ACUPUNCTURE today

GENERAL ACUPUNCTURE

Understanding Managed Care Terms

Kevin McNamee

Since the end of the 1980s, more workers have become enrolled in managed health care programs. In 1988, 29% of workers in companies of 200 or more were enrolled in managed health care. In 1997, that number grew to 81%. There is quite an alphabet soup to decipher when trying to understand the acronyms used in managed health care.

The following is a list of the more common acronyms:

- HMO -- Health Maintenance Organization
- PPO -- Preferred Provider Organization
- POS -- Point of Service
- IPA -- Independent Practice Association
- PCP -- Primary Care Physician or Primary Care Provider
- FFS -- Fee for Service

HMOs are health plans that provide comprehensive health care services to members for a fixed fee. Members are generally limited to using doctors and hospitals designated by a particular HMO. The HMO is responsible for both the financing and delivery of a broad range of comprehensive health services to an enrolled population for a prepaid fee. They are typically divided into the following four categories:

> Staff Model. An HMO that owns and operates its own facilities and directly employs its doctors. Doctors are typically salaried and considered independent employees of the HMO. Staff doctors are only allowed to treat enrollees. An example of this model is the Kaiser Permanente hospital system.
>
> Group Model. An HMO that contracts with an outside physician group practice to provide services to all of the HMO enrollees. Typically, the physician group signs an exclusive contract to provide services only to HMO enrollees (i.e., closed panel) and is paid based on a negotiated per capita (i.e., capitated) rate.
>
> Network Model. An HMO that, similar to the group model, contracts with physician groups. However, unlike a group model HMO, a network model contracts with two or more doctor groups. Typically, the doctor groups do not maintain exclusive contracts with the HMO and retain the right to treat non-HMO patients. It may be open or closed panel. An example of this model is Landmark Health Care, or American Specialty Health Plans.
>
> IPA Model. An HMO that contracts with one or more independent practice associations (IPAs) to provide health care services to its members. Physicians are members of the IPA and are reimbursed for services rendered through a fee schedule or capitated basis as established by the IPA as a whole.

Preferred provider organization (PPO) is a mixed health plan model that combines managed care and traditional insurance. If you use the plan's network providers, you may pay low cost sharing amounts like an HMO, but if you are willing to pay higher out-of-pocket costs (deductibles and coinsurance), you can use any provider you want, similar to traditional insurance. The PPOs are entities through which employer health benefit plans and health insurance carriers contract to purchase health care services for covered beneficiaries from selected groups of participating physicians, hospitals and providers. Typically, participating physicians in the PPO agree to abide by utilization management and other procedures implemented by the PPO and agree to accept the PPO's reimbursement structure and fee schedule. In return for providing the employer health benefit plan and/or insurance company with a discounted fee schedule, providers receive a guaranteed pool of patients. An example of the PPO model is Blue Cross/Blue Shield of California. These have PPO panels available for doctors to join.

Point of service (POS) is an option provided by some HMOs that allows members to go outside of the plan's provider network for care but requires that they pay higher cost-sharing than they would for network providers. This is a relatively novel type of health insurance plan and is considered a hybrid between traditional indemnity and managed care plans.

Independent practice association (IPA) is an association of physicians in private practice who have joined together to negotiate contracts with managed care plans. IPA physicians can be paid either on a fee-for-service basis or a fixed capitated fee for serving the health plan member. An example of an IPA is AcuCare.

Primary care physician or primary care provider (PCP) is the doctor the insured chooses to provide your basic medical care and to coordinate your other medical needs, including referrals to specialists. PCPs are sometimes referred to as gatekeepers. (Note: According to a 1994 Institute of Medicine report, primary care can be defined as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." This type of care includes the provision of continuous, comprehensive and coordinated medical care provided to patients with undiagnosed signs, symptoms or health concerns.) Primary care clinicians emphasize and educate their patients about health promotion and disease prevention, incorporate the biopsychosocial aspects of health in the provision of care, and refer to other medical and community resources when needed. Though primary care is typically delivered in an outpatient or ambulatory setting, it should be distinguished from ambulatory care.

Fee for service (FFS) is a traditional method of paying for medical services in which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement. In contrast to capitated systems, under FFS systems, the more services rendered by the physician, the greater the payment received.