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| MissouriFamilies.org - Health ***Health Feature Articles***[*This file is available as a pdf file*](http://missourifamilies.org/infosheets/health/mngdcr.pdf)**Managed Care****Understanding Our Changing Health Care System***Gail Carlson, MPH Ph.D, State Health Education Specialist, University of Missouri Extension*Rising health care costs over the last 30 years resulted in a call for health care reform. While legislative reforms failed, “market-driven” reform is occurring. As a response to growing concerns expressed by businesses and by the Federal and state governments, the health care industry is reorganizing itself in an effort to control costs. Managed care is the result. **What is Managed Care?** Managed Care is a system of health care that controls cost of services, manages the use of services, and measures the performance of health care providers. There are different types of managed care plans. Two of the most common types are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Most others are hybrids of the two. Since plans are different, it is important for individuals to know the details of their specific plan. Managed care is both a health care financing and a health care delivery system. Plans typically guarantee 24-hour, seven-day-a-week access to health care for its members. Under most plans, a primary care physician coordinates all care for a patient. When specialists are needed, the primary care provider makes a referral. The plan member selects a primary care physician from a list provided by the plan. **How Does Managed Care Differ from Conventional Insurance?** Historically, this country’s health care industry was made up of a large number of independent health care providers who owned their own practices. These were either solo practices or practices jointly owned by physicians who practiced together in a clinic setting. Furthermore, almost all communities of any size had their own hospital, most of which were independent from one another. Frequently these facilities were run as nonprofit institutions. Under managed care, physicians, hospitals, and other health care providers are linked contractually into networks. These providers agreed to provide care to members (patients) at fees established by the network. Network providers also agree to abide by other cost control and practice guidelines set by the network. In general, managed care differs from conventional health insurance in some of the following ways. **Choosing a Doctor****Conventional insurance**Individuals can choose any physician they want at any time they want. This includes choosing a specialist of their choice. **Managed care**Individuals choose a physician from a list provided by the plan. When using specialists, different plans have different requirements. In some plans, members can select any specialist from the list provided by the plan. In others, the individual’s primary care physician must make a referral. **Deciding about the quality of care****Conventional insurance**The individual is responsible for determining if her physician is qualified to provide the kind of care that was needed. The individual is also the one to determine if she is receiving quality health care. The health insurance plan usually does not get involved in this decision. **Managed care**The plan typically determines if a doctor is qualified before the doctor joins the managed care network. Annual surveys of patients and chart reviews are also done to maintain the quality of care. Some plans also have a grievance procedure which members are encouraged to use if they are not satisfied with the quality of the care.**Paying for Care****Conventional insurance**The usual method of payment is called fee-for-service. The physician is paid for each appointment. The bill increases as more services are provided, or as more expensive services are substituted for less expensive ones. Typically, the individual pays the bill and is partially reimbursed by their insurance company. **Managed care**The usual method of payment is known as “capitation”. Providers are paid a fixed amount for each person (member) enrolled in the plan. Whether the member never sees the doctor or sees her 20 times, the provider does not get any more money than the agreed upon amount. The capitated (fixed) amount is usually paid by the employer or Medicare. Some plans also have members pay a small co-payment for each visit. It is also worth noting that under managed care, individuals are being encouraged to assume more responsibility for their own health. At a minimum, this means taking a more active role in the health care decision making. However, some plans also emphasize greater responsibility for lifestyle decisions.**How Does Managed Care Control Costs?** The most obvious strategy for controlling costs is by contracting with providers to provide care for members at reduced rates. Another approach has been to spread the financial risk of providing care to providers. Under a capitated system, the provider assumes some of the financial risk for providing care. As a result, they have a vested interest in keeping members healthy and controlling access to more expensive tests and procedures. The associated risk to the consumer is that too few services will be provided. To ensure the quality of care, members should become familar with their plan’s grievance procedures and use them when necessary. Managed care plans also control costs by setting criteria for selecting providers and by establishing formal programs to monitor the amount and quality of care being given. Utilization review is one common monitoring strategy. Except for emergencies, doctors are often required to get approval from the plan before hospitalizing a patient or before providing expensive tests and procedures. **Are There Concerns About Managed Care?** Much less is known about other managed care models, but research shows that HMOs are achieving cost savings. While this is one advantage to managed health care, critics point to disadvantages. Managed care might result in too few services being provided. Most plans restrict a patient’s “free choice” of providers. Managed care does not address the issue of access to health care services for those without insurance, or for those living in rural communities where managed care may not be economically feasible. In the future, all of us will be expected to assume more responsibility for our own health. In part that involves learning about the plans that are offered and using the selected plan appropriately.  References:Cordes, Sam, Ph.D. 1995. *Hogs and Health Care: There are Similarities. Corn Husker Economics* (May 31). Lincoln, NE: University of Nebraska, Cooperative Extension. Lipman, Marvin M., M.D., *How to Manage with Managed Care, Consumer Reports on Health*. September, 1994. Yonkers, NY. MacLeod, Gordon K. 1993. *An Overview of Managed Health Care. In The Managed Health Care Handbook* edited by Peter R. Kongstvedt, MD. Gaithersburg, Maryland: Aspen Publications, Inc. Mueller, Kurt, Ph.D.; Andrew Coburn, Ph.D.; Robert Crittenden, M.D.; Sam Cordes, Ph.D.; J. Patrick Hart, Ph.D.; and Wayne Myers, M.D. 1996. *Changes in the Health Care Marketplace: What is the Future for Rural Health Care Delivery?* A National Key Informant Survey. Prepared by The Rural Policy Research Institute Expert Panel on Rural Health Delivery. Columbia, Missouri: University of Missouri.

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