist.

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This article is also available on our Web site: www.ama-assn.org/derm.
METHODS

Data from the 1995 National Ambulatory Medical Care Survey were used. This survey, conducted by the National Center for Health Statistics, represents a national probability sample of visits to office-based nonfederally employed physicians including visits to private offices, health maintenance organizations (HMOs), and nonhospital clinics. To select practices to be studied, the National Center for Health Statistics uses a multistage probability sampling technique. In 1995, the initial sample included 3724 physicians. A total of 1137 of these physicians did not meet eligibility criteria. Of 2387 eligible physicians invited to participate, 73% participated in the study. During the assigned reporting period, the physician completed a form for each patient visit. Information collected for each sampled visit includes reasons for that visit, patient demographic characteristics, expected source of payments, and services provided. Because of changes in the specific questions concerning insurance, precise and direct comparisons of 1995 and earlier surveys cannot be made with exactness. A simple type of insurance may make many different constructual arrangements with a physician. For example, a physician might see Blue Cross–insured patients pay fee-for-service and others may be seen under a managed care contract. In 1995, there were separate data items concerning the source of payment (ie, HMO, preferred provider organization [PPO], fee-for-service, or self-pay) as well as expected type of insurance (eg, Blue Cross or Medicare). Based on responses to these 2 questions, for this report I characterized the type and source of payment expected for visits to physicians into 6 categories: (1) PPO, (2) HMO/other prepaid (HMO), (3) Medicare not HMO/PPO (Medicare), (4) Medicaid not HMO/PPO (Medicaid), (5) commercial insurance not HMO/PPO (commercial insurance), and (6) other. The basis for defining these categories from the questions related to source of payment and type of insurance is provided in Table 1.

I then analyzed the number of visits with each type of payment for office-based visits overall, for common skin complaints to all office-based physicians, and to dermatologists. The association between type of payment and the demographic and disease characteristics of patients seen was also examined. Visits for common skin complaints were defined using the National Center for Health Statistics’ “reasons for visit classification system,” with common skin complaints defined as symptoms referable to skin, nails, and hair (reason for visit codes 1830-1895).3

The odds ratio was used as a measure of association between variables. The odds ratio also provides an estimate of the rate ratio. In calculating measures of association, the modified sample weights provided by the National Center for Health Statistics were applied. To calculate statistical significance, the relative SE estimate formula provided by the National Center for Health Statistics was used to calculate variance. Based on these estimates of variance, statistical significance was calculated using the $\chi^2$ test.

### Table 1. Definitions of Payment Arrangements for Outpatient Service*

<table>
<thead>
<tr>
<th>Type of Payment/Contractual Arrangement</th>
<th>Commercial BCBS, Other Insurance</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Other or Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HMO/other prepaid</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Insurer, fee-for-service</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Self-pay</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Other, not specified</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

*Payment categories used in analyses: 1, preferred provider organization (PPO); 2, health maintenance organization (HMO); 3, Medicare not HMO/PPO (Medicare); 4, Medicaid not HMO/PPO (Medicaid); 5, commercial insurance (not HMO/PPO); and 6, other. BCBS indicates Blue Cross/Blue Shield.

### Table 2. Number of Visits (Millions) and Percentage Distribution by Type of Payment for All Office-Based Visits and for Visits Only for Common Skin Complaints, 1995*

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>All Visits</th>
<th>Visits for Skin Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) PPO</td>
<td>80 (11.5)</td>
<td>5 (14)</td>
</tr>
<tr>
<td>(2) HMO</td>
<td>158 (22.7)</td>
<td>8 (24)</td>
</tr>
<tr>
<td>(3) Medicare</td>
<td>128 (18.4)</td>
<td>6 (16)</td>
</tr>
<tr>
<td>(4) Medicaid</td>
<td>45 (6.5)</td>
<td>2 (5)</td>
</tr>
<tr>
<td>(5) Commercial insurance</td>
<td>160 (23.0)</td>
<td>8 (23)</td>
</tr>
<tr>
<td>(6) Other</td>
<td>125 (18.0)</td>
<td>7 (19)</td>
</tr>
<tr>
<td>Total</td>
<td>697 (100)</td>
<td>35 (100)</td>
</tr>
</tbody>
</table>

*All values are number (percentage). See the “Methods” section for definitions of type of payment.

†See Table 1 for definitions of abbreviations and footnote for numbers 1 through 6.

As noted in Table 4, the importance of PPOs and HMOs in financing medical care for common skin complaints varied among geographic regions. The South remains the bastion of traditional fee-for-service medicine. Preferred provider organization and HMO provider care was far more important in metropolitan than nonmetropolitan areas (42% vs 17%; $P<.01$). The importance of prepaid insurance decreases with increasing age. Among individuals younger than 18 years presenting to an office-based physician with a common skin complaint, half of the visits were provided under managed care arrangements (HMOs or PPOs). For patients aged 18 to 64 years, managed care accounted for 48% of such visits. In 1995, only 25% of visits by those 65 years and older were provided under the auspices of a managed care plan.

COMMENT

The 1995 National Ambulatory Medical Care Survey provides more recent and detailed information on the importance of managed care in financing office-based care, overall and for skin complaints. By 1995, PPOs, HMOs, or other prepaid plans financed nearly 20% of office visits for skin complaints. In urban areas of the western United States, half of such visits are provided by managed care. Although the increase in the role of managed care in office-based practice is both dramatic and substantial, exact comparisons between
years are difficult because of changes in the survey questions. Still, even when differences in survey methodologies are considered, it appears that the proportion of visits for skin complaints provided under the auspices of managed care doubled from 1992 to 1995 and increased about 4-fold from 1985 to 1995. Some of this increase observed may reflect more precise classification of the type of insurance provided under the auspices of Medicaid and Medicare. This more precise classification is, however, unlikely to account for a substantial portion of the overall increase in the importance of managed care, especially for dermatologists, who provide relatively few services to Medicare and Medicaid recipients who enroll in managed care plans.

There is a marked difference in the type of relative importance of alternative managed care arrangements for dermatologists compared with other physicians who provide care for skin complaints. Patients enrolled in PPOs account for more than 60% of patients with managed care seen by dermatologists. Only about 20% of prepaid managed care patients with skin complaints seen by nondermatologists have PPO insurance, and PPOs insure only about 12% of office visits overall. Compared with PPO-insured individuals, HMO-insured individuals are far more likely to visit a nondermatologist than a dermatologist for a common skin complaint. Preferred provider organizations generally provide a physician with access to a panel of patients to whom the physician agrees to provide care, usually at a discounted rate. Although arrangements vary greatly, in general PPOs have less restrictions on referral to specialists than do HMOs, and PPOs are less likely to put providers at financial risk because of overuse of health care services.

For the individual physician the proportion of patients seen with different sources or types of payment is likely to vary according to many factors, including (1) the willingness of a physician to participate in a plan, (2) the willingness of the plan to include the physician, (3) the type of practice (eg, surgical, medical, or pediatric), (4) the organization of the practice (eg, solo, group, or hospital based), (5) the market penetration of managed care, and (6) the physician’s waiting list. Although the situation varies greatly among individual dermatologists, this study clearly demonstrates that for many if not most dermatologists, providing care for patients with managed care insurance will represent a substantial fraction of those individuals’ total practices.

Only a few years ago traditional Medicare, commercial insurance, and fee-for-service were the dominant sources of payment to dermatologists. Now the percentage of patients seeing dermatologists with managed care insurance equals that of the percentage who have Medicare and commercial insurance combined. Managed care plans are expanding rapidly among Medicare beneficiaries and other groups. As managed care grows, economic and competitive pressures on dermatologists are likely to expand.

Dermatologists account for about 3.6% of visits to office-based physicians for any reason, and 44% of visits for common skin complaints. Despite the increasing and aging population and more dermatologists in the United States, the number of office visits to dermatologists has changed little in the last 10 years (1985, estimated 24 million total visits; 1995, estimated 25 million total visits). About 60% of all visits to dermatologists were for common skin complaints, as defined in the National Ambulatory Medical Care Survey reason for visit classification system. The distribution of sources of payment for visits for common skin complaints and other visits to dermatologists were similar. As competition for access to patients and the supply of providers continue to increase, managed care plans are likely to continue to demand further lowering of reimbursement for the services they insure or further limit access to specialists, whose services may be considered to be more costly than those provided by nonspecialists.

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REFERENCES