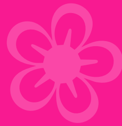
HMO PPO POS Indemnity

The Health Plan Guide for Women

How to Shop for a Plan & Get the Most Value

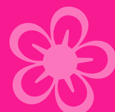
Read the label One-stop shopping

Access Wellness Quality



"A woman's sense of herself, her degree of personal power, her ability to use her talents in society are all tightly linked to her overall health and well being."

Bernadine Healy, M.D.



Managed Care: It's one-stop shopping

Brought to you by:

Funding provided by:

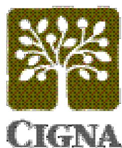


Table of Contents

What is Managed Care? 2

How Managed Care Works 7

Your Benefits: How Decisions Are Made 12

Plan Design 15

Prescription Drugs 18

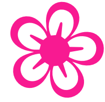
Quality: How Good Is Good Health Care 21

Your Rights and Responsibilities 25

Managed Care At-A-Glance 33

Glossary of Managed Care Terms 35

This brochure is intended to provide you with general information and should not be relied on in making decisions about your health care. The terms of the health benefits plan in which you participate will determine the scope of your health coverage.



Managed Care: It's One-Stop Shopping

If you're old enough, you might remember the little neighborhood grocery store. It had narrow aisles, tiny shopping carts and it gave you green stamps. For each food item, there were maybe two or three brands represented — if you were lucky. Choices were limited but, still, everybody there knew your name.

As decades passed, the humble grocery store grew up and turned into the supermarket — with an emphasis on the "super." The aisles widened, the carts bulked up and the green stamps became points on your scannable bonus card. But the biggest change was in the selection. Hundreds of brands of canned, boxed and frozen foods. A bewildering cereal selection. A branch of the local bank over by the checkout. Dry cleaning. Pharmacy services. Now you can do it all at the supermarket. Just don't forget your list!

So it is with health care. Today's health care plan is not your mother's health care plan. It's not the one-size-fits-all plan of the past. It's a plan that covers more ground and offers more services. And just like the supermarket, it makes more demands on us as consumers. Now we have to apply the same shopping savvy to health care that we apply to food, clothes, cars and houses. But we're up to the task! And we have a head start:

- Women are the primary health care decision-makers in their families.
- Women spend most of the nation's health care dollars.
- Women comprise more than half of the enrollees in the nation's managed care plans.

Managed care is the supermarket of health care. To understand it, we need information. We need to read the label, do some research, make comparisons and ask questions.

This guide is designed to get you started. Read it in good health!

What Is Managed Care?

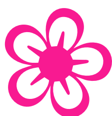
Getting Ready to Shop

You wouldn't think about putting something in your cart that you don't know anything about. Here you'll pick up a little history, plus some basic information you can use to comparison shop.

Some History

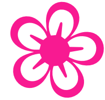
At the turn of the last century in America, the need for health care was triggered by major life events. Childbirth. Serious illness. Sharp blows to the head. People didn't summon a doctor for anything less. Then the pace picked up. Cures were discovered for diseases like smallpox and tuberculosis. "Miracle" drugs and vaccines were developed. By the mid-20th century new medical breakthroughs and technologies were coming fast and furious. People sought out health care more often, and doctors provided more services than they had in the past.

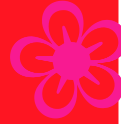
Meanwhile, health insurance was invented as a way to pay for it all. For a long time there was just one type of health plan — the indemnity plan. You paid premiums, met a deductible and paid part of the expense. The rest of the premium was paid by your employer and the insurance company paid the rest of the



The Bottom Line

Managed care can offer real advantages for women. With managed care, it can be easier to get the health screenings and preventive care so important to your health and your family's health. You can get coordination and guidance when you or a member of your family has a major health problem and needs extensive care. You also generally get more information and more assurance that the care you're receiving is quality care. To reap these benefits, you need to understand how your health plan works and take an active role in making it work for you. With managed care, you must shop carefully.





Participation in managed care plans has grown quickly in a short time. Among Americans enrolled in employer-sponsored health plans in 1999:

- 28% were enrolled in Health Maintenance Organizations (HMOs)
- 25% were enrolled in Point-of-Service (POS) plans
- 38% were enrolled in Preferred Provider Organization (PPO) plans

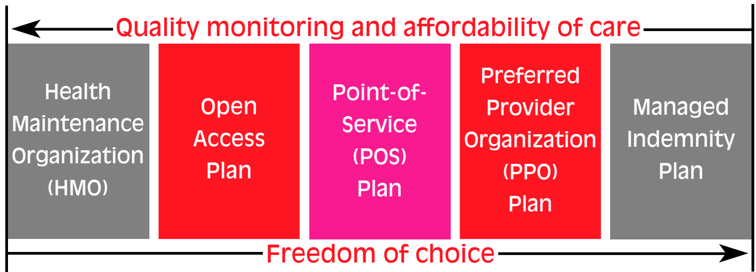
By contrast, a mere 9% of health plan enrollees were in traditional indemnity plans.

expense. As for how much was paid — and for how many services, tests or procedures — the sky was the limit. Over time this drove up not just the price of health care but also the cost of health insurance.

Other factors added fuel to the fire — an increasing number of uninsured people whose costs were passed on to the insured; an aging population requiring more health care services; and, perhaps most important, the growing complexity of medical and drug technology and the need to coordinate diverse health care services and treatments. Employers — wanting to offer health plans that were both affordable and responsive to their employees — were looking for new options. Working with insurers, they found an alternative solution in managed care: the ability to provide access to comprehensive care and the opportunity to manage the cost of that care.

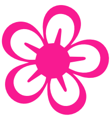
A Definition

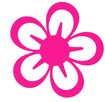
Managed care plans organize the way health services are provided and how they are paid. Plans have agreements with certain doctors, hospitals and health care providers to give you a range of services at a lower cost.



Managed care is an approach to health care that seeks to balance cost and quality through:

- An emphasis on prevention and wellness.
- Networks of carefully screened health care providers and health care facilities.
- Better communication and coordination between health care providers and patients.
- Quality measures and programs.





The Spectrum of Managed Care

Today there's a choice of managed care plans — from HMOs that offer maximum affordability to managed indemnity plans that generally offer freedom of choice, usually at a higher cost.

Health Maintenance Organizations (HMOs)

In an HMO, your care is coordinated by a health care provider known as a primary care physician (PCP) and by other health care providers who belong to the HMO network or work at the health care center. Your care must be provided or coordinated by your PCP.

Open Access Plans

In an Open Access Plan, when you need specialty care, you can visit any specialist in the network without a referral. Generally, your out-of-network care is not covered.

Point-of-Service (POS) Plans

In a POS plan, you can receive care in or out of network. If you decide to go out of the network, it will cost you more. Typically, if you choose to stay in-network, your care is coordinated by your PCP.

Preferred Provider Organization (PPO) Plans

In a Preferred Provider Organization (PPO) plan you can choose any licensed health care provider in the network when you need care. If you choose a provider out of the network, you will pay more.

Managed Indemnity Plans

With a managed indemnity plan you can choose any doctor. Built-in plan features provide you with additional savings for things like hospital services and prescription drugs. You pay the cost of the visit and file a claim directly with the insurance company. You will be reimbursed for a percentage of the visit cost — less any deductible you are required to pay.

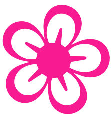
Shopping for a Plan?

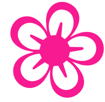
Remember to Read the Labels!

Before managed care, preventive and wellness services weren't usually covered. Now, managed care plans provide coverage for a host of services and programs designed to keep you and your family healthy.

Check to see if your plan offers:

- ☐ Routine exams, annual physicals and health screenings (Pap tests, mammograms, cholesterol tests)? These help catch problems early and give you the information you need to stay healthy.
- ☐ "Well-Woman," "Well-Baby" and "Well-Child" benefits? Usually, a group of services — health screenings, immunizations, routine blood work, etc. — is included under each of these banners.
- ☐ Prescription drug coverage? Is there a drug formulary that lists prescription drugs covered under the plan?
- ☐ Birth control?
- ☐ Infertility treatment?
- ☐ A high-risk pregnancy program? This sort of program provides special attention, care coordination and support throughout pregnancy and delivery.
- ☐ Mental health and substance abuse benefits? These can include counseling as well as inpatient and outpatient services. Also, you'll want to find out if your mental health benefits and pharmacy benefits are administered by the same carrier, whether information about you is shared — and how.
- ☐ Disease management? These programs provide support and information for people with chronic conditions such as diabetes and asthma.
- ☐ Case management? These programs offer help with complex health problems.
- ☐ Vision and dental care?
- ☐ A complementary/alternative medicine program? Such programs integrate complementary medicine (acupuncture, massage, chiropractic, nutritional supplements, etc.) into traditional medicine through special provider networks and discounts.
- ☐ An organ/tissue transplant support program? Some managed care companies contract with hospitals and other facilities with special expertise in complex procedures. Patients with special needs can tap into this network for specialized care and support.





How Managed Care Works

Getting to the Meat of the Matter

Fifty years ago consumers were reluctant to challenge the cost or quality of their care. Many simply trusted their doctor or caregiver to provide the best care at the lowest price. Health care, like the "super" supermarket, is more sophisticated these days. It's up to you to navigate the aisles, and managed care offers resources to help you, because making good choices is the key to receiving quality care.

Your Connection to Care

With most managed care plans you have your own health care provider — often called a primary care physician or PCP. This is someone you'll want to get to know really well. You choose your PCP from a network of doctors who participate in the plan. Not all doctors are in the plan.

Your health care provider is your connection to the complex world of medicine. She provides basic and routine care and, when specialty care is needed, arranges referrals to specialists in your plan's network. Your provider maintains your medical history and records, which means he knows about past and present illnesses, prescription drugs taken and care provided by specialists.

Choosing a Health Care Provider

Managed care plans establish certain kinds of health care providers as PCPs. In most cases, a PCP is:

- A family practitioner,
- A general practitioner,
- An internist, or
- A pediatrician.

Some plans allow you to choose an obstetrician/gynecologist, nurse practitioner or physician's assistant (PA) as your PCP. Once you choose your PCP, you're not locked in. You can select another PCP anytime you want.

Can you use your current health care provider?

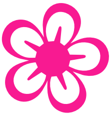
If you're enrolling in a new plan, find out if the health care provider you're currently using can be your PCP under that plan. Check the provider directory. Call her office and ask or check out the web.

Be picky about picking a health care provider

First, check out the provider directory for your plan. PCPs are usually listed under their own category. Or go online. Some managed care companies offer provider directories at their websites. Talk to friends, family and coworkers. Then get picky.

Scope out your prospective health care provider's background and services. Call his office, or visit your plan's website for answers to these questions:

- ☐ How long does it take to get an appointment for a physical exam?
- ☐ Who takes care of you when your PCP is unavailable?

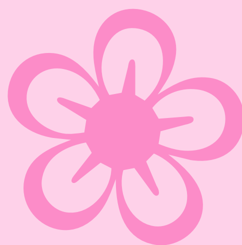


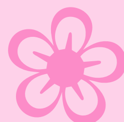
- ☐ Does the health care provider keep weekend and evening hours?
- ☐ Is the health care provider board certified?
- ☐ At which hospitals can the health care provider admit patients?
- ☐ Can you get the reproductive services you need? (Some doctors may have personal beliefs that prevent them from providing a full range of reproductive services.)
- ☐ Are languages other than English spoken in the office?

Alphabet Soup

Need a little help deciphering all those letters that follow your health provider's name?

MD:	Doctor of Medicine
FACP:	Fellow of the American College of Physicians
FACOG:	Fellow of the American College of Obstetricians and Gynecologists
FACS:	Fellow of the American College of Surgeons
FACC:	Fellow of the American College of Cardiologists
FACG:	Fellow of the American College of Gastroenterologists
DO:	Doctor of Osteopathy
OD:	Doctor of Optometry
FAAO:	Fellow of the American Academy of Optometrists
DSW:	Doctor of Social Work
MHP:	Master of Health Professions
MHS:	Master of Health Science
MPH:	Master of Public Health
MSW:	Master of Social Work
PhD:	Doctor of Philosophy
PsyD:	Doctor of Psychology
PA:	Physician's Assistant
RNP:	Registered Nurse Practitioner
PNP:	Pediatric Nurse Practitioner
NP:	Nurse Practitioner
FNP:	Family Nurse Practitioner
ANP:	Adult Nurse Practitioner
CNM:	Certified Nurse Midwife
DDS:	Doctor of Dental Surgery
FACD:	Fellow of the American College of Dentists
DMD:	Doctor of Dental Medicine





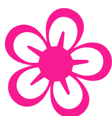
About Direct Access

Many managed care plans now allow women to make appointments directly with their obstetrician/gynecologist without first checking with their PCP. Other "direct access" arrangements may include eye care from network optometrists and ophthalmologists, and mental health/substance abuse treatment from whatever behavioral health company the plan has contracted with. Check your plan materials or call the plan's information number to find out what types of specialized care don't require a referral.

While you're at it, check out these other sources for more information:

- Visit Physician Select at www.ama-assn.org and choose "Doctor Finder." You'll find education, residency and certification information on just about every licensed physician in the United States.

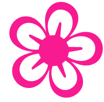
- Go to your local library and look for the American Board of Medical Specialties (ABMS) reference. This is another good source of information about a health care provider's education and certification.



- Check with your state's Department of Health or state licensing agency to find out about disciplinary actions taken against a health care provider.

Some managed care plans pay for a "get acquainted" visit to a prospective health care provider. Check with your managed care plan's customer service line or your employer's Human Resource department to find out if your plan will cover such a visit. A face-to-face meeting gives you a sense of a health care provider's personality and approach to health care.

You can also find out how he feels about issues that are important to you. For example, if you use chiropractic and other complementary/alternative medical services, what does the PCP think about those services? Some health care providers are traditionalists; others are more innovative in their approach.



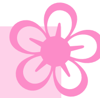
Credentialing

Doctors who belong to managed care networks go through a process called *credentialing*. This is a background check that looks at:

- Education – Where did the doctor go to medical school?
- Residency – Where did he do his residency?
- Board certification and licenses – Is the doctor board certified and licensed to practice medicine? In what specialty?
- Experience – How many years has she been in practice?
- Admitting privileges – At which hospitals can he admit patients?
- Disciplinary actions – Has the health plan or state or local medical review board taken disciplinary actions against the doctor? (For example, has she had her license suspended?)
- Malpractice suits – Has he ever been the subject of a malpractice suit?

Some managed care companies will also tour the doctor's offices and check her record keeping as part of the evaluation process.

Once a doctor has been admitted to a provider network, this check is usually repeated on a regular basis — every two years, for example — to make sure he continues to meet the health plan's requirements.



Get off to a good start with your health care provider

Once you've chosen a health care provider, make an appointment for a checkup. This will give you a chance to talk about your health issues and concerns, and establish yourself as an active, involved patient. (Some family practitioners, internists and nurse practitioners provide routine gynecologic care, including pelvic exams, Pap tests and other services. Ask about this when you're in the process of choosing a health care provider.)

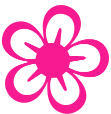
Your Benefits: How Decisions Are Made

Balancing health care cost and quality is a tough job — but someone's got to do it. Why are certain medical expenses not covered? Why are benefits denied? Why is prescription drug coverage such a hot issue right now? The answers get to the heart of managed care — and the challenge of keeping good health care affordable.

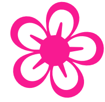
Medical Management: The Right Care at the Right Time in the Right Place

Managed care companies provide cost efficiency and quality through a collection of tools and techniques called medical management. The goal of medical management is to make sure people have access to health care services that meet their needs. It also seeks to ensure that these services are provided at the right time and in the right place.

Medical management seeks to prevent three types of situations that can be hazardous to your health:



- *Overuse* of medical services — patients receive tests, treatments, drugs or surgeries that are not needed, risky and expensive.
- *Underuse* of medical services — patients don't receive the care they need. Depression and high blood pressure are examples of conditions where underuse of services has been a problem. These conditions are often left untreated, only to result in more serious problems later on.
- *Misuse* of medical services — patients are not diagnosed properly with a problem, or diagnosis comes late. Misuse also refers to mistakes in treatment or medication.



Precertification

Let's say your health care provider recommends outpatient surgery or a hospital stay. You wonder, "Is this the best option for me?" Through a process called precertification, you gain the advantage of a second look. A trained health professional (doctor or nurse) reviews the proposed hospital admission or outpatient treatment to determine:

- Whether the treatment is a covered benefit under your plan, and
- Whether the treatment is recommended by medical experts for your particular condition.

Guidelines and Protocols

Managed care companies use guidelines and protocols recognized by professional medical organizations such as the American Cancer Society, American College of Obstetricians and Gynecologists, and the American Academy of Pediatricians, in making coverage decisions. These guidelines reflect the collective wisdom and experience of practicing physicians as well as the results of medical research, and are considered evidence-based guidelines. By adopting these guidelines and protocols, your managed care company attempts to provide access to the right care at the right time in the right place.

Referrals to Specialists

If you've ever shopped for a specialist, you know the drill. You ask friends, family and coworkers for their suggestions; you thumb through the Yellow Pages. And you end up with more questions than answers.

But if you're in a managed care plan, you get help. When your health care provider determines that specialty care is the way to go, she will refer you to a network specialist, then keep in touch with the specialist as your treatment proceeds. And if you have a concern about the specialist, you can ask your health care provider for a different referral.

Disease Management

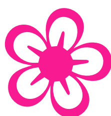
It's a fact that people with certain conditions — such as diabetes, asthma and heart disease — benefit from close management and monitoring. Today many managed care plans offer disease management programs that provide education, information and advice for people with these and other chronic conditions. Diabetics, for example, might receive information about proper blood sugar monitoring, while asthmatics might get information about different inhalers and how and when to use them. Such support has been proven to reduce trips to an emergency room, improve health and enhance the quality of life for program participants.

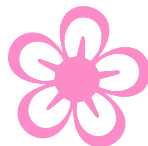
Case Management

If you or a family member has a serious or complex condition that requires greater attention and coordination of services, such as cancer, AIDS or a high-risk pregnancy, you may be a candidate for case management. A case manager is usually a trained registered nurse who provides information about treatment and care alternatives, guidance in choosing among these alternatives and help finding services and resources in the community.

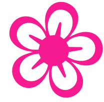
New Treatments and Technology

There's something new in medicine just about every day. New treatments, new cures, new technologies. But how do you know which ones are OK? Most managed care companies have medical technology assessment programs. Through these programs your plan keeps track of new developments in health care. This helps the plan make coverage determinations.





ClinicalTrials.gov is an information service of the National Institutes of Health (NIH) that provides patients, family members, health care professionals and the public with access to information on clinical trials for a wide range of diseases and conditions.



Plan Design: Looking at the Label

When you look closely at a health plan, you'll find that all of its workings — what gets covered, how benefits are paid — have been figured out in advance. But by whom?

- *Your employer* decides which plan(s) — and which benefits within the plan(s) — to purchase for your company. Employers can choose from a wide variety of benefits and coverages, including what you will pay and what they will pay for each plan.
- *Your employer* also determines "plan design." The "plan design" includes deductibles, coinsurance and/or copayments as well as what is covered — for example, routine exams, hospitalization, diagnostic tests, prescription drugs. And every plan has a list of exclusions and limitations — things like experimental and investigational procedures, and cosmetic surgery.
- *State and federal governments* require health plans to cover certain expenses. These are called mandated benefits. Some examples are reconstructive surgery after mastectomy, a minimum 48-hour maternity hospital stay, and the requirement that mental health benefits be treated the same as physical health benefits.

Remember, too, that your benefits can change from year to year or even more often. When a contract with a managed care plan is up, your employer may decide to change plans or revise the contract in a way that changes your benefits. Your deductible may go up or down. Benefit levels may change. You may even have a different type of plan altogether — say, a PPO instead of an HMO. Whatever the change, your employer is legally required to report it to you.

In 2000, employer-sponsored health benefit costs rose 8.1%—more than double the rate of general inflation—making it the third straight year of increases. And the average cost per employee rose from $4,097 in 1999 to $4,430 in 2000.

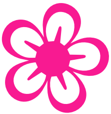
The Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2000

A word to the wise: a smart consumer reads the health plan materials provided by her employer. These can include enrollment guides, plan highlights brochures and Summary Plan Descriptions (the most detailed guides to your plan). Also check out your health plan's website.

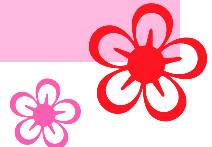
Before you check out...

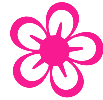
To help you choose a health plan that's right for you and your family, here are a few things to check out:

- ☐ How much is your deductible? Is there more than one deductible?



- ☐ How are out-of-network benefits paid? (Some plans pay a percentage of the fee; others pay according to a schedule used by the health plan.)
- ☐ Does the plan have copayments? What are the copayments for office visits? For emergency room services and hospitalization? For prescription drugs?
- ☐ How much are your premiums? How much does dependent coverage cost?
- ☐ What are the differences in benefits for in-network and out-of-network services? **Remember, when you use the network, you save money.**





What's the Plan? Getting the Scoop on What Your Plan Offers

The only way to get the most out of your health plan is to know how it works and what it offers. So here are some helpful tips:

- *Read your EOB statements*. When you file a claim for benefits, you'll receive an Explanation of Benefits (EOB) statement in the mail. It will show the expenses submitted for reimbursement, benefits that were paid and how much of the expense was applied to your deductible. If you don't agree with how benefits were calculated, call the plan's help number (usually printed on the EOB). Have the EOB and any applicable medical bills handy.

- *Pull out your ID card*. Health plan ID cards often contain information about certain plan requirements, benefits and copayments, and telephone numbers to call if you have questions. *Call the health plan's toll-free number.* The managed care company's customer representatives can tell you what's covered and what's not.

- *Check the plan's Summary Plan Description*. If this document isn't included in your enrollment package, ask your employee benefits representative for a copy.

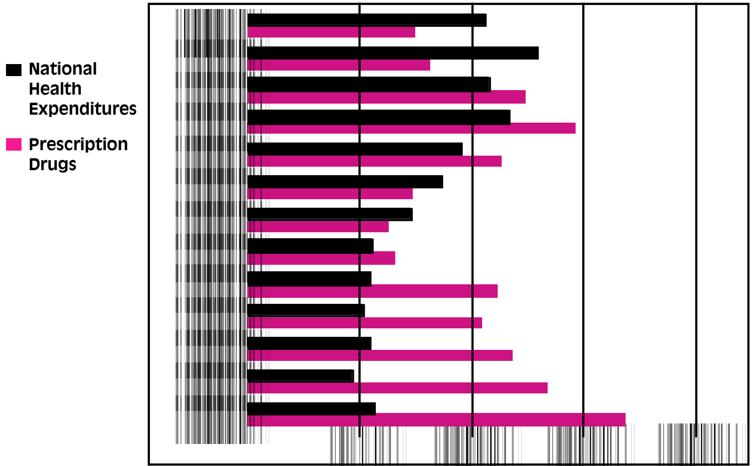
- *Ask tough questions*. The cutting edge of medicine could cut your way if a new treatment or technology is right for you or a family member. How does your plan define "experimental and investigational" treatment? Does your plan cover drugs currently in clinical trials? For answers ask your employer, read your Summary Plan Description or call the health plan's information number.

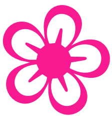
Claim not paid?

If your benefit payment is delayed or is less than you expected, you need to investigate. Begin at the beginning. Call your health care provider's office or your health plan and ask to have its paperwork checked. Forms can be filled out incorrectly, dollar amounts can be scrambled, procedure codes can be wrong. If bad data goes into the claim process, you won't get the benefits you're entitled to.

Prescription Drugs

Understanding Generics, Brand Names and Formularies



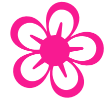


If health care is the supermarket, prescription drugs are the filet mignon in terms of costs. Why are they so expensive these days?

- There are more new drugs being developed;
- The costs of developing, testing and marketing these drugs are breathtaking; and
- There are more people using prescription drugs.

The bottom line? People are paying more for drugs, and their employers are paying more for prescription drug benefits.

The response? Managed care companies are helping to manage costs — without compromising quality—by offering programs that use drug formularies and different benefit levels for generic and brand-name drugs.



What Is a Formulary?

A formulary is a list of Food and Drug Administration (FDA)-approved drugs that are covered under the health plan. Not all FDA-approved drugs will be on the formulary. To develop the formulary list, doctors and pharmacists help a managed care company review data about each drug's clinical safety, effectiveness and cost — and make decisions based on that data. When it comes to cost, managed care plans negotiate directly with pharmaceutical manufacturers to get the best possible price for the drugs on their formulary. However, a drug won't make the list if it hasn't been proven safe and effective. Most formularies reflect the latest advances in medical science. This means you and your family have access to drugs that can improve your quality of life.

Most formularies provide you with incentives to choose generic drugs whenever possible.

Plans can have different kinds of formularies. For example:

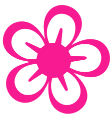
- If your plan has a *closed formulary*, drugs not on the list are not covered. Exceptions to your plan's formulary may be made if you have a legitimate medical need for a drug not on the list (check with your plan for details).
- If your prescription drug plan is a *tiered option plan*, it provides different benefit levels (or copayments) for different types of drugs; for example, $5 for generic drugs, $10 for preferred brand-name drugs and $25 for non-preferred brand-name drugs. The advantage of this type of plan is that most types of drugs are covered.

Shopping smart for prescription drugs

- *Check out the formulary.* When you enroll in your plan, your information package may include a formulary list. If it doesn't, ask your Employee Benefits Representative or call your managed care plan's information number for a copy. Some managed care companies also put their formulary list on their website.

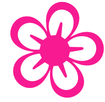
- *Check your coverage.* Before you leave the health care provider's office, ask the staff to check whether or not the drug is covered under your plan.

- *Check your prescription.* Sometimes a pharmacy will automatically substitute a generic equivalent for a brand-name drug unless the doctor has written "DAW" (Dispense as Written) on the prescription. Check your prescription label to make sure you're getting what your health care provider intended. Ask the pharmacist if you aren't sure.



- *Consider generics.* Some drugs have generic equivalents that cost less. Ask your health care provider if there is a generic substitute and if it's right for you.

- *Use your mail-order service.* If your plan includes a mail-order drug service, use it! Mail-order services are convenient and can save you money.



Quality: How Good Is Good Health Care?

As good shoppers, we know quality when we see it. But quality in health care is a bit more complicated than quality in a head of lettuce.

Before the advent of managed care, there was no system for setting standards or making comparisons, so it was hard to make decisions based on quality. Managed care has changed that. Now nearly all managed care companies have formal, ongoing quality improvement. They can evaluate patient outcomes and determine which treatments work best and which providers are providing quality service to their patients. They can give providers feedback on their performance and help them improve their practice. They can supply solid evidence to providers, which helps the providers make decisions about which treatments are best for their patients. They can track whether or not their customers are getting the care they should — such as mammograms or immunizations. And they can evaluate patient satisfaction with the care and services they're receiving.

None of this was possible before managed care. Quality has become an integral part of the relationship between managed care companies, members and health care providers. And one of the facts to emerge from this dialogue is that quality can and should be measured in terms of both the patient's satisfaction with her care and the outcome of that care.

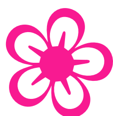
Consumer Satisfaction

Managed care companies have a number of ways to measure health care quality, and consumer satisfaction is at the top of the list. Are you a satisfied health care consumer? Here's how to find out:

- Did you get the care you felt you needed? When and where you needed it?
- Did the health care provider answer all your questions?
- Were you treated with respect and consideration?
- Did you get the emotional support and information you needed?
- How was the service you received from the managed care company? Were your questions answered? Were claims paid promptly?

People define quality and satisfaction in subjective and personal ways, which is why *all* of the questions above are used by managed care companies — as well as outside evaluators of health plans — to define quality and satisfaction.

Get Involved!



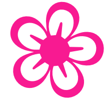
Your ideas and opinions count when it comes to how managed care companies evaluate and ensure the quality of care you and your family receive. Here's what you can do:

Take part in satisfaction surveys

If your managed care company sends you a member satisfaction survey, fill it out! Flex your consumer muscle!

Join your health plan's consumer advisory board

Many of the larger managed care companies have a consumer advisory board that meets on a regular basis to discuss health plan policies, procedures and provisions. Call the company that administers your plan, and find out how you can join such a group. Then don't be shy about speaking your mind.



Accreditation: The approval seal

The accreditation process reviews consumer satisfaction, health outcomes and other important factors to measure the quality of health plans and the care their members receive.

Accreditation is an objective evaluation conducted by third-party organizations and agencies to determine whether or not a health plan meets specific standards. Because it's an entirely voluntary process, a plan's participation is a good indication of its commitment to quality care.

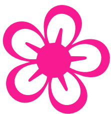
Check to see if your plan is accredited by one of these organizations:

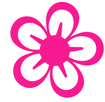
- *The National Committee for Quality Assurance (NCQA—www.ncqa.org)* is the nation's largest accrediting agency for managed care plans (HMO, PPO, etc.). If a health plan wants NCQA accreditation, it must submit to an evaluation that applies more than 60 standards in areas that include how complaints are handled, how rigorous the provider credentialing process is, communications to plan members, preventive and wellness programs, and quality improvement.
- *The Joint Commission on Accreditation of Healthcare Organizations (JCAHO — www.jcaho.org)* is another accrediting organization, best known for hospital accreditation. However, JCAHO also accredits HMOs, visiting HMO-run health care centers to evaluate, among other things, how care is provided, how the staff is managed and how routine and preventive care are promoted and provided.
- *URAC, also known as the American Accreditation HealthCare Commission,(www.urac.org)* operates accreditation programs for hospitals, HMOs, PPOs, third party administrators (TPAs) and other health care organizations. Some programs review the entire organization (such as a health plan) while others review a single function, such as utilization management or an external review program.

Is Your Health Plan a "Grade A"?

Sources for results, rankings and reports:

- *Member satisfaction results.* Most health plans run member satisfaction surveys on a regular basis. You can get the results of these surveys for your plan (or a plan you're considering) by calling the managed care company's toll-free information number or by reviewing your health plan's newsletter and website.
- *Performance rankings.*
  - *HEDIS®,* the *Health Plan Employer Data and Information Set*, creates a report card that grades health plans on more than 60 indicators, including quality of care, access and availability of care, and satisfaction with the experience of care. Call the NCQA or visit their website to find report cards on the health plans you're considering.
  - Many (but not all) states provide health plan performance information. Check with your state's Department of Health or Department of Insurance to see what's available.
- *Accreditation reports.* You can also order accreditation summary reports on the health plans you're considering. Call the NCQA toll-free at 1-800-839-6487 or visit its website — www.ncqa.org. There is a small charge for each report. For accreditation information on PPO plans, you can also contact URAC at www.urac.org.
- *Complaint information.* You may be able to find complaint information on specific health plans by contacting your state's insurance department or state department of health.





Your Rights and Responsibilities

Understanding the Fine Print

One of the reasons it's important to read and understand your plan documents is that they contain information about your rights and responsibilities under the plan. In this section we've pulled out some of the more important ones. Read, be aware and be informed.

If Payment Is Denied

Benefits (i.e., reimbursement for the provision of health care services/supplies) can be denied by a health plan for a number of reasons. If the service you received is not covered by the plan your employer has selected, coverage (i.e., payment) will be denied. Your plan will send you an explanation. If you believe your plan has made a mistake about your coverage, you can call your health plan's toll-free number or contact your company's Employee Benefits Representative.

Appealing the Health Plan's Decision

An appeal is when you request the health plan to reconsider its coverage decision. You may have grounds for appeal in several instances. Some examples:

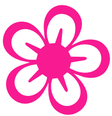
- The service you received is not considered medically necessary.
- The drug your doctor prescribed is not listed on the plan's formulary.
- You received care outside the plan's provider network.
- You didn't meet the plan's precertification requirement.

**Remember,
not everything is covered.
Many plans don't cover services such as
cosmetic surgery and infertility treatment.
Payment for services not covered by your plan
will be denied. Check your benefit plan to
see what is covered.**

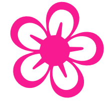
To start the appeal process:

Call your health plan's customer service representative and state that you want to file an appeal. You may be able to start the appeal over the telephone. If not, you'll receive forms and other paperwork to read and complete. Be sure to read these materials carefully and call the health plan back if there's something you don't understand.

Here are other points to keep in mind:



- Look up your plan's appeal process in your plan materials (such as the Summary Plan Description). Detailed plan documents will spell out your appeal rights as well as the procedure to follow.
- Pay attention to deadlines. There may be a limited timeframe for filing an appeal.
- Keep good records. Keep all paperwork and correspondence related to the appeal. Write down important dates, names and telephone numbers.
- If your original appeal is turned down, you may be able to file a second appeal. But you'll need to do it within a certain period of time.
- You also may have the right to request an external appeal by an independent medical professional.
- In most cases your doctor can represent you in your appeal. Or you can hire legal representation, which can be expensive but can save you time and energy.



Pre-Existing Conditions

Some plans won't cover certain pre-existing conditions for a period of time. In general, a "pre-existing condition" is an illness, injury or condition for which you were diagnosed and/or received treatment within the six-month period right before your new plan took effect.

Passed in 1996, the Health Insurance Portability and Accountability Act (HIPAA) regulates the way insurance companies cover pre-existing conditions. Here are some examples of the protections that HIPAA provides:

- You can't be refused coverage — or charged a higher premium than others in the group — because of a pre-existing condition.
- You can't be denied coverage for a pre-existing condition caused by domestic violence.
- You can't be denied coverage for pregnancy-related care if you are pregnant when you enroll in a new plan.
- You can't be denied coverage for a pre-existing condition if you were covered for that condition under your prior plan.

For more information about HIPAA and other health care laws, visit the U.S. Department of Labor's website, www.dol.gov/dol.pwba, or the National Partnership for Women and Families' website, www.nationalpartnership.org.

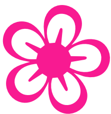
Coordination of Benefits: No Double Coupons

What if you're married and covered under your husband's health plan as well as your own? Or what if you're retired and covered under Medicare and the retiree health plan provided by your former employer? When you have health benefits from more than one source, benefits are coordinated so that your payment is not more than your covered expenses, or more than what your plan would pay if it was the only plan that covered you.

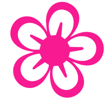
Health plans have different rules about how benefits are coordinated. It all comes down to which plan pays its benefits first. For example:

- The plan that covers you directly (your employer's plan) pays benefits before the plan that covers you as a dependent (your husband's plan).
- If you're divorced and have legal custody of your children, a divorce decree sets out whose coverage is primary.
- There's also a "birthday rule" in most plans stating that if a child is covered under both parents' plans (assuming they're not divorced), the plan of the parent whose birthday falls earlier in the year would pay benefits first.

What You Should Do



- If you or your dependents have coverage under more than one health plan, be sure you understand the coordination of benefit rules for both plans. You'll find the plan's coordination rules spelled out in the Summary Plan Description. If you don't have this document, you can request it from your company's Employee Benefits Representative.
- When you enroll in a new plan and your enrollment form asks for information about other plans that cover you (such as your spouse's), be sure to supply this information. Remind your spouse to do the same.



- When you file a claim and receive an Explanation of Benefits (EOB) statement, hang onto it. If there's any question of how much your plan paid for a covered expense, the EOB will come in handy.
- Be prepared to talk with the customer representatives (or claims representative) of both plans that cover you or your dependents if there's a question about how benefits are coordinated. When you get on the phone, have your health plan ID card and any applicable medical bills and EOBs ready.

If Coverage Ends: Extending Coverage With COBRA

Under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), you have the right to continue your health coverage if a "qualifying event" happens to you — and if you're willing to pay for the coverage. COBRA coverage will be the same as what you had before coverage ended. It's expensive. You'll pay the full price for your coverage, plus a 2% administration charge.

Below are examples of qualifying events:

- You lose or leave your job.
- You get divorced or your spouse dies, and you are no longer covered as a dependent under his plan.
- You or one of your dependents no longer meets the eligibility requirements for the plan. For example, you switch from full-time to part-time hours, or your child reaches the age limit for coverage as a dependent.

There is a deadline for applying, so you need to act quickly. Contact your Employee Benefits Representative or the company that administers your plan and get the forms you need. Pay attention to the deadline for returning the completed form. If you miss the deadline, you won't have health coverage under COBRA.

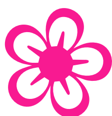
You can maintain COBRA coverage as follows:

- 18 months for work-related events; i.e., if you leave your job voluntarily or involuntarily, or if your work hours are decreased and you lose your coverage.
- 29 months for disability-related events.
- 36 months for family-related events; i.e., if you become divorced or legally separated, the insured employee dies, you lose your dependent child status or you lose your dependent coverage because the insured employee is entitled to Medicare.

Continuity of Care

It's possible for your coverage under a health plan to be interrupted because your employer changes managed care companies, or your health care provider leaves your plan's network. If this happens, your health plan may have a "continuity of care" provision that will:

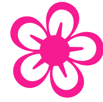
- Let you finish your treatment with your existing provider; or
- Continue with the same provider for a certain period of time; or
- Help you find a provider within the plan's network.



If your plan has *no* continuity of care provision *or* if the time limit runs out, you have a decision to make:

- **Stay** — and pay the entire cost of your treatment. If you're in a POS plan or a PPO plan, you'll be able to stay with your provider, but you'll pay more than if you switched to an in-network provider.
- **Switch** — to another provider in the network.

Special Circumstance: Pregnancy. Virtually all managed care plans will let you stay with the same OB/GYN through your second and third trimester and delivery (and some portion of post-natal care).



Your Information Rights

Your information rights fall into two main categories:

- ERISA rights, which govern your access in connection with private employer-sponsored group health plan information; and
- Privacy rights, which control access to information about you.

Your ERISA Rights

When you participate in an employer-sponsored health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Under ERISA you have the right to:

- Review all plan documents, including those filed with the U.S. Department of Labor.
- Appeal a coverage determination.
- Ask the plan administrator (which is usually your employer) for copies of plan documents and other plan information. You may need to pay a small charge for copies.
- Receive a copy of the plan's annual financial report.
- File suit in federal court or get help from the U.S. Department of Labor if you don't receive the materials you request within 30 days, if you feel benefits have been unfairly denied, or if you feel you're being discriminated against for asserting your ERISA rights.

If you want more information about ERISA, you can contact the nearest U.S. Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone book. You also may contact:

The Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Your Privacy Rights

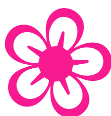
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health plans are required to protect the confidentiality of patient-identifiable information. HIPAA requires managed care companies to implement physical safeguards, technical security and administrative procedures that:

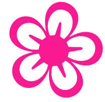
- Keep private data private.
- Confirm the identities of people who have access to private data.
- Ensure that only authorized people have access to private data.

For more information about HIPAA and other health care laws, visit these websites:

- U.S. Department of Labor's website — www.dol.gov/dol.pwba
- U.S. Department of Health and Human Services — www.os.dhhs.gov
- National Partnership for Women and Families — www.nationalpartnership.org

In addition, each state has privacy rules; for example, rules that cover mental health conditions or the handling of mental health information.





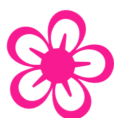
Managed Care at a Glance

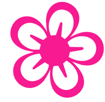
A handy chart to use to compare the different types of managed care plans.

Managed Care at a Glance

Cut out this handy chart and use it to compare the different types of managed care plans.

Plan	Choosing Your Providers	How You Access Care	Prevention and Wellness	Quality Monitoring	Cost Sharing	How Claims are Filed
Health Maintenance Organization (HMO)	You must select a PCP at enrollment.	PCP provides routine care and makes referrals to specialists.	Preventive services & screenings (mammograms, childhood immunizations, etc.) Special programs (wellness, disease management, discounts)	Quality controls & programs Review of providers' credentials Independent accreditation (NCQA, URAC, JCAHO)	In-network services covered at 100% after copayment/ coinsurance. No coverage for out-of-network care, except emergency care.	No claims for covered services. Network providers bill plan directly. If you receive emergency care from an out-of-network provider, you or the provider file the claim.
Open Access Plan	You can select a PCP at enrollment, but are usually not required to do so.	You can access specialty care directly from network providers without going through a PCP. No referrals.	Preventive services & screenings (mammograms, childhood immunizations, etc.) Special programs (wellness, disease management, discounts)	Quality controls & programs Review of providers' credentials Independent accreditation (NCQA, URAC, JCAHO)	In-network services covered at 100% after copayment/ coinsurance. No coverage for out-of-network care, except emergency care.	No claims for covered services. Network providers bill plan directly. If you receive emergency care from an out-of-network provider, you or the provider file the claim.
Point-of-Service Plan (POS)	Depending on your plan you may need to select a PCP at enrollment -or- you can receive care from any provider.	Depending on your plan, when accessing in network care your PCP provides routine care and referrals to specialists -or- you can access in-network specialty care yourself — without a referral.	Preventive services & screenings (mammograms, childhood immunizations, etc.) Special programs (wellness, disease management, discounts)	Quality controls & programs Review of providers' credentials Independent accreditation (NCQA, URAC, JCAHO)	In-network services covered at 100% after copayment/ coinsurance. Lower level of benefits for out-of-network care, however, coverage at 100% when annual out-of-pocket maximum is met.	No claims for covered services. Network providers bill plan directly. If you receive emergency care from an out-of-network provider, you or the provider file the claim. For out-of- network care, you or the provider file the claims.
Preferred Provider Organization (PPO)	You select any provider in the network or out of the network.		Some preventive services & screenings may be subject to deductibles or not covered. Special programs (wellness, disease management, discounts)	Quality controls & programs Review of providers' credentials Independent accreditation (NCQA, URAC, JCAHO)	Higher level of benefits for in-network care. Lower level of benefits for out-of-network care. Coverage at 100% when annual out-of-pocket maximum is met.	In-network claims filed by network provider. You or the provider file claims for out-of-network services.
Managed Indemnity	You select the provider. No network of providers.		Some preventive services & screenings may be subject to deductibles or not covered.		Higher level of out of pocket costs. Deductible must be satisfied before benefits are paid. After deductible is satisfied, benefits subject to coinsurance. Coverage at 100% when annual out-of-pocket maximum is met.	You or the provider file claims.





Glossary of Managed Care Terms

What Does It All Mean?

Accreditation
A review process in which a third-party organization determines whether or not a health plan meets certain standards.

Admitting Privileges
When health care providers are able to admit patients to certain local hospitals, they have "admitting privileges" at those hospitals.

Board-Certified
A physician who has passed an examination given by a medical specialty board.

Case Management
Ongoing support for plan members with a serious or complex condition, such as cancer, AIDS or a high-risk pregnancy, that requires greater attention and coordination of services.

Clinical Trial
A research study that tries to answer scientific questions and find better ways of treating, preventing or diagnosing a disease or illness.

COBRA
Stands for Consolidated Omnibus Budget Reconciliation Act of 1985. Under COBRA you have the right to continue your health coverage after a qualifying event (i.e., you get divorced, lose or leave your job or reduce your work hours).

Coinsurance/Coinsurance Limit

Coinsurance is the part of a health care expense you pay after you've met the plan's deductible. For example, if x-rays are covered at 80% after the deductible, your coinsurance is 20%. Health plans place a limit on the amount of coinsurance you're required to pay in one calendar year. Once you reach this limit — called the coinsurance limit (or out-of-pocket maximum) — the plan usually pays 100% of your covered expenses for the rest of the calendar year.

Complementary and Alternative Medicine

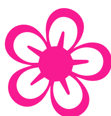
Services such as chiropractic, acupuncture, massage and nutritional supplements.

Coordination of Benefits

The process by which a health plan determines which of two or more plans will pay its benefits first and the amount payable by each plan. Coordination of benefits comes into play when a person is covered under more than one health plan.

Copayment

A flat fee paid for a health care service. For example, your plan may require you to pay a copayment of $10 each time you visit your health care provider's office. Copayments are common in HMO and POS plans and in an increasing number of PPO plans.

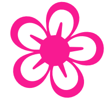


Credentialing

Credentialing is the evaluation process a managed care company uses to determine whether or not to admit a health care provider to its network. As part of this process, the provider's education, licenses, board certification, work history and admitting privileges are reviewed.

Deductible

The amount of covered medical expenses you're required to pay each year before the health plan starts to pay benefits. Most plans that have a deductible have an individual and a family deductible.



Direct Access

Most managed care plans require you to get referrals from your PCP for specialty care. However, some managed care plans will give you “direct access” to certain specialists, allowing you to make appointments with certain network providers — without a referral from your PCP. For example, in many plans you can visit your network OB/GYN without a PCP referral.

Disease Management

The process by which a managed care company coordinates care and provides support, information and other services to members with chronic conditions such as asthma, diabetes and low back pain.

ERISA

Stands for Employee Retirement Income Security Act of 1974. ERISA sets out your rights to detailed plan information and establishes certain procedures for the review and appeal of claims.

Exclusions and Limitations

Health plans don’t cover everything. The plan’s “exclusions and limitations” tell you what the plan does not cover and describe any limits imposed on coverage. For example, a plan may exclude cosmetic surgery from coverage, or it may limit the number of home health care visits.

Experimental and Investigational

The designation given to medical, surgical, psychiatric or other health care services that a health plan determines to be either:

- Not generally accepted by health care professionals in the United States as effective in treating a condition; or
- Not proven by scientific evidence to be effective in treating a condition.

Explanation of Benefits (EOB) Statement

When you file a claim for benefits, you receive an EOB statement that shows the expenses submitted for reimbursement and explains how benefits were paid. The EOB also shows how far along you are toward meeting the plan’s deductible and coinsurance limit (if these apply to your particular plan).

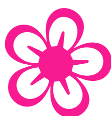
Formulary
A list of FDA-approved drugs — selected for their safety, effectiveness and cost — covered under a health plan's prescription drug benefit.

Generic Drug/Generic Equivalent
A generic drug or generic equivalent is a drug identified by its chemical name rather than by a brand name. An example is ibuprofen versus Motrin. Generic drugs have active ingredients that are identical to their brand-name counterparts, but inactive ingredients may differ. Generic drugs usually cost less.

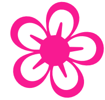
HEDIS®
Stands for Health Plan Employer Data and Information Set. HEDIS® is a "report card" prepared each year by the National Committee on Quality Assurance (NCQA), which grades health plans on more than 60 indicators, including quality of care, access and availability of care, and satisfaction with the experience of care. To find HEDIS scores for your current health plan or a plan you're considering, visit www.ncqa.org.

HIPAA

Stands for Health Insurance Portability and Accountability Act of 1996. Legislation that addresses pre-existing conditions, discrimination based on health status, renewal of coverage and privacy/confidentiality issues, among other concerns. "Portability" refers to your ability to keep health coverage when switching employers or health plans. "Accountability" refers to a health plan's obligation to safeguard health care business transactions and private information.



For more information about HIPAA and other health care laws, visit the U.S. Department of Labor's website www.dol.gov/dol.pwba, or the National Partnership for Women and Families' website, www.nationalpartnership.org.



HMO

Stands for Health Maintenance Organization. An HMO is a type of health plan that offers prepaid coverage for medical services when you receive care through a primary care physician (PCP) who belongs to the HMO network. In an HMO many services are covered at 100% after you make a small copayment. Benefits for non-emergency care are covered only when you receive care from a PCP or a PCP-referred network specialist.

Indemnity

An indemnity health plan is a "fee-for-service" plan that allows you to receive care from any licensed health care provider. Your health expenses are reimbursed after you meet a deductible and pay a certain percentage of the expense (coinsurance).

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The Joint Commission on Accreditation of Healthcare Organizations is an accrediting organization best known for hospital accreditation. However, JCAHO also accredits HMOs, evaluating such factors as how care is provided, how the staff is managed and how routine and preventive care are promoted and provided (www.jcaho.org).

Malpractice

Improper or negligent treatment of a patient by a provider that results in damage or injury.

Managed Care

An approach to health care that seeks to balance quality and cost by:

- Putting an emphasis on prevention and wellness through benefit incentives and special programs;
- Creating networks of health care providers and facilities that charge negotiated fees;
- Coordinating care through primary care physicians;
- Monitoring the appropriateness and medical necessity of care; and
- Imposing quality measures and standards on the delivery of care.

Mandated Benefits

Coverages that health plans are required — by state and/or federal government — to provide. Examples of mandated benefits are length of maternity stays and reconstructive surgery after mastectomy.

Medically Necessary

Health care services are considered medically necessary if they are:

- Medically appropriate and needed to meet basic health needs;
- Consistent with the diagnosis or condition at hand; and
- Known to be effective in improving health outcomes, which is determined by scientific evidence and professional standards.

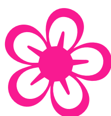
Check your coverage document to determine how medical necessity may be defined for your plan.

Medical Management

The name given to reviews that evaluate medical treatment according to recognized and accepted clinical guidelines and protocols.

NCQA

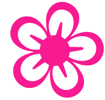
Stands for National Committee for Quality Assurance. The NCQA is an organization that evaluates and accredits health plans by applying more than 60 standards in six different categories. Each year the NCQA gathers information from managed care companies to compile “report cards” (see HEDIS®) that consumers can use to help them choose a health plan.



To view accreditation reports or HEDIS® scores on a health plan, visit www.ncqa.org.

Network/Provider Network

A network is a group of health care providers, hospitals and other health care providers and facilities organized by a managed care company to provide health care. Networks are generally organized by ZIP Code in order to provide you and your family with easy access to local care.



Outcome
The result of health care, measured in terms of survival, complications and physical and mental health status.

POS Plan
A point-of-service plan, or POS plan, gives you freedom of choice at the "point-of-service." You may be required to select a PCP when you enroll. Then each time you need care, you decide whether to receive care coordinated by your PCP or not. Benefits are paid at a higher level when care is coordinated through your PCP and paid at a lower level when you seek care on your own.

Precertification
An advance review of the medical necessity of an inpatient hospital admission and, in some plans, certain outpatient procedures. Many managed care plans require precertification and reduce benefits if the precertification procedure is not followed.

Pre-existing Condition
A medical condition for which a person was diagnosed and/or received care within a certain number of days or months before coverage under a new plan became effective. Health plans often limit coverage for pre-existing conditions to a certain dollar amount or time limit. However, these limits must fall within those set by HIPAA regulations.

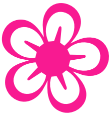
PPO
A preferred provider organization, or PPO, plan gives you the freedom to use any licensed health care provider or facility, but pays a higher level of benefits when you use a network provider.

PCP
A primary care physician, or PCP, is a health care provider who provides basic, routine care (such as checkups and certain health screenings) and referrals to specialty care. Your PCP functions as a care coordinator and health advocate, helping you navigate the health care system and understand the options available to you.

Provider
An individual (doctor or other health care professional) or facility (hospital) licensed to provide health care (including dental, vision and mental health/substance abuse) services, treatments and supplies.

Summary Plan Description
A detailed document that describes a health plan's benefits, coverage, policies, procedures and administration. A Summary Plan Description also includes information pertaining to a member's rights under COBRA, ERISA and HIPAA.

Utilization Management
The name given to reviews that seek to prevent the overuse, underuse or misuse of medical services, treatments and supplies.



Funding provided by: