Health Maintenance and Other Managed Care Organizations

The concept of health maintenance organizations, and various forms of managed care is not a new phenomenon to the U.S. The most famous of these is the Kaiser Permanente plan in California. **The Health Maintenance Organization Act was passed in 1973 to promote managed care in an attempt to curb rising health care expenditures.** President Carter attempted to pass legislation curbing costs, but it was defeated in the Congress. The 1980s saw an explosion of various managed care plans.

The most popular is the health maintenance organization (HMO). There are several key features of the HMO: 1) a defined population is served 2) a range of medical services is provided with the plan assuming the financial risk and contract management 3) a fixed payment is made to the plan regardless of the actual use of services, usually paid on a monthly basis 4) utilization of medical services is "managed." The attempt is to shift the financial risk to the hospitals, physicians, and other providers.

There are two prevalent HMO models, the first being the staff model. In this model, the HMO staffs its own clinics with physician employees. The physicians are salaried, and manage almost all aspects of a patients' care. HMOs, due to their risk model, must be licensed by state insurance agencies. The HMOs sign limited agreements with selected hospitals for their enrollees.

HMOs tend to be the most restrictive forms of managed care. To gain access to the network, an enrollee must see a primary care physician for evaluation. If an enrollee receives care outside of the network, except under emergency circumstances, the care will not be covered.

Managed care penetration and acceptance has been slower in the consulate region than in the rest of the U.S. The region has experienced a 20% increase in managed care enrollment, with the Pittsburgh region progressing from 11.5% of the population in HMOs in 1991 to 24% in 1994.

The second form of HMO is one whereby they contract with independent providers for care. This is an independent provider association (IPA). The IPA contracts with any number of providers, who in turn provide services to HMO enrollees.

Looser forms of managed care organizations (MCO) also exist. One of these is a point of service (POS) plan. A POS combines traditional fee for service and HMO qualities. An enrollee chooses a provider who may or may not be in the network. If the provider is not a network member, the enrollee must pay higher out of pocket costs. POS plans employ a primary care physician (PCP), also known as a "gatekeeper," for referral to specialist care. These plans are the fastest growing in the consulate region.

A third form of MCO is the preferred provider organization (PPO). A PPO is similar to a POS in that enrollees pay lower rates for care delivered by a preferred provider network member. The difference with the PPO is the enrollees may see a specialist without a PCP referral.