Definition of Managed Care

A method of providing and paying for health care services which organizes MDs, hospitals, other providers into health care delivery groups, ostensibly, for the purpose of improving the quality and cost-effectiveness of health care.

Managed Care

“If managed care means organizations that combine health insurance and healthcare competing on price and quality to serve informed consumers with the primary goal of enhancing health, managed care is over in most of the country. In fact, it barely got started.”

Paul Elwood, 2001
Consumers’ Understanding of Managed Care

- Nearly two-thirds of Americans said that they do not have a good understanding of the differences between fee-for-service and managed care plans.
- Many Americans have either never heard important health care terms or have heard them but do not know what they mean.

PROVIDER’S FAMILIARITY WITH MCO CONCEPTS

Anecdotal reports from UF alumni indicate a desire to learn more about how to survive and thrive in a managed care marketplace.

Residents and Attendings do not behave as if they understand the constraints managed care brings to a health care system like Shands.
A Better Definition of Managed Care

“A set of techniques used by or on behalf of purchasers of health care benefits . . . (to influence) patient care decision making through case-by-case assessments of the appropriateness of care.”

Institute of Medicine’s Committee on Utilization Management by Third parties, 1985

Definition of Managed Care

THINK ABOUT

THE ORGANIZATIONS THAT PERFORMS THE FUNCTIONS OF MANAGED CARE

THE TECHNIQUES OF MANAGED CARE

Anatomy of a MCO
The Four P’s
Fee-For-Service Health Care

- Physician’s thoughts
  - “The more I treat, the more I get paid, and no one is watching me”
  - “It’s my responsibility to do everything I can for this patient”

- “All the incentives worked in the direction toward overtreatment. Doctors and hospitals were incapable, from an economic standpoint, of governing themselves.”


HOW DO YOU SPELL “RELIEF”? HOW DO YOU SPELL “RELIEF”?
MANAGED CARE

Prepaid Health Plans
Basic Concepts

People have fewer choices among doctors and hospitals

The plans shift decision making and power to managed-care administrators
Your doctor may want to do something and the plan won’t permit it

The plan monitors the treatment patterns of doctors more closely than ever before
Prepaid Health Plans

Cheaper than fee-for-service

Paul Ellwood MD who advised President Nixon in the 1970s coined the term “Health Maintenance Organization” or HMO

1970s -- about 30 managed care plans
Today - - about 1,500 -- >80% of them for-profit

Basic Principles of Early Forms of Managed Care

• Prospective budgeting (i.e., capitation)
• Coordinated care
• Case management
• Primary care providers
• Controlled utilization

The Environment of Medicines Use

Definitions for understanding the MCO jargon
What are HMOs and PPOs?
HMO enrollment stats

Richard Segal, Ph.D.
University of Florida
Types of Managed Care Organizations

- Health maintenance organization (HMO)
  - Independent practice association (IPA) model
  - Network model
  - Staff or group model
- Preferred provider organization (PPO)
- Point-of-service (POS) plans

JARGON

- Benefit Package
- Capitation
- Case Management
- Coinsurance
- Concurrent Review
- Coordination of Benefits
- Co-Payment
- Deductible
- Economic Credentialing
- Encounter
- FFS, MCO, HMO, IPA, PMPM, PPO
- Gatekeeper
- Guidelines
- Member
- Out-of-Area
- Referral Authorization
- Risk
- FFS, MCO, HMO, IPA, PMPM, PPO
- Gatekeeper
- Guidelines
- Member
- Out-of-Area
- Referral Authorization
- Risk

Intensity of Managed Care in Different MCOs

- Least managed
  - Managed indemnity plan
  - PPO
  - POS
  - IPA or Network model
  - Group model HMO
  - Staff model HMO

- Most managed
HMOs

- Organized health care systems responsible for financing and delivery of broad range of comprehensive health services to an enrolled population.
  - Gatekeeper provision
  - Performance or risk-based reimbursement to pay a group practice of physicians or individual physicians (e.g., capitation)

HMO DEFINITIONS

- **Staff Model**: HMO delivering services via physician group employed by HMO
- **Group Model**: HMO contracts with 1 independent practice to provide service
- **Network Model**: HMO contracts with > 2 independent group practices
- **IPA Model**: contracts directly with an entity that organizes physicians in independent practices

Anatomy of an HMO

- Employers
- Providers
- Group Model HMO
  - 1 Health Center
- Network Model HMO
  - Small groups of providers
- Network Pharmacists
  - In-house Pharmacists (1)
  - Network Pharmacists

- Who Bears Financial Risk for the Member in group-model HMOs?
- What differences exist between group-model and staff-model HMOs?
- What differences exist between group-model and Network/IPA-model HMOs?
Capitation Rates

Employer pays approx. $400 PMPM for health coverage, employee pays part of premium ($150)
Total Premium Paid approx. $550 PMPM

PCP Medical Group is paid $29 PMPM in 1999
$45 PMPM in 1993

PCP receives $10 to $13 PMPM

**Implications to Pharmacists**

**PMI rate for all physician services**

<table>
<thead>
<tr>
<th>Year</th>
<th>Managed Care</th>
<th>Medicare</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>'99</td>
<td>$1200</td>
<td>$1150</td>
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<tr>
<td>'97</td>
<td>$1100</td>
<td>$1050</td>
<td>$900</td>
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**Primary Care Physicians**

<table>
<thead>
<tr>
<th>Market Size</th>
<th>% of HMO contracts that capitate physicians</th>
<th>% of HMO contracts paying discounted FFS*</th>
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</thead>
<tbody>
<tr>
<td>Large</td>
<td>44.3%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Medium</td>
<td>22.7%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Small</td>
<td>12.2%</td>
<td>13.9%</td>
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</table>

**Specialists**

<table>
<thead>
<tr>
<th>Market Size</th>
<th>% of HMO contracts that capitate physicians</th>
<th>% of HMO contracts paying discounted FFS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>48.1%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Medium</td>
<td>24.5%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Small</td>
<td>17.2%</td>
<td>18.3%</td>
</tr>
</tbody>
</table>

*Average of all markets in each market size category. Figures are as of July 1, 1995.
DEFINITIONS

- **Preferred Provider Organization (PPO):**
  - A negotiated fee-for-service product where members receive care from selected panel of providers. Providers agree to discounted fee schedule and don’t accept capitation risk.

- **Point of Service (POS):**
  - Provides members option to use selected panel of providers. If use panel, out-of-pocket same as HMO. Using non-panel, cost is substantial in form of deductibles or co-payments

The Rise of Managed Care

### PLAN CHARACTERISTICS FOR HMOs*

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Staff</th>
<th>PPO</th>
<th>Network</th>
<th>Group</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members (in millions)</td>
<td>0.82</td>
<td>30.60</td>
<td>4.13</td>
<td>8.01</td>
<td>28.64</td>
</tr>
<tr>
<td>Annual Change</td>
<td>7.5%</td>
<td>11.3%</td>
<td>23.8%</td>
<td>-7.9%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Total HMOs (N)</td>
<td>15</td>
<td>322</td>
<td>72</td>
<td>27</td>
<td>205</td>
</tr>
</tbody>
</table>

As of July 1, 1997. N=Number. Adapted from Internal data.

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### 2000 Managed Care Profile Map

#### HMO Penetration Rates and Key Players

- Poster: Size Map Ordering Information

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### Florida Hot Spots

- **Jacksonville**: 36%
- **Tampa**: 41%
- **Orlando**: 38%
- **West Palm Beach**: 40%
- **Fort Lauderdale**: 45%
- **Miami**: 43%
<table>
<thead>
<tr>
<th>#1</th>
<th>#2</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC/BS of Florida Inc.</td>
<td>Aetna (+ Prudential)</td>
</tr>
<tr>
<td>2.2 million people</td>
<td>1.5 million people</td>
</tr>
<tr>
<td>PPO (largest)</td>
<td>HMO network and group models (largest)</td>
</tr>
<tr>
<td>HMO network model called Health Options</td>
<td>PPO</td>
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