MANAGED CARE PRINCIPLES

At the conclusion of these sessions you will:

1. Understand the historical development of managed care plans, including factors, which promoted their development and reasons for resistance to them.
2. Understand the different types of managed care plans, including their operational features and the advantages and disadvantages of each type of plan.
3. Understand the relationships among the different parties involved in managed care systems.
4. Understand the different types of reimbursement for the parties involved in managed care systems and how reimbursement affects their behaviors.
5. Understand some of the major future trends in managed care systems.

I. History and Rationale for Interest in Managed Care Plans - see slides (to be emailed) and the Managed Care portion of Chapter 4 (Part 5).

History

Read the article by Mayer and Mayer. It is important to understand the history of these plans because of the opposition they still face in many traditional quarters of the U.S. medical community.

Q: What was/is the basis of opposition to these plans?
Q: Do you think a "health maintenance organization," in the truest sense of the term, is ever attainable?

II. HMO's

A. We will first review the recent reasons for emergence of managed care as a prevalent insurance mechanism. A part of this discussion will focus on the role managed care has played in moderating healthcare costs.

See slides.

We will next review some of the decisions employers make when choosing health plans for their employees - with special reference to their choice of managed care plans.

See slides.
C. Definition

Various definitions of managed care will be reviewed and key factors differentiating managed care from fee for service will be highlighted.

See slides.

In discussing this section, we will key on two important concepts: changing physician behavior through restructuring financial incentives and coordinating care across the continuum of services.

D. We will then review the different types of HMO’s and how the premium dollar is distributed.

See slides.

E. We will next review who the different parties are and who the different constituencies are in managed care and what each wants from their relationship with the others.

1. What consumers want from their health plans - see slide.

2. What primary care physicians and groups want from managed care plans - see slides.

3. What managed care plans want from physicians - see slide.

4. What physicians want from their hospitals - see slide.

5. What hospitals want from their physicians - see slide.

F. We will then talk about organized delivery systems and managed care implications.

In contrast to the fee-for-service and Medicare systems, how do physician and health system incentives "line up"?

See slides.
G. Given the above information, we will discuss the results of HMO implementation and current trends and recommendations.

1. Read the article by Miller and Luft. Understand the major points they make as well as methodological problems in interpreting data. Pay attention to answering the following questions:

   Q: Is there a difference in quality of care between the fee for service sector and HMO's? Remember our initial class discussions on tradeoffs in cost/quality/access.

   Q: On what types of factors does the answer to this question depend?

2. Read the article by Berwick.

   One of the criticisms often cited in discussing HMO's is the potential for conflict of interest for the physician in a capitated system. Read this article with the following questions in mind:

   Q: What does he say is the major advantage of managed care systems?

   Q: What are the pros and cons of such a system?

   Q: What effect does varying the number of patients assigned to a provider have on decision making?

   Q: Should plans contract with all providers who meet their cost criteria? Why or why not? (This issue is becoming increasingly important as some states enact laws which require plans to contract with "any willing provider.")

3. Read the article by Tu.

   Do the findings of the study indicate a change in public sentiment about this issue?

III. Preferred Provider Organizations (PPO's)

   A. Definition - See slide.

   B. Evaluative questions:

   Q: What was the impetus for PPO development?

   Q: Is discounting an effective cost control mechanism?

   Q: How do these plans identify "cost effective providers"?

   Q: Compare and contrast HMO's and PPO's. What are the strengths and weaknesses of each?
IV. Hybrids

An additional product has emerged which is a hybrid between an HMO and a PPO. These plans are commonly called "point of service" (POS) plans because the patient determines whether the HMO benefit or the PPO benefit will be accessed at the point of service (the site at which they receive care). As is the case with the difference between HMO's and PPO's, benefits are always better if the member uses a contracted provider rather than an out-of-plan provider. Sometimes the term "exclusive provider organization" (or EPO) is applied to this hybrid. An even more recent innovation is a product called "open access." The plans operate like capitated HMO's except that patients can self-refer for most services within the contracted network without a referral from his or her primary care physician.