Managed Care Models and Products

Managed care appears in many forms. This section reviews the different models of managed care plans and their insurance products. Another section describes the different payment and risk-sharing arrangements between health plans and providers (Forms of Reimbursement and Risk Sharing, and Capitation).

Managed care organizations integrate the financing and delivery of medical care. Their goal is to provide high quality medical care services within a predetermined budget to an enrolled population. The integration of financing and delivery typically involves:

- contracts between payers, health plans and selected providers (physicians, hospitals and others) that establish a comprehensive set of healthcare services for enrolled members, usually for a predetermined monthly premium;
- utilization and quality controls that contracting providers agree to accept;
- financial incentives for patients to use providers and facilities associated with the designated delivery system; and
- assumption of some level of financial risk by providers.

HMO Models: Managed care organizations (MCOs) are also referred to as Health Maintenance Organizations (HMOs). The various HMO models are defined according to the relationship between the health plan and its providers. Over time, the relationship may change: e.g., an HMO may diversify from one type of provider arrangement to multiple types; or an HMO's salaried physicians may form a separate corporation to contract with the HMO. The standard models are as follows:

- Closed panel HMO: A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients from another managed care organization; this usually refers to staff and group model HMOs.
- Staff model: An HMO in which physicians are salaried employees of the HMO. Medical services are delivered in HMO-owned medical facilities that generally are open only to HMO members. In this model, the physicians and the health plan are really one and the same.. The physicians adopt the principles of managed care and the system tries to reinforce high quality and cost-effective care with administrative supports. A very small percentage of physicians practice in these settings.
- Group model: An HMO that contracts with a single medical group for the provision of healthcare services to its members. The physicians are employed by the independent, physician-owned group practice, not the HMO. However, the HMO members represent a significant, if not the dominant, proportion of the group practice's patients and revenues. The financial incentives driving the individual physicians can vary depending on the form of compensation: salary, modified fee-for-service, or some risk-sharing formula. Group-model HMOs represent a relatively small sector of the physician workforce. In the Kaiser-Permanente HMO, Kaiser is the HMO and Permanente is the medical group.
- Open panel HMO: A managed care plan that contracts with independent physicians to deliver care to health plan enrollees in their own offices. Physicians may contract with multiple plans to care for members of

these plans, along with the physicians' non-HMO patients. This usually refers to an IPA model HMO.

- IPA (independent or individual practice association) model: Organized system of health insurance and medical care in which an HMO contracts with independent, private-practice physicians or associations of such physicians, who serve HMO members and other patients. Most physicians in the U.S. have contracts with one or more HMOs. Physicians in this model generally are paid on a modified fee-for-service or capitated basis. IPAs are the most common form of HMO.
- Network model: An HMO that contracts with multiple independent group practices and/or integrated organizations to provide health services.
- Mixed model: An HMO that uses a combination of the closed panel and open panel models described above.

Each of these models has its issues, but the most complicated situation confronts independent physicians. They have the least experience with managed care. They traditionally have had few formal relationships with other physicians to facilitate a new group dynamic and infrastructure (although this is changing rapidly). Their panel includes a wide variety of health plans and payment arrangements, with the at-risk managed care portion likely to be a small part. Overcoming these obstacles to practice comfortably and effectively in the new environment is the challenge that faces those who are just beginning their professional careers, as well as veteran practitioners who learned their skills in a very different system.

HMO Products: The traditional HMO insurance product set strict requirements on its members. They could use only those physicians and hospitals that had contracts with the health plan, i.e., its participating providers. Members needed to secure authorization and referral from their primary care physician before accessing almost all non-primary services. In effect, consumers were trading choice of providers and open access to specialists for lower insurance and out-of-pocket costs. By the mid-1990s, most HMOs were introducing new coverage options in response to marketplace demands for greater flexibility. Two common variations are open-access plans and point-of-service plans.

- Open-access plan: A variation on the standard HMO benefit plan in which members are allowed to seek specialty care from participating providers without first consulting with their primary care physician. In this model, members have more freedom in the form of self-referral to specialists who contract with the health plan, but the members also incur greater expenses in the form of higher co-payments when they go directly to specialists without receiving authorization from their primary care physician.
- Point-of-service (POS) plan (also identified as open-ended HMO): A plan combining the features of an HMO with an indemnity insurance option. The member most commonly uses the plan like an HMO and receives HMO coverage; but the member may exercise "freedom of choice" and seek care outside the HMO system with additional charges (e.g., the HMO pays 80% and the member pays 20% of charges, instead of the $5-10 copayment for participating physicians). It is called "point-of-service" because members choose how and from whom to receive services at the time they need them. The majority of HMOs now offer open-ended or POS products.

Preferred provider organizations (PPOs): PPOs are often referred to as a variation of managed care, although they do not meet the criteria of an HMO. In this arrangement, the health insurance plan contracts with independent physicians, hospitals and other healthcare providers who become the "preferred" or "participating" providers. Most PPOs are owned by insurance companies or independent investors; few are operated by HMOs. Providers typically accept reduced, "discounted fee-for-service" rates of reimbursement from the insurer in exchange for access to the PPO's enrollees. PPOs have fewer restrictions than HMOs (e.g., patients are not required to select a primary care physician or seek prior authorization for services). Like a POS plan, patients may choose to receive care from providers who do not participate in the PPO, with higher copayments and deductibles attached to services provided by non-participating providers. Unlike managed care plans, PPOs do not involve financial risk-sharing between the insurer and provider.