

STUDENT ACTIVITY 7-4

<http://www.schip-info.gov>

Organization Name:

State Children's Health Insurance Program

Mission Statement:

?

Overview of Activities:

provide ins. to children in families at or below 200% of the federal poverty line.

Importance of organization to US health care:

The State Children's Health Ins. program, or SCHIP was established by the fed. gov. in 1997 to provide health ins. to children in families that meet specified income requirements

<http://www.ebms.com>

Organization Name:

Employee Benefit Mgmt. Services Inc.

Mission Statement:

Overview of Activities:

See port.

Importance of organization to US health care:

Impact of Managed Care on Healthcare Delivery

LEARNING OBJECTIVES

The student will be able to:

- Define managed care.
 - Describe the network-based types of managed care organizations (MCOs).
 - Discuss the history of managed care.
 - Discuss four major goals of managed care.
 - Assess the relationship of managed care with providers.
 - Identify four cost control methods of MCOs.
- The Health Plan Employer Data and Information Set (HEDIS) is a data set of healthcare plan's service activities and is used to evaluate healthcare plans. Although there is a voluntary submission process, nearly 100% of all health plans submit their data to HEDIS.
 - According to *Fortune* magazine's analysis of industries, managed care had the highest growth rate of the five major healthcare sectors.

DID YOU KNOW THAT?

- The concept of managed care has been evolving since the early 1930s.
- The oldest form of managed care is the health maintenance organization (HMO).
- From 2000 to 2007, healthcare premiums rose 98% while wages only rose 23%, despite the prevalence of managed care models that focus on cost control.
- Carve outs are healthcare services that will not be paid by MCOs and could include experimental treatment, drug costs, and behavioral health costs.

INTRODUCTION

Managed care refers to the cost management of healthcare services by controlling who the consumer sees and how much the service cost. MCOs were introduced 40 years ago, but became more entrenched in the healthcare system when the Health Maintenance Organization Act of 1973 was signed into law by President Nixon (Buchbinder & Shanks, 2007; Shi & Singh, 2007; Sultz & Young, 2006). Healthcare costs were spiraling out of control during that period. Encouraging the increase in the development of HMOs, the first widely used managed care model, would help to control the healthcare costs. MCOs' integration of the financial industry with the medical service industry resulted in controlling the reimbursement rate of services, which allowed them more

control over the health insurance portion of health care (Sultz & Young, 2006).

Physicians were initially resistant to managed care models because they were threatened by loss of income. As the number of managed care models increased, physicians realized they had to accept this new form of healthcare delivery and, if they participated in a managed care organization, it was guaranteed income. Managed care became very popular in the 1990s. Enrollment increased from 27% in 1988 to 95% in 2002 ("Managed care organizations," 2007). For a period, healthcare costs decreased during the 1990s as a result of the influence of MCOs. However, the influence was short-lived and healthcare costs continued to increase. From 2000 to 2007, healthcare premiums rose 98% while wages only rose 23% (Wunker & Duncan, 2009). Projections for 2009 indicated that there will be an increase of 10.6% for HMOs as compared to the 2008 increase of 10.9%. Prescription drug costs will increase 9.2%, which is below the 2008 9.5 increase ("Health costs decelerate," 2008).

This chapter will discuss the history of the evolution of managed care and why it developed, the different types of managed care, the MCO assessment measures used for cost control, the issues regarding managed care, and how managed care has impacted the delivery of healthcare services.

HISTORY OF MANAGED CARE

As discussed in Chapter 1, the delivery of health care evolved around the individual relationship between the provider and patient/consumer. The payment was either provided by a health insurance company or paid out of pocket by the consumer. This **fee-for-service (FFS)** system or **indemnity plan** increased the cost of health care because there were no controls on how much to charge for the provider's service. As healthcare costs continued to spiral out of control throughout the decades, more experiments with contract practice and prepaid service occurred randomly throughout the US healthcare system (Shi & Singh, 2007; Sultz & Young, 2006).

According to Shi and Singh (2007), from 1850 to 1900, railroad, mining, and lumber companies provided their employees with healthcare services. The companies contracted with a physician to provide services to their employees at a rate per worker (which is a capitation rate because it limits the amount the provider will be

paid for per service). The reason these companies had to contract with a physician was because of the remote areas of work locations. When group health insurance programs were formed in the 1940s, it reduced the power of the corporations over managing the healthcare coverage and increased the power of the health insurance companies. The health insurance companies and providers had no incentives to control the costs of services. The concept of contractual practices and capitation were not adopted nationwide, which pleased the American Medical Association (AMA) because providers could increase their income with a traditional FFS practice. As a result of this system, healthcare costs continued to increase dramatically.

The concept of managed care has been evolving seriously since the early 1930s. The Committee on the Costs of Medicare Care recommended in 1932 that health care should be reorganized into a type of prepaid formula to control costs of services (Committee on the Costs of Medical Care, 1932). The FFS system was recognized even then as inefficient because there was no coordination of care of the patient between the primary care provider and other providers. There was also no focus on minimizing cost of services.

In the early 1930s and 1940s, several health plans adopted the concept of prepaid practice plans: the Group Health Association of Washington, the Group Health Cooperative of Puget Sound, the Health Insurance Plan of Greater New York, and the Group Health Plan of Minneapolis and the Kaiser Permanente Medical Care program, which became the model for HMOs (Shi & Singh, 2007). According to the Kaiser Permanente Web site, the Kaiser Permanente Plan was developed in 1933 as a result of providing care to construction, shipyard, and steel workers for Kaiser Industries, which they owned during this period. Dr. Sidney Garfield, a surgeon, recognized the potential to provide care to the thousands of workers involved in extensive projects so he built a hospital and set up a practice to care for these workers. Unfortunately, he often did not receive pay for his services because the insurance companies were not timely in their reimbursement and some workers were uninsured. Harold Hatch, an insurance agent, developed the prepaid concept of medical care. Dr. Garfield would receive insurance remuneration up front per day for each worker. This system worked extremely well and was used for several different industrial projects until 1945 when many of these large projects were completed. Kaiser Permanente opened this type of managed

care system to the public in 1945. Membership increased to 300,000 members as a result of union membership. Kaiser Permanente, located in Oakland, CA, has continued this type of concept successfully. It is the largest nonprofit health plan today with 8.6 million members (Kaiser Permanente, 2009).

Legislative Influence on Managed Care Development

In 1973, President Nixon signed into law the HMO Act. This Act authorized \$375 million in funding (loans and grants) for HMO expansion of existing facilities, which rewarded them for focusing on cost control. The Act also required that any business that had 25 or more employees offer an HMO option if available. According to a 2004 report by AMA's Council on Medical Services on managed care, over the next 30 years, several legislative acts were passed that impacted how managed care developed (Hoven, 2004).

The HMO Act of 1973 was amended in 1976 and 1978, which relaxed requirements for HMOs and restricted funding for HMO assistance programs for 2 years. In 1988, the HMO Act was amended to allow employees to contribute less to HMO plans than to traditional FFS plans. In 1982, the Tax Equity and Fiscal Responsibility Act cut more federal funding for health care, including HMOs. The Balanced Budget Act of 1997 established Medicare+Choice (M+C; Part C) which developed different structures for managed care plans. In 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 replaced M+C with Medicare Advantage (Hoven, 2004).

Over three decades, MCOs' strategies increased their exposure. More companies and health insurance companies became interested in controlling healthcare costs. The federal government decided to use HMOs for their army veterans. In the 1990s, the growth rate of MCOs was 10% per year. The peak enrollment of MCOs was 1999 with a total membership of nearly 90 million. There are currently 78 million members enrolled in MCOs (Simoner, 2007).

MANAGED CARE CHARACTERISTICS

Regardless of the type of MCO, all MCOs have five common characteristics:

- They all establish relationships with organizations and providers to provide a designated set of services to their members.

- They all establish criteria for their members to utilize the MCO.
- They all establish measures to estimate cost control.
- They all provide incentives to encourage health service resources.
- They all provide and encourage utilization of programs to improve the health status of their enrollees (Knight, 1998).

The MCO provides comprehensive services that include primary, secondary, and tertiary care. Depending on the type of MCO, physicians may work exclusively for the MCO or may be under contract with the MCO. MCOs will also contract with hospitals and outpatient clinics to ensure they provide comprehensive services.

Different Types of Managed Care Models

There are six organizational structures of MCOs.

1. **Health maintenance organizations (HMOs):** HMOs are the oldest type of managed care. Members must see their primary care provider first in order to see a specialist. There are four types of HMOs: staff model, group model, network model, and the independent practice association.
 - The **staff model** hires providers to work at a physical location.
 - The **group model** negotiates with a group of physicians exclusively to perform services.
 - The **network model** is similar to the group model but these providers may see other patients who are not members of the HMO. There is a negotiated rate for service for members to see providers who belong to the network.
 - The **independent practice associations (IPAs)** contract with a group of physicians who are in private practice to see MCO members at a prepaid rate per visit. The physicians may sign contracts with many HMOs. The physicians may also see non-HMO patients. This type of HMO was a result of the HMO Act of 1973.
2. **Preferred provider organizations (PPOs):** These providers agree to a relative value-based fee schedule or a discounted fee to see members. They do not have a gatekeeper like the HMO so a member does not need a referral to see a

specialist. The PPO does not have a copay but does have a deductible. This plan was developed by providers and hospitals to ensure that non-members could still be served while providing a discount to MCOs for their members. A member may see a provider not in the network but they may pay more out of pocket for their services. The bill could be as much as 50% of the total bill. They are currently the most popular type of plan (American Heart Association, 2009; Sultz & Young, 2006).

3. **Exclusive provider organizations (EPOs):** They are similar to PPOs but they restrict members to the list of preferred or exclusive providers members can use.
4. **Physician hospital organizations (PHOs):** These organizations include physician hospitals, surgical centers, and other medical providers that contract with a managed care plan to provide health services (Judson & Harrison, 2006).
5. **Point-of-service (POS) plans:** The POS plans are a blend of the other MCOs—a type of HMO/PPO hybrid (American Heart Association, 2009). They encourage but do not require that plan members to use a primary care provider who will become the gatekeeper of services. Members will receive lower fees if they use a gatekeeper model. They may also see an out-of-network provider at any time but will be charged a higher rate. This type of plan was developed as a result of complaints about the inability of a member to choose their provider (Anderson, Rice, & Kominski, 2007).
6. **Provider-sponsored organizations (PSOs):** These organizations are owned or controlled by health-care providers. This is an emerging term that describes provider organizations that are formed to directly contract with purchasers to deliver healthcare services. PSOs are formed by organizations such as IPAs. However, unlike IPAs, they assume insurance risk for their beneficiaries (Longest & Darr, 2008).

THE MANAGED CARE ORGANIZATION PAYMENT PLAN

Depending on the type of MCO structure, their financing structure with providers may differ as well.

There are three major types of provider remuneration: capitation, discounted fees, and salaries. With a **capitation policy** or per member per month policy the provider is paid a fixed monthly amount per employee, often called a PMPM payment. This member fee is given to the provider regardless of how often the members use the service and the types of services used. The provider is responsible for providing all services deemed necessary.

Discounted fees are a type of FFS but are discounted based on a fee schedule. The provider provides the service and then can bill the MCO based on the fee schedule. Each service can be billed separately. The provider anticipates a large referral pool from the MCO so they will accept the discounted rates.

Salaries are the third method of payment. In this instance, the provider is actually an employer of the MCO. Annually, a type of bonus is distributed among the providers based on how often services have been used by members. So although they receive a salary, they will be rewarded by additional performance measures (Centers for Medicare and Medicaid Services [CMS], 2009).

COST CONTROL MEASURES OF MANAGED CARE ORGANIZATIONS

Restriction on Provider Choice

Members of an MCO often have restrictions on their choice for a provider. As the types of MCOs have evolved over the years, the restrictions have lessened, but there is a financial penalty such as a higher copayment or higher deductible for choosing a provider out of the network.

Gatekeeping

In some MCOs, the primary care provider is the gatekeeper of all of the care for the patient member. Any secondary or tertiary care would be coordinated by the gatekeeper. The primary care provider is responsible for the case management of a member patient. If additional medical services are needed, the primary care provider must refer the member patient for additional services. Some members do not like having a gatekeeper and would prefer to make these decisions themselves. As a result of this model, some MCOs require a preauthorization of services by the MCO. Many MCOs have clinical guidelines to determine service approval (Buchbinder & Shanks, 2007).

Services Review

Utilization review evaluates the appropriateness of the types of services provided. According to Shi and Singh (2007), there are three types of utilization reviews: prospective, concurrent, and retrospective. **Prospective utilization review** is implemented before the service is actually performed by having the procedure authorized by the MCO, having the primary care provider decide to refer the member for the service, or assessing the service based on the clinical guidelines. **Concurrent utilization reviews** are decisions that are made during the actual course of service such as length of inpatient stay and additional surgery. **Retrospective utilization review** is an evaluation of services once the services have been provided. This may occur to assess treatment patterns of certain diseases. This type of review may include a financial review to assure accuracy of billing. **Practice profiling**, an offshoot of retrospective utilization review, examines specific provider patterns of practice. This is a type of employee performance review because the focus is to determine which provider also fits in with the organizational culture of the MCO.

MEDICARE AND MEDICAID MANAGED CARE

Medicare Managed Care

As stated previously, the M+C program was created as a result of the Balanced Budget Act of 1997. Implemented in 2000, the purpose of M+C was to encourage Medicare enrollees to use managed care services. Medicare offered risk plans and cost plans for their enrollees. **Risk plans** pay a premium per member that is based on the member's county of residence. Members could use both in-network and out-of-network providers. The risk plans covered all Medicare services and vision and prescription care. **Medicare cost plans** reimburse the MCOs on a preset monthly basis per enrollee based on a forecasted budget. The cost plans allowed members to pursue care outside the network. In 2000, the program's enrollment was at a high of over 6 million members (CMS, 2009; Shi & Singh, 2007).

In 2003, the Medicare Prescription and Drug Improvement and Modernization Act (MMA) renamed the program **Medicare Advantage (MA)** and allowed PPOs as an option. It also allowed enrollees to participate in private fee-for-service (PFFS) plans as

part of the MA. CMS evaluated the administration of the MA program and, based on that evaluation, they developed strategies to recruit more MCO participation. Despite these improvements, managed care enrollment initially dropped nearly 2 million in 2004. With changes in MA, 2006 enrollment surpassed the M+C enrollment (CMS, 2009). As a result of the MMA, the newly revamped MA program has been a financial boost to MCOs. Prior to the passage of the MMA, many providers refused Medicare and Medicaid patients because the reimbursement rates were low. As a result of the MMA, the top MCOs—Aetna Healthcare, Wellpoint, and United HealthCare—received reimbursements from the federal government for nearly \$80 billion in 2007, which was an increase from nearly \$25 billion in 2003 (Trombetta, 2008). The MA program is slated to cost \$100 billion this year and critics say that about \$15 billion of that is excess. Analysts estimate that in 2009, CMS will pay MA plans an estimated 14 to 18% more than comparable PFFS costs (Wechsler, 2009). The Obama administration anticipates introducing health-care reforms that will target MA for cost reductions.

Medicaid Managed Care

According to CMS, of the total Medicaid enrollment in 2004, approximately 60% were receiving Medicaid managed care benefits. All states except Alaska and Wyoming have Medicaid managed care. Managed care plans use the gatekeeper model, **HMOs**, and prepaid health plans. **Carve outs** are services that Medicaid is not obligated to pay for under an MCO contract. Carve outs have occurred because the MCO cannot provide the service or it is too expensive. Unfortunately, mental health services and substance abuse treatment services are often categorized as carve out services (CMS, 2009).

A recent study performed by the Urban Institute indicated that MCOs had an impact on access to care for some of the Medicaid beneficiaries. Supplemental security income (SSI) beneficiaries, a subgroup of Medicaid, who were located in urban areas were less likely to have had a healthcare visit within a 12-month period than those Medicaid beneficiaries enrolled in FFS programs. In rural areas, SSI beneficiaries were more likely to have made a healthcare visit within the past 12 months although they also used the emergency room as their healthcare provider (Coughlin & Young, 2004).

ASSESSMENT OF MANAGED CARE MODELS

National Committee on Quality Assurance

From a health consumer perspective, when an organization's top priority is cost control, there may be concerns about losing a level of quality. As discussed in Chapter 1, the iron triangle of cost, access, and quality can be applied to manage care. When an organization focuses on cost, quality and access may suffer. As managed care was integrated into Medicaid and Medicare, the government also became more involved in the evaluation of managed care providers. Also, as competition increased in the managed care arena, there was fear that more services would be reduced to maintain lower premiums (Sultz & Young, 2006). As a result of these issues, the National Committee on Quality Assurance (NCQA) was established to maintain the quality of care in health plans.

NCQA was established in 1990 to monitor health plans and improve healthcare quality. Their focus is to measure, analyze, and improve healthcare programs. The NCQA accredits MCOs and, although a voluntary review process, the process includes surveys completed by managed care experts and physicians. They evaluate access and service and quality of the MCO's providers, primary prevention activities, and case management for the chronically ill. An organization can be accredited at three levels: excellent, commendable, and accredited. This accreditation, although voluntary, has alleviated concerns of the MCOs' focus on cost control. The NCQA has developed a report card of accredited health plans that consumers can access on their Web site. In the past, the NCQA had developed different criteria for the different types of MCOs. As of 2009, the NCQA developed standards and guidelines for all MCOs regardless of their organizational structure. The NCQA also has a physician directory that recognizes quality practices. There are 40 states that recognize NCQA accreditation and believe that the organization improves the quality of care provided by health plans. As the MCO industry has become very competitive, it is to the benefit of an MCO to become accredited (NCQA, 2009).

Health Plan Employer Data and Information Set

HEDIS was established by the NCQA in 1989. It is used by nearly 100% of all health plans to measure service and quality of care. The reported data is available

to MCOs and physicians. HEDIS uses 71 measures from different areas of health care. Because so many health plans submit data to this HEDIS database and because the measures are so specifically defined, comparisons of health plans' performance can be performed. Health plans also use HEDIS results to assess performance (NCQA, 2009).

HEDIS measures health issues such as medication use patterns, breast cancer rates, rates of chronic diseases such as diabetes, childhood health issues, high blood pressure issues, heart disease and mental health disease, and health plans' treatment of these major health issues. Healthcare plans and providers use this database for performance assessment and consumers may use this information by using the State of the Health Care Quality Report, which analyzes the healthcare system. The Committee on Performance Measurement has members which represent the consumers, providers, health plans, employers, and other stakeholders who decide what type of data should be collected by the HEDIS and what type of measures should be used. There are four standards that are the focus of a NCQA review: quality management, utilization standards, members' rights and responsibilities, and services. The following are the focal points of these four areas. This information is a summary of evaluation criteria developed by the NCQA (NCQA, 2009).

Members' Rights and Responsibilities

Members' Written Information

- Written plan that outlines the members' rights and responsibilities and how written information is distributed to members
- Written plan that outlines the benefits, charges, and complaint process to members
- Directory for members to access necessary telephone numbers
- Written policy of MCO's protection of members from violation of their medical privacy

Member Services

- Resource accessibility for members to submit claims
- Efficiency measurement of claims processing
- Technology to improve access to and processing of claims
- Accessibility of pharmaceutical benefits and member responsibility

- The Web site's ease of use for member services
- Assurance of member information accuracy
- Member health risk appraisal using different Web educational tools
- Health information availability 24 hours a day
- Member assessments for wellness programs
- Member incentives to develop healthy behaviors

Accessibility of Services/Practitioners Availability/Member Satisfaction will focus on:

- Access to medical care for emergency and after-hours care
- Mental health services accessibility and performance measures to ensure quality of care
- Coordination between mental health and general medical care
- NCQA review of MCO to determine member accessibility to MCO physicians in the designated areas
- MCO is culturally sensitive to its patients, such as resolving language barriers
- Adequate number of both specialty and general practitioners available to MCO members
- Measures performed to ensure quality performance of providers
- MCO has a system in place to address members' complaints and if there are periodic member satisfaction surveys to assess quality of care
- Plan in place for how the MCO will take steps to rectify any quality issues

Complex Case/Disease Management/Clinical Practice Guidelines Review will focus on:

- Does the MCO have a system in place to recognize members who have more complex medical issues that require case management?
- Is there a system in place to ensure that case management is done efficiently and effectively?
- Services offered to chronically ill patients and how the patient is managed.
- Review the clinical practice guidelines and, if they are changed periodically, distributed to the providers.
- Review medical record policies to ensure all care is documented and any policies in place to improve medical documentation.

Denials and Appeals of Medical Care

- Obtaining appropriate clinical information for medical decisions
- Denial plan for medical care requests
- Appeal plan for denial of care decisions
- Written notification plan of denials to members
- Written notification of any overturned decisions to members

Additional Procedures for Pharmaceutical/Mental Health Care

- Written plan for drug coverage
- Policy for patient safety
- Routine review of the policy
- Are mental health patients appropriately referred and managed by mental health practitioners?

Quality Management and Improvement

Program structure/operations reviews will focus on the following:

- MCO's written quality assurance program that is updated annually and has specific measures regarding behavioral health.
- Assessment whether quality assurance program has a quality improvement (QI) committee that manages the program with a physician involved.
- Is there a work plan so quality assurance activities can be updated?
- How active is the QI committee in reviewing the program and is the QI program known to the providers of the MCO?
- If the QI committee takes action, review if there are issues regarding QI.
- Review if providers are cooperating with the QI committee and ensure access to medical records and other information is made available while maintaining provider-patient confidentiality.

Utilization Management

Structure/criteria for utilization of services/physician participation review will focus on the following:

- Written procedure for managing care
- Designation of appropriate physician to type of care

- Evaluation of the program on a timely basis
- Use of evidence-based clinical criteria for denying and approval of care
- Physician participation in developing criteria
- Evaluation plan of the criteria used
- Quality of healthcare professionals who review denials of care
- Use of consultants to assess medically necessary determinations
- Time frames for clinical decisions
- Notification process for members regarding clinical decisions

ISSUES WITH MANAGED CARE

According to AMA's 2003 survey, the *Portrait of Physicians*, physicians who contract with several MCOs are concerned with providing quality care to their patients because the MCOs' focuses are on cost. As a result of their focus on cost, the physician's ability to practice without close monitoring of their healthcare choices can be limited. Surveys indicate that the more managed care networks the physician contracts with, the less satisfied they are with managed care. However, if providers are provided an orientation regarding managed care during their education, they are more receptive to MCOs (AMA, 2009).

Physicians are also concerned with physician network rentals or silent PPOs, which are unauthorized third parties outside the contract between the MCO and the physician that gain access to the MCO discount rates. Examples of these network rentals are automobile insurers or workmen's compensations insurers. They obtain the physician's rates from a database. The main insurer who has the contract with the physician does not provide the information to the physician and the third parties continue to benefit from the discounted rates. There are currently 14 states that prohibit these silent PPOs (Berry, 2008; Carroll, 2009). This scheme takes money from the physicians because they are obtaining discounts fraudulently. Physicians have pursued legal action against MCOs because of issues with reimbursement such as the abuse of these discounted rates by unauthorized users.

As a result of these issues, the AMA has developed a Private Sector Advocacy Unit which addresses issues with managed care such as those identified here. They have provided guidance to physicians on contract

development, claims management, complaint processes, and HIPAA compliance forms. The AMA has also been a strong lobbyist for legislation to protect physicians from silent PPOs (Hoven, 2004).

The concept of medical loss ratio or the minimum amount of dollars a healthcare plan spends on providing care rather than administration has been targeted by the California Medical Association, which has been lobbying state government to require healthcare plans to spend at least 85% of their profits on reimbursement claims (Carroll, 2008). This cap would limit the continued increase in premiums that healthcare consumers continue to pay year after year. The healthcare plans feel that if that cap would occur, there would be less focus on providing quality customer service. This long running battle is a result of annual Rand Reports that give medical loss ratio (MLR) statistics on healthcare plans. For example, Great-West Healthcare of California's MLR is 69.4%, a decrease from 86% in 2003. This indicates that more funds are being targeted to operational rather than quality healthcare services. It is important to note that the MLR will be different between nonprofit and for-profit organizations because their missions are different (Carroll, 2008). As a result of the varying differences in MLRs of health organizations, some states have passed MLR laws to ensure that a minimum amount is being spent on delivering quality healthcare services to their patients.

Recently United HealthCare paid a \$350 million settlement because their subsidiary, Ingenix, had underestimated (as much as 28%) the schedule of usual and customary fees, which are the standardized rates assessed for reimbursement of both in-network and out-of-network healthcare services. This underestimation resulted in increased out-of-pocket expenses for their members. There were 100 million beneficiaries that were assessed out-of-pocket expenses based on this database. As part of this settlement, United HealthCare was also required to develop a new database that would be developed by an independent contractor (Miller, 2009).

CONCLUSION

The managed care model for healthcare delivery was developed for the primary purpose of containing healthcare costs. By administering both the healthcare services and the reimbursement of these services, and therefore eliminating a third party health insurer, the industry felt that this model would be very

cost-effective. Both the consumer or patient and the physician's concerns were the same—worry about providing quality care while focusing predominantly on cost. The consumer was also worried about loss of freedom of choice of their primary care provider. The physician was worried about loss of income.

As managed care evolved, more managed care models evolved that allowed more choice for both the consumer and the physician. Eventually, there were models such as PPOs and POS plans that allowed a consumer to more freely choose their provider. However, there was a financial disincentive to use a provider outside the network of the MCO. The provider was also able to see non-MCO patients, which increased their income. The provider also received a financial disincentive because any MCO patient was given health care at a discounted rate.

Critics of MCOs have said that although they have eliminated the health insurer from the equation of providing care, the MCOs have absorbed that savings into their organization. With the passage of the MMA, MA MCOs have been reimbursed by the government at very high rates. In 2007, United HealthCare and Humana earned 66% and 11% respectively of their net income from MA reimbursements (Trombetta, 2008).

There also have been reimbursement issues with how MCOs have reimbursed the physicians. As discussed in the chapter, the issue with silent PPOs has financially hurt the physicians. Physicians have also had problems with timely reimbursement from MCOs. As also discussed in the chapter, there were issues with fraudulent reimbursement rates of out-of-network services, which resulted in members paying exorbitant out-of-pocket expenses.

Many MCOs have been very profitable for years. The recent CEO of United HealthCare retired with

a \$1.2 billion package. The most profitable HMO in the United States is Coventry Health Care of Bethesda, Maryland. Their MLR is approximately 80%. Kaiser Permanente, a nonprofit MCO, has an MLR of 99%—that means that nearly all of their premiums are returned to the members for their care (Carroll, 2008). With the economic issues that have been and will be facing the United States, with the number of uninsured Americans rising daily as more people lose their jobs, it seems almost unethical that some MCOs' MLRs are so low.

PREVIEW OF CHAPTER NINE

Chapter 9 discusses the tremendous impact of information technology (IT) on health care. Health information technology's (HIT) goal is to manage health information that can be used by all stakeholders in the industry which includes the consumer, the providers, the health insurance companies, employees, and pharmaceutical companies. HIT has allowed the documentation of every transaction to be more quickly documented, which has resulted in the increased efficiency of healthcare data. HIT allows different systems to share patient data which will increase the quality and efficiency of health care. From a consumer standpoint, HIT has impacted the ability for a patient to access more data via electronic sources. There have also been electronic initiatives to provide basic health-care online.

The Obama administration is committed to a national computerized system of patient data that will focus on increased efficiency and quality of care and has budgeted nearly \$20 billion to accelerate the development of computerizing physician's offices by creating regional IT centers. This chapter will discuss the history of HIT, the different applications, and the barriers for the implementation of IT in health care and the impact of IT on you as a healthcare consumer.

VOCABULARY

Capitation policy

Carve outs

Concurrent utilization reviews

Discounted fees

Exclusive provider organizations

Fee-for-service plans

Gatekeeper

Group model

Health maintenance organization (HMO)

Health Plan Employer Data and Information Set (HEDIS)

Indemnity plan	Preferred provider organizations (PPO)
Independent practice associations	Private Sector Advocacy Unit
Managed care	Prospective utilization review
Medical loss ratio	Retrospective utilization review
Medicare Advantage	Risk plans
Medicare cost plans	Salaries
National Committee on Quality Assurance (NCQA)	Silent PPOs
Network model	Staff model
Physician hospital organizations	Usual and customary fees
Point-of-service plans	Utilization review
Practice profiling	

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