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Susmita Pati, MD, MPH
*LDI Senior Fellow,
Assistant Professor of Pediatrics
Children's Hospital of
Pennsylvania and
University of Pennsylvania*

Gatekeeping and Children's Health Care Costs

Editor's note: In the 1990's, primary care gatekeeping became a hallmark of managed care and a major model of health care delivery. Proponents claimed that gatekeeping—requiring that primary care providers preauthorize specialty visits—could control costs and improve coordination of care. However, much of this potential has remained unrealized, and managed care organizations are beginning to loosen these restrictions. This Issue Brief adds to the growing literature on the ineffectiveness of gatekeeping in controlling costs in pediatric care. The following study focuses on privately insured children, and analyzes the impact of gatekeeping on their health care expenditures.

*Gatekeeping plans
predominate insurance
market, but effects on
pediatric care are unknown*

Gatekeeping arrangements have been used for decades by managed care organizations as a tool to control costs (by reducing use of expensive specialty care) and improve care (by promoting coordination between generalists and specialists.) Little is known about how these arrangements affect pediatric care and children's health care costs.

- Even before the introduction of gatekeeping requirements, the vast majority of children obtained health care coordinated by a pediatrician. National data indicate that general pediatricians in the community manage almost 98% of all office visits without a referral. Formal gatekeeping requirements may have introduced additional administrative hurdles for families without improving the delivery of care or reducing overuse of specialists.
- Gatekeeping has proven unpopular with both physicians and patients, because of its perceived restrictions on choice.
- Prior studies have focused on children with chronic illness, or on Medicaid managed care enrollees. These studies have provided mixed results on whether gatekeeping affects utilization of subspecialists, and whether these arrangements control costs.

*Authors study large sample
of privately insured
children*

Pati and colleagues analyzed data from the 1996 Medical Expenditure Survey (MEPS) to determine whether expenditures were lower for privately insured children in gatekeeping plans compared with those in indemnity plans. The 3,254 children in the study were representative of 40.4 million privately insured children in 1996, who accounted for \$35.7 billion in health expenditures that year.

- Gatekeeping plans included all HMOs or other plans requiring a primary care gatekeeper. All other plans (including traditional fee-for-service plans and preferred provider organizations that did not have a gatekeeping requirement) were considered indemnity plans.
- By these definitions, 58% of children were enrolled in gatekeeping plans, and 42% were enrolled in indemnity plans.
- Members of racial/ethnic minorities were more likely than non-Hispanic whites to belong to gatekeeping plans. Children in gatekeeping plans were more likely to reside in the West or Northeast than those in indemnity plans.
- Functional status and parent-reported health status of the children did not differ significantly between the two types of plans.

Few differences found in total health expenditures by type of plan

Looking at total health expenditures, the authors found no significant difference between children in gatekeeper plans compared with those in indemnity plans.

- Average annual health expenditures for children in gatekeeping plans (\$887) were nearly identical to expenditures for children in the indemnity plans (\$881).
- The proportion of children with no health expenditures was slightly lower in the gatekeeping group than in the indemnity group (9% vs. 11.2%).
- The following table describes expenditures by the type of service. The proportion of enrollees with any inpatient expense was similar in both plans (1.6% -2.4%) and too small to be confident that the costs were significantly different between the groups. The proportion of enrollees with any ambulatory expenses was higher among gatekeeping plan enrollees than indemnity enrollees (78% vs. 74%); among those with any outpatient expenses, gatekeeping and indemnity expenditures were similar.

Average per capita expenditures, privately insured children, 1996

Type of service	Gatekeeping	Indemnity
Total expenditures	\$ 887	\$ 881
Inpatient	135	180
Ambulatory visits	225	220
Prescription drugs	74	67
Dental	223	219

Families paid less out-of-pocket in gatekeeper plans

The authors also examined costs from the insurer's and family's perspectives, to determine whether gatekeeping had affected the distribution of costs.

- Enrollment in a gatekeeping plan was associated with lower out-of-pocket payments. Families of children enrolled in such plans paid on average of \$62 less out-of-pocket than indemnity plan enrollees (\$205 vs. \$267). The lower amounts were primarily due to lower copayments for outpatient visits and prescription drugs.

- In contrast, insurers paid an average of \$41 more in gatekeeping plans compared to indemnity plans (\$636 vs. \$595). This difference arose primarily because children in gatekeeping plans were more likely to have ambulatory expenditures.
- The following table describes expenditures by the source of payment:

	Gatekeeping	Indemnity
Private third-party (insurer)	\$ 636	\$ 595
Ambulatory visits	166	121
Out-of-pocket	205	267
Ambulatory	49	89
Prescription drugs	25	32

Model predicts savings of 4% in gatekeeper plans if enrollees had the same baseline characteristics

In addition to tracking actual expenditures in both types of plans, Pati and colleagues conducted another analysis to predict total health care expenses as though gatekeeping and indemnity enrollees had similar health status and demographic characteristics.

- A number of characteristics were significantly associated with having a health care expenditure, including age less than 2 years, non-Hispanic White ethnicity, nonpoor status, functional impairments, and parental reports of poor health status.
- A predictive model was used to account for these characteristics and the probability of having any health expenditure. If all enrollees had similar characteristics, the model predicted that average total health care expenditures would have been about 4% lower among gatekeeping beneficiaries than indemnity enrollees.

POLICY IMPLICATIONS

This analysis suggests that gatekeeping is not an effective cost containment strategy for children. In 1996, total annual per capita expenditures differed by less than 1% for children in gatekeeper plans compared with those in indemnity plans.

- For the vast majority of children, pediatricians have historically served as the source of primary care. Underuse, rather than overuse, of specialists may be a more relevant problem in children’s health care. In that case, gatekeeping arrangements have little potential to decrease costs by targeting inappropriate use of specialty care.
- This study did not explore the impact of gatekeeping on quality of care. Some studies suggest that managed care gatekeeping arrangements might improve access to primary preventive health care services. Consistent with these findings, this study found that children in gatekeeping plans were slightly more likely to have a visit within the past year compared with those in indemnity plans.

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POLICY IMPLICATIONS

Continued

Conversely, other studies have indicated that such arrangements create unnecessary administrative burdens and may decrease access to care for children with special health care needs.

- In the last few years, employers and insurers have begun abandoning stringent gatekeeping requirements in favor of less restrictive preferred provider arrangements. Contributing factors to this trend include the so-called “managed care backlash” from patients and providers, and threats of tighter government regulation. This study suggests that, at least in the case of child beneficiaries, insurers have little to lose from opening the gates.

This Issue Brief is based on the following article: S. Pati, S. Shea, D. Rabinowitz, and O. Carrasquillo. Does gatekeeping control costs for privately insured children? Findings from the 1996 Medical Expenditure Survey. Pediatrics, March 2003, vol. 111, pp. 456-460.

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Janet Weiner, MPH, Associate Director for Health Policy, Editor

David A. Asch, MD, MBA, Executive Director

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3641 Locust Walk
Philadelphia, PA 19104-6218
215.898.5611
fax 215.898.0229
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