Employee rights, managed care and patient safety

Primary Managed Care Organizational Models in US Today Introduction

Health care in US have undergone great changes in the recent times. The history is long but major changes in the managed care systems date back in 1973 when the Health Maintenance Organization Act was enacted. Since then, transformations defining legal frameworks that govern financing continue to prevail. Additionally, these changes have introduced guidelines on how primary managed care ought to be organized. This has led to the introduction of a full package of health services which is facilitated through capitation payments. All these factors have been instituted to aid the American citizens enjoy dignified health care at the most affordable costs.

Health Maintenance Organization

Managed care organizations, commonly referred as MCOs (Pozgar 2012) have been a key feature in this sector. According to the (Altenstettter &Bjorkman 2000) it has been seen that integration of both the insurer and provider functions been in the increase. Health Maintenance Organizations not only finances, but also ensure delivery of health services, which are comprehensive, to all the bonafide beneficiaries. The charges, under this model, are made on the employer for each subscriber. The fixed premium charge goes a long in giving the beneficiary rights of both being insured and provided medical care in case of ailments (Pozgar 2012). Subscriber should though note that, once in this system they can only get service from HMO contracted physicians. The HMO model has several forms which include staff and Independent practice association model. Under staff-model, an arrangement is made for the physician to proved services to the subscribers on full-time basis. The IPA- model has arrangements made between the independent physicians and HMO to offer services on contract to the

beneficiaries.

Preferred Provider Organization

Health care services can be bought from a group of providers who are carefully selected. Care in selection is emphasized so that the beneficiaries get the best treatment. This is accomplished through preferred provider organizations which are characterized by a well utilization management plan. Under this model, negotiation of payment rates and speeded payment terms are facilitated. In addition, the beneficiaries have freedom to choose services from other providers though at their own cost (Pozgar 2012). The major essence of this model is the negotiation of charges between the payer and panel providers whom the terms are on contract basis. The payer also selects a panel of providers whom are consulted by the enrollees in case of ailments or other medical necessities.

Exclusive Provider Organizations

This model has taken the direction of a gatekeeper. Its enrollees are restricted to seek services from only authorized primary provider. The selection and conduct between all the stakeholders under this model is governed by laws and regulations in the insurance industry. The model is basically characterized by performance-based reimbursements which include capitation payments (Altenstettter &Bjorkman 2000). This seems similar to HMO model but the rules which govern the two models are quite different as seen above.

Conclusion

Other most plans are modifications of HMOs model. This includes Specialty HMOs which only cover for specified components of healthcare. The experience-rated HMO benefits from previous experiences of traditional

plans in making reimbursements and payments to all stakeholders. The Point-of-Service plans offer choice either to opt for HMO or indemnity-style benefits. All these plans have really been beneficial in cutting all medical costs for the American people. Through these models quality of healthcare services have been improved as best providers are the one selected to offer the services.

References

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