Errata in *Essentials of Managed Health Care, Sixth Edition*

Note: Not all errors exist in all books. Some were corrected upon subsequent printings.

Chapter 1: A History of Managed Health Care and Health Insurance in the United States

- Error on page 10 as the first sentence under the subheading Managed Care Expands Rapidly. The existing sentence reads: "HMOs and PPOs grew rapidly, with commercial HMO enrollment increasing from 15.1 million in 1984 to 63 million in 1996 and 104.6 million in 1999.13" That last number is wrong, as is the reference. Here's what it *should* read: "HMOs grew rapidly, growing from 3 million in 1970 to over 80 million in 1999" (Reference *should* be: InterStudy Extra, Vol. 1, Issue 4 (December 2000) p.1).

Chapter 5: Provider Payment

- Page 114 under heading The Chargemaster, the size of chargemaster is wrong. A sentence currently reads "The typical chargemaster now lists over 5,000 separate billing codes…" It *should* read "The typical chargemaster now lists between 20,000 and 50,000 separate billing codes…"
- Page 92 on RBRVS. The maximum calculated Medicare FFS allowed payment for non-participating physicians should be 109.25% rather than 107.25% (115% of 95%).

Chapter 7: Basic Utilization and Case Management

- Page 176, second column, second major bullet and its sub-bullets. The error is in one of the metrics that should be PMPY, not PMPM. Here is how it currently reads:
  - "Metrics that take membership into account such as
    - Per Member Per Month or PMPM; e.g., 4.2 physician office visits PMPM, or $29.17 PMPM for office visits
    - Per Member Per Year or PMPY; e.g., 9.2 prescriptions PMPY, or $474.53 PMPY for prescription drugs."
- It *should* read:
  - "Metrics that take membership into account such as Per Member Per Year (PMPY) or Per Member Per Month or (PMPM), for example:
    - 4.2 physician office visits PMPY, or $29.17 PMPM for office visits
    - 9.2 prescriptions PMPY, or $474.53 PMPY for prescription drugs."

Chapter 24 Health Plans and Medicare

- Error on page 513 of Chapter 24. The text says: "The plan then must charge beneficiaries a premium that equals the difference between the plan's bid and the base beneficiary premium" However, it *should* say: "The plan must charge beneficiaries a premium equal to the difference between the plan's bid and the direct subsidy." This rewording more closely matches the diagram on top of the page.

- On a separate note on same page, there is a slight deficiency in the diagram. The diagram part that says “Plan Bid” should cover the entire bar (white and grey part) not just the white bar part. It’s labelled in misleading way. See illustration below:

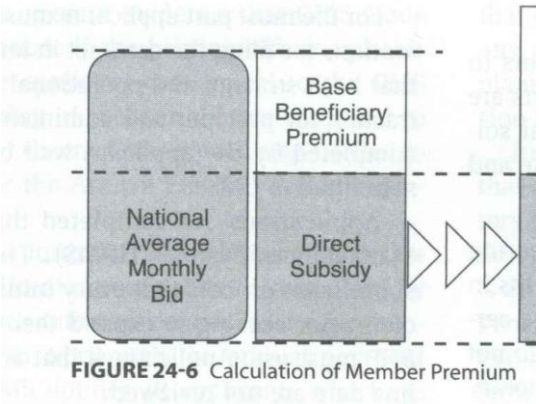

Figure 24-6 (partial) as it currently appears.

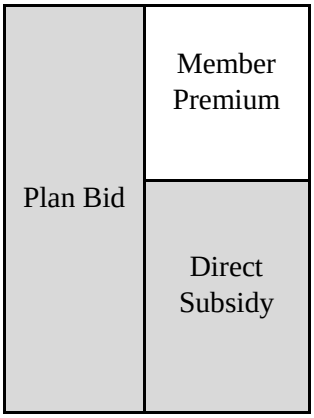

Figure 24-6 (partial) as it *should* appear.

- Outdated information on page 515. It says that the plan has until mid-April to submit a formulary. This rule was changed in the last few years. The PBM can get the plan a formulary on June 1, the same day bids are due.
- On page 530, in the first sentence of the last paragraph of the second column on the page reads, "President George W. Bush signed the Balance Budget Act into law on August 5, 1997 which created SCHIP." The name of the act is actually the "Balanced Budget Act" and was signed by President Bill Clinton. (Reference: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf)