This New Mexico consumer guide to selecting a managed care plan explains how different kinds of plans work.

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New Mexico Consumer Guide to Selecting a Managed Care Health Plan

The health plan you choose can make a difference in the quality of care and service you receive.

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BACKGROUND on types of plans... and how they work

The type of plan you join can affect what is covered, what you pay and the doctors and hospitals you can use. Contact the plan or your employer directly for information about cost and covered benefits.

This report covers Managed Care Plans. Managed Care is NOT traditional insurance.

Traditional Insurance (fee-for-service)

You use any doctor or hospital, but it usually costs you more. The insurance company does not usually coordinate or manage the care you receive.

There is usually a "deductible," which is the dollar amount you must pay each year before the insurance company begins to pay.

When your insurance does pay, you also pay a portion, a “co-payment”, of the cost. For example, the “co-pay” may be 20% of the charge. You are responsible for managing your care with guidance from the providers you choose. Providers are paid a fee for the services they provide.

Things to Consider

- You will have no limitations on choice of providers.
- You usually pay more when you get health care (office visits, hospital stays, etc.).
- There is more paperwork, such as filing claims forms to get payment for covered services, and keeping track of payments toward the deductible.

MANAGED CARE plans: ... how they work

Health Maintenance Organizations (HMOs):

How do they Work?

You use the HMO network to get care. The HMO closely manages the network of providers and the care provided. There are usually advantages in cost and coverage.

As long as you use the doctors in the network, the HMO pays for covered services. You usually have to pay a small "co-pay", for example, $10 per office visit.

Most HMOs require you to choose a doctor to be your "primary care provider" or "PCP". Your PCP takes care of most of your medical needs.

In most HMOs, in order to see a specialist, you must talk to your PCP to get approval for a referral. In New Mexico new rules require that HMOs allow women to see a gynecologist without a referral from a PCP for annual check-ups and other women's health care.

Things to Consider

- You will usually have limits on the doctors and hospitals you can use.
- You will usually pay less when you get care.
- You will have very little paperwork.
- More health care services may be covered that are not usually covered by traditional insurance.

Point of Service (POS) Plans:

How do they Work?

You don't have to use the POS network of providers, but the plan covers more of the cost if you do.

The POS plan closely manages the network of providers and care provided. When you use the providers in the plan's network you usually have to pay only a small "co-pay" such as $10 when you get care.

Most POS plans require you to choose a doctor to be your primary care provider. Your PCP takes care of most of your medical needs and referrals to specialists.

In a POS plan you have the option of going to a provider outside the network, if you choose, just as you do in a traditional plan. You will pay more to go to a provider outside the plan's network.

Things to Consider

When you use providers IN THE NETWORK:

- You usually pay less when you get care.
- You have less paperwork.

When you use a provider *NOT* IN THE NETWORK:

- You will pay more when you get care.
- Fewer health services may be covered.
- You probably will need to file claims.